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## A. References

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## B. Technical Notes

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### 1. Population Pyramids (Section II) Modified from the Canadian Statistical Reference Centre Website: <http://www.statcan.ca/english/kits/animat/pyone.htm>

The age-sex distribution of a population is an important feature to analyze if you wish to understand a country's demographic situation. A good way to illustrate the structure of a population is to graph the number of males and females for various ages. A horizontal bar graph with data for males on the left and females on the right is called a "population pyramid".

Vivian Z. Klaff describes age structure models (in *Dem-Lab: Teaching Demography Through Computers*, 1992 Prentice Hall) that range from an "expansive" population—with a high proportion of children, a rapid rate of population growth, and a low proportion of older people—to "stable" growth (e.g. Latinos in LAC), to "declining" population—with a high proportion of older persons and declining numbers (e.g. Whites in LAC).

### 2. Mode of Exposure and the redistribution of AIDS cases with "no identified risk"

Exposure categories are assigned in a hierarchical fashion, so that cases for which more than one exposure category have been identified are assigned to the category listed highest in the hierarchy. For example, a man who reports having sexual contact with another man and also reports having "heterosexual" contact with an HIV-positive woman would be classified as "male-male sexual contact", because that is the highest risk exposure category. The only exposure category that includes two risk exposures is the MSM-IDU category—that is, men who report both sexual contact with another man (MSM) as well as engaging in injection-drug use (IDU).

The "Undetermined" exposure category includes persons with no history of exposure to HIV through one of the defined exposure categories. If subsequent case investigation identifies a mode of exposure, the case is reclassified into the corresponding exposure category. For purposes of analysis, the number of cases with no identified risk (NIR) is distributed into one of the defined exposure categories proportionately, based upon the past pattern of reclassification of undetermined exposure cases.

### 3. Estimation of population size and HIV prevalence in Behavioral Risk Groups

Population sizes for BRGs were estimated using a variety of sources. The first was the 2002 population estimate based on the 2000 Census provided by the Data Collection and Analysis Unit of the LAC Health Assessment and Epidemiology Program, from data smoothed and projected by Dr. John Hedderson and Joyce Bixler of Walter R. McDonald & Associates of Sacramento, California.

Other population estimate sources include the LA Health Survey, the STD Clinic HIV database kept by Office of AIDS Programs and Policy, the 2001 Consensus meeting on HIV/AIDS Incidence and Prevalence in California, and the LAC Alcohol and Drug Program Administration. In addition, a variety of local research studies involving these behaviors and groups were used.



Because only AIDS and not all HIV have been reportable in LAC until recently, HIV prevalence for BRGs had to be estimated as well. These estimates were based on a CDC recommended formula for estimating all persons living with HIV from the number of persons living with AIDS. Using this formula, we estimate about 56,000 persons to be living in LAC with HIV/AIDS, of whom one in four are either unaware of their infection or have only tested anonymously. Again, a variety of sources were used to estimate HIV prevalence within each BRG. For further information on how population size and HIV prevalence were estimated for BRGs, please call Dr. Douglas Frye at HIV Epidemiology Program (ph. 213-351-8196).

#### **4. Comparing the odds of infection with TB and HIV for demographic groups**

The Odds Ratio describes the odds a person in one demographic group has of being co-infected with HIV and TB compared with a person in the referent group. Since the odds ratio is a statistical estimate, it is not exact. To account for this inherent error, a “95% confidence interval” is used to give a range of odds within which the “true” odds ratio will be 95% of the time. If the confidence interval does not include 1.0 (or even odds), then a person in one demographic group has “statistically significant” higher or lower odds of being co-infected than a person in the referent group.

For example, in Table 7.1, Blacks with active TB have significantly higher odds of being co-infected with HIV than do the referent group, Whites, because the 95% confidence interval of their odds ratio (1.4 - 2.9) is greater than 1.0. Similarly, in Table 7.2, among persons reported with AIDS, injection drug users have significantly higher odds of being co-infected with TB than do the referent group, MSM, because the 95% confidence interval of their odds ratio (2.2 - 2.9) is greater than 1.0.

#### **5. The Hepatitis C – HARS Database Match**

HIV Epidemiology Program worked with Acute Communicable Disease Control staff to do a match of persons reported in the HIV/AIDS Reporting System (HARS) database with persons reported as having any laboratory evidence of having been infected with the hepatitis C virus. The match was conducted within the premises of HIV Epidemiology Program’s core surveillance unit after deduplication of hepatitis cases was performed. To estimate prevalence of HIV-HCV co-infection for persons reported in HARS, HCV cases were matched against all cases in HARS, against those still living with AIDS, against those diagnosed with non-AIDS HIV, and against those reporting injection drug use. Matching criteria included last and first names (for AIDS cases), soundex, date of birth, gender, social security number, etc.) If you have any questions about the methods or results of this match, please contact either Dr. Douglas Frye at HIV Epidemiology Program (ph. 213-351-8196) or Virginia Hu, Data Analysis Unit Chief (ph. 212-351-8142).

## C. Population Ranking

Populations of Los Angeles County SPAs and individual U.S. states by rank as of the U.S. Census 2000.

1.	California	31.	Iowa
2.	Texas	32.	Mississippi
3.	New York	33.	Kansas
4.	Florida	34.	Arkansas
5.	Illinois	35.	Utah
6.	Pennsylvania	36.	Nevada
7.	Ohio	<b>37. SPA 2-San Fernando (1,981,961)</b>	
8.	Michigan	38.	New Mexico
<b>9.</b>	<b>Los Angeles County (9,519,338)</b>	39.	West Virginia
10.	New Jersey	<b>40. SPA 3-San Gabriel (1,734,254)</b>	
11.	Georgia	41.	Nebraska
12.	North Carolina	<b>42. SPA 8-South Bay (1,500,185)</b>	
13.	Virginia	43.	Idaho
14.	Massachusetts	<b>44. SPA 7-East (1,285,210)</b>	
15.	Indiana	45.	Maine
16.	Washington	46.	New Hampshire
17.	Tennessee	47.	Hawaii
18.	Missouri	<b>48. SPA 4-Metro (1,144,083)</b>	
19.	Wisconsin	49.	Rhode Island
20.	Maryland	<b>50. SPA 6-South (955,054)</b>	
21.	Arizona	51.	Montana
22.	Minnesota	52.	Delaware
23.	Louisiana	53.	South Dakota
24.	Alabama	54.	North Dakota
25.	Colorado	55.	Alaska
26.	Kentucky	56.	<b>SPA 5-West (613,191)</b>
27.	South Carolina	57.	Vermont
28.	Oklahoma	58.	District of Columbia
29.	Oregon	59.	Wyoming
30.	Connecticut	<b>60. SPA 1-Antelope Valley (305,400)</b>	

Source: *Key Indicators of Health*, available at: [www.lapublichealth.org](http://www.lapublichealth.org)

## D. Acronyms & Common Terms

ACRONYM/TERM	DESCRIPTION
<b>AA</b>	African American. A category to describe the racial/ethnic characteristics of individuals.
<b>AAC</b>	AIDS Action Council. AAC provides media and policy focus to federal AIDS legislative and policy issues.
<b>AAR</b>	Annual Administrative Report is required of all CARE Act Title I grantees, and provides information on agencies funded by CARE Act Title I.
<b>ACMS</b>	Automated Case Management System (IMACS). ACMS is a corporation that developed IMACS.
<b>ACRS</b>	AIDS Contractor Reporting System. ACRS is used by some providers of outpatient medical care in Los Angeles County to report the number of clients and services provided.
<b>ACTG</b>	AIDS Clinical Trial Group. A national group that advises the National Institutes of Health on clinical trials related to HIV/AIDS treatments.
<b>ADA</b>	Americans with Disabilities Act. Federal legislation designed to protect and ensure the rights of the disabled. The ADA protects people with HIV and AIDS.
<b>ADAP</b>	AIDS Drug Assistance Program. ADAP is supported by Title II of the CARE Act. In California, ADAP is funded by the Title II ADAP set-aside, state general funds, Title II general funds and a mandatory manufacturer's rebate.
<b>Adjustment</b>	When comparing an event or disease in two populations, the difference in composition of the two populations must be taken into account. For example, one population may be younger than the other, thus you would expect more heart disease in one, just because they are older. Or one population may have mostly women, while the other mostly men; so the rate of breast cancer in the first group will be higher. Adjustment uses statistical methods to allow you to compare two populations as if they both had the same age, sex, race, and/or other sociodemographic distribution, so that you can check for other factors of interest—such as risk behaviors—that might put a population at risk for disease.
<b>AETC</b>	AIDS Education Training Centers. The AETC are supported by Title IV of the CARE Act and are responsible for providing AIDS education to health care professionals.
<b>AI/AN</b>	American Indians/Alaskan Natives. A category to describe the racial/ethnic characteristics of individuals.
<b>AIDS</b>	Acquired Immune Deficiency Syndrome. Originally called GRID (gay related immune deficiency), the term "AIDS" was proposed by Bruce Voeller and adopted in July 1982. Most often caused by chronic infection with the human immunodeficiency virus, or HIV, a syndrome diagnosed when the host immune system is depressed or damaged to such an extent that the CD4+ lymphocyte cell count is below 200 cells per microliter, or when an opportunistic infection is shown to have caused illness.

ACRONYM/TERM	DESCRIPTION
<b>AMCWP</b>	AIDS Medi-Cal Waiver Program. Administered by the State of California, AMCWP supports in-home health and attendant care. See also MCWP.
<b>Anonymous HIV Testing</b>	Testing a person for HIV without the person having to give personal identifying information; all specimens are marked with a code number and cannot be linked to the person. Positive anonymous HIV tests are not reportable. (Compare Confidential HIV testing)
<b>Antibody</b>	Protein molecule produced by white blood cells to bind up and disable infectious agents, such as viruses and bacteria.
<b>Antigen</b>	Substance—such as a virus or bacterium—that provokes an immune response when introduced into the body. (See Antibody)
<b>Antiretroviral Therapy</b>	Drugs used specifically for the treatment of HIV disease. (See HAART, NNRTI, NRTI and Protease inhibitors)
<b>APHA</b>	American Public Health Association
<b>API</b>	Asian and Pacific Islanders. A category to describe the racial/ethnic characteristics of individuals.
<b>ARC</b>	AIDS Related Condition (Complex). Formerly used to denote a medium acuity of HIV disease.
<b>ARF</b>	Adult Residential Facility. A licensed category of care administered by the State of California.
<b>ARS</b>	Acute Retroviral Syndrome
<b>ASO</b>	AIDS Service Organization
<b>Asymptomatic</b>	Showing or having no symptoms. (See Incubation period)
<b>ATS</b>	Alternative Test Site, Anonymous Test Site. Anonymous testing for HIV is provided at ATS.
<b>AZT</b>	Azidothymidine (Zidovudine), the first medication approved for anti-retroviral therapy.
<b>Behavioral Risk Group (BRG)</b>	Behavioral Risk Group(s). For prevention planning purposes, seven mutually exclusive subpopulations identified to be at high risk for HIV; they are men who have sex with men (MSM); men who have sex with men and women (MSM/W); MSM and MSM/W who also inject drugs (MSM/IDU); heterosexual men who inject drugs (HMIDU); women at sexual risk (WSR), female injection drug users (FIDU); and transgendered men and women and their sexual/injection partners (TG).
<b>Bias</b>	Error not cause by chance in a study that leads to a distorted result.
<b>Blinded Study</b>	Study in which subjects are assigned one of the multiple treatments being compared against each other, in such a way that the subjects (single-blind) or both subjects and treating physicians (double-blind) are kept unaware of the actual treatment assigned to them.
<b>BY</b>	Budget Year. The number of months associated with a budget period. Budget years are not always twelve months long, do not always begin in January and vary among funding sources.

ACRONYM/TERM	DESCRIPTION
<b>Candidiasis</b>	Fungus that usually infects the mucous membranes, commonly occurring in the mouth (thrush) or in the vagina (yeast infection). These infections usually result in painful or burning red lesions with or without white spots.
<b>Case</b>	Occurrence of the disease or event of interest in a person.
<b>Case-control Study</b>	Observational study in which subjects are sampled based on the presence (cases) or absence (controls) of the disease of interest. Information is collected about prior exposure to potential risk factors for the disease of interest.
<b>Case fatality rate</b>	The proportion of persons with a particular disease who die from that disease within a year, compared with the number of new cases of the disease reported in the same year.
<b>CAPS</b>	Center for AIDS Prevention Studies.
<b>CARE Act</b>	Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, amended and reauthorized in 1995 and again in 2000.
<b>CARE/HIPP</b>	Health Insurance Premium Payment. Funded by Title II of the CARE Act and administered by the OA. CARE/HIPP will pay the insurance premium costs for eligible clients with HIV/AIDS. CARE/HIPP cannot be used to purchase a new insurance policy.
<b>CASC</b>	Community Assessment Service Centers.
<b>CBA</b>	Capacity Building Assistance.
<b>CBC</b>	Congressional Black Caucus. See also MAI.
<b>CBO</b>	Community Based Organization.
<b>CCLAD</b>	California Conference of Local AIDS Directors
<b>CCLHO</b>	California Conference of Local Health Officers
<b>CCU</b>	Crack Cocaine Users
<b>CD4 Cell</b>	Type of white blood cell that oversees the action of the human immune system and is the main target of HIV. Also known as the "helper T" cell.
<b>CD4 Cell Count</b>	A commonly used surrogate marker for assessing the state of the immune system. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal range of CD4 cell counts is 500 to 1500 per cubic millimeter of blood. CD4 counts are usually rechecked at least every six to 12 months for people with HIV and CD4 counts are greater than 500/mm <sup>3</sup> . If the count is lower, testing every three months is usual.
<b>CDBG</b>	Community Development Block Grant. A federal program designed to support housing and related services. Typically, the CDBG program is coordinated with local HOPWA programs.

ACRONYM/TERM	DESCRIPTION
<b>CDC</b>	The National Centers for Disease Control and Prevention is a federal agency within the U.S. Department of Health and Human Services based in Atlanta, Georgia. It administers HIV/AIDS prevention programs including the HIV Prevention Community Planning process, among other programs. It also monitors and reports infectious diseases, administers AIDS surveillance grants and publishes epidemiological reports such as the HIV/AIDS Surveillance Report.
<b>CDE</b>	California Department of Education
<b>CFR</b>	Code of Federal Regulations
<b>CHAC</b>	California HIV Advocacy Coalition. An umbrella advocacy organization for AIDS service organizations, government agencies and individuals with AIDS.
<b>CHEAC</b>	County Health Executive Association of California
<b>CHHS</b>	The Los Angeles County Commission on HIV Health Services serves as the planning body for Title I of the Ryan White Comprehensive AIDS Resources Emergency Act and all other publicly funded HIV services and programs administered by the Office of AIDS Programs and Policy.
<b>CHIPTS</b>	Center for HIV Identification, Prevention & Treatment Services
<b>Chlamydia</b>	Sexually transmitted disease (STD) caused by the bacteria Chlamydia trachomatis. In men, chlamydia is characterized by a discharge from the urethra (penis). In women, most will have no symptoms; if left untreated, however, pelvic inflammatory disease (PID) can develop, which can lead to chronic pain or infertility. Chlamydia is curable when treated with appropriate antibiotics.
<b>CHPG</b>	California HIV Planning Group Formed by the California Office of AIDS (OA) by merging the CCWG and the CPWG (Comprehensive Care Working Group and Community Prevention Working Group) at the end of 1999, the CHPG advises the OA on a wide variety of planning and policy issues.
<b>CLI</b>	Community level intervention
<b>CMP</b>	Case Management Program. See also HCBC
<b>COBRA</b>	Consolidated Omnibus Budget Reconciliation Act of 1985.
<b>Cohort</b>	Group of persons who share a common attribute – such as birth in a particular year – which is followed over time.
<b>Cohort Study</b>	Epidemiologic study in which a specified population (the cohort) is observed for long enough to calculate reliable disease incidence or mortality rates.
<b>Combination therapy</b>	Use of two or more drugs to fight infections. Combinations may be more effective in some ways than single-drug treatment.

ACRONYM/TERM	DESCRIPTION
<b>Comprehensive Planning</b>	The process of determining the organization and delivery of HIV services; strategy used by a planning body to improve decision making about services and maintain a continuum of care for PLWH
<b>Confidence interval (CI)</b>	Range of values for an estimate, such as a proportion or rate, that is believed to contain the true value within a specified level of certainty. For example, "95%CI=2-5" suggests that we have 95% confidence that the true rate lies between 2 and 5. Similar to Confidence Limit.
<b>Confidence limit (CL)</b>	Similar to confidence interval. The values for an estimate, such as a proportion or rate, between which the true value can be found within a specified level of certainty. For example, "95%CL=2, 5" suggests that we have 95% confidence that the true rate lies between 2 and 5.
<b>Confidential HIV testing</b>	Testing a person for HIV where his or her name is known or given; specimens are marked with a code number, but can be linked to a name. Positive confidential HIV tests are reportable. (Compare with Anonymous HIV testing)
<b>Confounding</b>	Systematic error in a study in which the effect of an exposure on the study outcome is distorted due to the exposure of other factor(s) that also have an influence on the outcome.
<b>Consortium (HIV Care Consortium)</b>	A regional or Statewide planning entity established by many State grantees under Title II of the CARE Act to plan and sometimes administer Title II services; an association of health care and support service providers that develops and delivers services for PLWH under Title II of the CARE Act
<b>Control</b>	Study subject without the disease of interest in a case-control study.
<b>Convenience sample</b>	Sample of study subjects selected without using those probabilistic methods needed to obtain a "random sample." It is precarious to generalize from the results of a survey based upon a convenience sample, as there is no way of knowing what sorts of biases may have been operating.
<b>Correctional institution</b>	Prison or jail.
<b>CPG</b>	Community Planning Group, a generic term used by the Centers for Disease Control and Prevention for groups planning prevention services.
<b>CPR</b>	Cardiopulmonary Resuscitation
<b>CPWG</b>	California Prevention Working Group. A CPG created by the State of California. The CPWG merged into the CHPG in 2000.
<b>CQI</b>	Continuous quality improvement
<b>CRAS</b>	Countywide Risk Assessment Survey
<b>CRC</b>	Community Resource Center (for referrals)
<b>Cross-sectional study</b>	Study that examines the relationship between diseases and other variables of interest as they exist in a defined population at one particular time—such as a one-time survey.
<b>CSAP</b>	Center for Substance Abuse Prevention

ACRONYM/TERM	DESCRIPTION
<b>CSAT</b>	Center for Substance Abuse Treatment
<b>CSW</b>	Commercial Sex Worker
<b>CTRPN</b>	Counseling, Testing, Referral & Partner Notification
<b>CTS</b>	Confidential Test Site
<b>Cumulative</b>	Pertaining to the total number; made up of accumulated parts.
<b>Cumulative incidence</b>	Risk of developing a particular disease within a specified period of time.
<b>Cumulative AIDS Rate</b>	The cumulative number of persons reported with AIDS during a specified period divided by the total population at the midpoint of that same period.  Example: Cumulative Number of AIDS cases reported in 1999-2001 ÷ 2000 LAC population (x 100,000)
<b>DCFS</b>	Department of Children and Family Services
<b>DDD</b>	Data Design & Development
<b>Demographic</b>	Pertaining to characteristics of a population—such as age, race/ethnicity and gender.
<b>DHHS</b>	Department of Health and Human Services
<b>DHS</b>	Department of Health Services
<b>DHS/OA</b>	Department of Health Services/Office of AIDS
<b>DOC</b>	Department of Corrections
<b>DOE</b>	Department of Education
<b>DPH</b>	Department of Public Health
<b>DPSS</b>	Department of Public Social Services
<b>DTC</b>	Drug Treatment Center
<b>EIA</b>	Enzyme Immunoassay
<b>EIP</b>	Early Intervention Program (see EIS)
<b>EIS</b>	Early Intervention Services.  Applied in the outpatient setting. Assures a continuum of care which includes (1) identifying persons at risk for HIV infection and offering to them counseling and testing services, and (2) providing lifelong comprehensive primary care for those living with HIV/AIDS
<b>ELISA</b>	Enzyme-Linked Immunosorbent Assay  Blood test which indicates the presence of antibodies to HIV. The HIV ELISA test does not detect the disease AIDS, but only indicates if HIV infection has occurred. (See also Western Blot test)



ACRONYM/TERM	DESCRIPTION
<b>EMA</b>	Eligible Metropolitan Area The geographic area eligible to receive Title 1 CARE Act funds. The Census Bureau defines the boundaries of the metropolitan area while AIDS cases reported to the CDC determines eligibility. Some EMAs include just one city and others are composed of several cities and/or counties; some EMAs extend over more than one state.
<b>EMSA</b>	Eligible Metropolitan Statistical Area
<b>Endemic rate</b>	The usual rate of occurrence of particular disease in a population.
<b>EPI</b>	Epidemiology - Study of the distribution and determinants of disease in a specified population in order to promote, protect and restore health in that population.
<b>Epidemic</b>	Dramatic increase above the usual or expected rate of occurrence of a particular disease in a population.
<b>Epidemiology</b>	Study of the distribution and determinants of disease in a specified population in order to promote, protect and restore health in that population.
<b>Exposure</b>	Contact with a factor that is suspected to influence the risk for a person developing a particular disease.
<b>FIDU</b>	Female injection drug user.
<b>FY</b>	Fiscal Year. See also Budget Year
<b>GAO</b>	General Accounting Office
<b>Gender</b>	Term or variable to classify persons as male or female; recent gender categories may now include both male-to-female and female-to-male transgender.
<b>GHPP</b>	Genetically Handicapped Person Program
<b>GLI</b>	Group Level Intervention
<b>Gonorrhea</b>	Common sexually transmitted disease caused by the organism <i>Neisseria gonorrhoeae</i> ; it is often abbreviated "GC". GC is often used as a surrogate to identify persons at sexual risk for HIV transmission. GC is curable when treated with appropriate antibiotics.
<b>Grantee</b>	The recipient of state or federal funds responsible for administering the funds.
<b>HAART</b>	Highly Active Antiretroviral Therapy Combination of three or more anti-HIV drugs, of which at least one is usually a protease inhibitor. Aggressive anti-HIV treatment usually including a combination of protease and reverse transcriptase inhibitors whose purpose is to reduce viral load to undetectable levels.
<b>HAB</b>	HIV/AIDS Bureau. The entity within HRSA responsible for administering the CARE Act.
<b>HARS</b>	HIV/AIDS Reporting System; surveillance database containing HIV and AIDS reports.

ACRONYM/TERM	DESCRIPTION
<b>HCFA</b>	Health Care Financing Administration
<b>HCT</b>	HIV counseling and testing
<b>Hepatitis</b>	Inflammation of the liver; often caused by viruses, drugs, or other chemicals.
<b>Hepatitis A</b>	Called "infectious hepatitis." Form of viral hepatitis caused by the hepatitis A virus (HAV). HAV may be transmitted through oral contact with infected feces (stool) or surfaces and objects recently contaminated with infected feces. Usually causes mild illness that resolves within weeks.
<b>Hepatitis B</b>	Called "serum hepatitis." More severe form of viral hepatitis caused by the hepatitis B virus (HBV). HBV may be transmitted through contact with infected blood, saliva, seminal fluid, vaginal secretions, and breast milk. With persistent disease, may lead to cirrhosis, liver failure, and/or death.
<b>Hepatitis C</b>	Once called "Non-A/non-B hepatitis." Severe form of viral hepatitis caused by the hepatitis C virus (HCV). HCV is most often transmitted through contact with infected blood, but may also be transmitted through contact with other body fluids. Persists for decades, leading to cirrhosis, liver failure, and/or death.
<b>Hepatocellular carcinoma</b>	Liver cancer. Often associated with chronic hepatitis B or C disease.
<b>HERR</b>	Health Education Risk Reduction
<b>HICCP</b>	Health Insurance Continuum of Coverage Program
<b>HICP</b>	Health Insurance Continuation Program
<b>HIPP</b>	Health Insurance Payment Premium
<b>HIRS</b>	OAPP's HIV Information Resources System
<b>HIV</b>	Human Immunodeficiency Virus. Infection with HIV is the usual cause of Advanced HIV Disease, or AIDS. (See AIDS)
<b>HIV Epidemiology Program</b>	Los Angeles County program that collects, analyzes, and disseminates HIV/AIDS surveillance and epidemiologic study data essential for the planning, implementation, and evaluation of programs and policies involving HIV and AIDS care, prevention, education, and research in Los Angeles County.
<b>HMO</b>	Health Maintenance Organization
<b>HOPWA</b>	Housing Opportunities for People with AIDS. A federal program designed to support housing and related services for people with HIV and their families. The City of Los Angeles is the grantee for HOPWA funds to be used in the County of Los Angeles.
<b>HPV</b>	Human Papilloma Virus
<b>HRSA</b>	The Health Resources and Services Administration is the agency of the Department of Health and Human Services that administers all components of the Ryan White CARE Act.
<b>HTTP</b>	HIV Transmission Prevention Project

ACRONYM/TERM	DESCRIPTION
<b>ICF</b>	Intermediate Care Facility
<b>IDU</b>	Injection Drug User. Person who injects illicit drugs into their body, usually to get high.
<b>IGA</b>	Intergovernmental Agreement
<b>IHMC</b>	In-Home Medical Care
<b>IHSS</b>	In-Home Support Service
<b>ILI</b>	Individual Level Intervention
<b>Immunology</b>	Study of the body's response to foreign organisms and how humans and other animals fight off disease-causing microorganisms, such as viruses and bacteria.
<b>Immuno-suppressed</b>	State of the body where immune system defenses do not work normally. This can be the result of an immune deficiency from birth, an illness such as cancer or AIDS, or from the administration of certain drugs.
<b>Incarcerated person</b>	Person who is in prison or jail.
<b>Incidence</b>	The number of new cases of a disease that occur during a specified time period.
<b>Incidence Rate</b>	Rate at which new events, such as cases of a particular disease, arise in a given population—for instance, the number of new cases diagnosed in 1 year divided by the population at risk in that same year. Example: In 1998, 1700 persons were diagnosed with AIDS in LAC. The 1998 population estimate for LAC was 9,693,353. Therefore, the 1998 AIDS Incidence Rate = $1700 \div 9,693,353 \times 100,000 = 17.5$ per 100,000.
<b>Incubation period</b>	Period of time between contact with an infectious agent and the first clinical evidence of illness resulting from that infection.
<b>Independent variables</b>	Variables that are thought to explain or predict an outcome or event.
<b>IV</b>	Intravenous
<b>IVDU</b>	Intravenous Drug User (see IDU)
<b>JCAHCO</b>	Joint Commission on Accreditation of Health Care Organizations
<b>KABB</b>	Knowledge, Attitudes, Beliefs and Behaviors — used in outcome measurement of HIV programs
<b>Karnofsky Performance Status Scale</b>	Scale that measures physical function (activities of daily living). The Karnofsky scale is often used to assess eligibility for in-home or other supportive services.
<b>KS</b>	Kaposi's Sarcoma, a form of cancer associated with HIV disease.
<b>LAC</b>	Los Angeles County
<b>LAO</b>	Legislative Analyst's Office. The LAO provides objective analysis of legislation and policy options for the State of California.

ACRONYM/TERM	DESCRIPTION
<b>Latent period</b>	See Incubation period.
<b>LCSW</b>	Licensed Clinical Social Worker
<b>Lead Agency</b>	The agency within a consortium responsible for contract administration; also called a fiscal agent.
<b>LHJ</b>	Local Health Jurisdiction
<b>LIG</b>	Local Implementation Group. See CPG.
<b>LOI</b>	Letter of Intent
<b>Longitudinal study</b>	See Cohort study.
<b>LVN</b>	Licensed Vocational Nurse
<b>MAI</b>	Minority AIDS Initiative. The Congressional Black Caucus (CBC) took leadership in 1998 to create the CBC Initiative, now known as the Minority AIDS Initiative, a source of funding for HIV/AIDS care and prevention services to communities of color.
<b>Marker</b>	Substitute measure, or proxy, for an event or disease that cannot readily be measured by any other method.
<b>MCWP</b>	Medi-Cal Waiver Program.
<b>Median</b>	That value which divides a set of measurable values into 2 equal halves, such that half of all values are above the median, and half are below. For example, the median age of study participants was 35 years.
<b>MFCC</b>	Marriage, Family, and Child Counselor. See MFT.
<b>MFT</b>	Marriage and Family Therapist (formerly MFCC), a certification given by the State of California.
<b>MGA</b>	Master Grant Award. A mechanism used by the State of California to allocate funds to local health jurisdictions.
<b>MICRS</b>	Medically Indigent Care Reporting System
<b>Migration</b>	Movement from one area or jurisdiction to another.
<b>MLB</b>	Multicultural Liaison Board. Convened and supported by the State of California Office of AIDS, the MLB reviews materials for cultural appropriateness and likely effectiveness and advises the OA.
<b>MMWR</b>	Morbidity and Mortality Weekly Report. A publication of the CDC. The first cases of what we now know as AIDS were reported in the MMWR on June 5, 1981.
<b>MOA</b>	Memorandum of Agreement
<b>MOE</b>	See Maintenance of Effort
<b>MOU</b>	Memorandum of Understanding
<b>MSM</b>	Men who have Sex with Men. MSM defines individuals by behavior, and is inclusive of gay men, as well as those men who have sex with other men but do not identify themselves as gay.
<b>MSMW</b>	Men who have sex with men and women, no matter how they identify themselves.

ACRONYM/TERM	DESCRIPTION
<b>MTU</b>	Mobile Testing Unit
<b>NAPWA</b>	The National Association of People with AIDS It represents the health, public policy, HIV -treatment and prevention issues of people living with HIV disease.
<b>NASTAD</b>	The National Alliance of State and Territorial AIDS Directors It represents the AIDS Directors of states and local health jurisdictions directly funded by the CDC (currently Chicago, Houston, Los Angeles, New York City, Philadelphia, San Francisco) on legislative, administrative, policy, budget, and appropriation issues in Washington, D.C.
<b>Needs Assessment</b>	A systematic process to determine the service needs of a defined population; a definition of the extent of need, available services, and service gaps by population and geographic area.
<b>NEP</b>	Needle Exchange Program
<b>NGO</b>	Non-Governmental Organization
<b>NIAID</b>	National Institute of Allergies and Infectious Disease
<b>NIDA</b>	National Institutes on Drug Abuse
<b>NIH</b>	The National Institutes of Health The federal agency that includes 24 separate research institutes and centers, among them the National Institute of Allergy and Infectious Diseases, the National Institute of Mental Health, and National Institute of Drug Abuse. Within the office of the NIH Director is the Office of AIDS Research, which is responsible for planning, coordinating, evaluating, and funding all NIH AIDS research.
<b>NIJ</b>	National Institute of Justice
<b>NIMH</b>	National Institute of Mental Health
<b>NIR</b>	No identified risk; cases of HIV or AIDS in which no risk behavior for infection was identified.
<b>NLM</b>	National Library of Medicine
<b>NMAC</b>	The National Minority AIDS Council provides technical assistance to community-based minority providers, public policy support and sponsors the annual US conference on AIDS.
<b>NORA</b>	National Organizations Responding to AIDS. About 150 organizations- AIDS specific and non-AIDS specific-who advocate at the national level on AIDS policy and appropriations.
<b>NRTI (“nuke”)</b>	Nucleoside/nucleotide Reverse Transcriptase Inhibitor. Antiretroviral drug that works by interfering with the elongation of the viral chain during viral DNA synthesis; includes ddl, ddC, D4T, 3TC, AZT, abacavir, lamivudine, tenofovir.

ACRONYM/TERM	DESCRIPTION
<b>NNRTI</b> (“non-nuke”)	Non-Nucleoside Reverse Transcriptase Inhibitor. Antiretroviral drug that works by interfering with the elongation of the viral chain during viral DNA synthesis; includes nevirapine, efavirenz, delavirdine.
<b>Non-named code</b>	Code required by regulation for use when reporting new cases of HIV infection in California; includes alphanumeric code (based on last name), date of birth, gender, and last four of social security number.
<b>Non-gonococcal urethritis</b>	NGU. Sexually transmitted disease that causes inflammation of the urethra, but not caused by gonorrhea—most commonly, it is caused by Chlamydia trachomatis. (See Chlamydia)
<b>OA</b>	Office of AIDS. The entity within the California Department of Health Services responsible for planning and administration for AIDS services within the state.
<b>OAPP</b>	The Los Angeles County Office of AIDS Programs and Policy (OAPP) was established in 1985 in the Department of Health Services, Public Health. The office directs the overall response to the HIV/AIDS epidemic in Los Angeles County.
<b>Odds ratio</b>	Odds of a person with a disease of interest having a particular exposure divided by the corresponding odds of a person without the disease of interest having the same particular exposure.
<b>OMB</b>	Office of Management and Budget Office within the Federal executive branch, which prepares the President's annual budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulation.
<b>OMH</b>	The Office of Minority Health (OMH) is a component of the Office of the Secretary (OS) within the Department of Health and Human Services. It attempts to provide support to and focus on the many health issues that disproportionately impact communities of color.
<b>ONAP</b>	The Office of National AIDS Policy Created by President Clinton, within the White House, to provide focus on the HIV/AIDS epidemic at the highest level of government.
<b>OI</b>	Opportunistic Infections are diseases caused by agents commonly present in our bodies or environment but only cause illness when the host immune system becomes damaged or depressed—as in AIDS.
<b>Pandemic</b>	Epidemic occurring over a very wide area, crossing international boundaries and usually affecting a large number of people.
<b>PCM</b>	Prevention Case Management
<b>PCP</b>	Pneumocystis Carinii Pneumonia
<b>PCRS</b>	Partner Counseling and Referral Service
<b>PEP</b>	Post Exposure Prophylaxis

ACRONYM/TERM	DESCRIPTION
<b>Planning Council</b>	A body appointed or established in an EMA which plans the delivery of HIV care services in the EMA and establishes priorities for the use of Title I CARE Act funds.
<b>PLWA</b>	Persons Living With AIDS
<b>PLWH</b>	Persons Living with HIV
<b>PLWH/A</b>	Persons Living with HIV or AIDS
<b>PMDC</b>	Professional Management Development Corporation. A corporation contracted to manage the California AIDS Drug Assistance Program (ADAP).
<b>Point prevalence</b>	Number of persons with a disease or an attribute at a specified point in time
<b>POPA</b>	People of Positive AIDS. POPA is a coalition of members of the California HIV Planning Group.
<b>PPC</b>	The Prevention Planning Committee is a select committee of the Los Angeles County Commission on HIV/AIDS Health Services, which makes ongoing evidence-based recommendations on the full range of HIV prevention activities in Los Angeles County.
<b>PPP</b>	Public Private Partnership. A PPP is a contractual between the Los Angeles County Department of Health Services and non-profit health care providers to support health care to indigent clients.
<b>Prevalence</b>	Proportion of persons in a given population who have a particular disease at a specified point or interval of time.
<b>Prevalence Rate</b>	The number of persons living with AIDS at a specified time divided by the total population at that same time. Example: In 1998 there were 15,652 persons living with AIDS in LAC. The 1998 population estimate for LAC was 9,693,353. Therefore, the 1998 AIDS Prevalence Rate = $15,652 \div 9,693,353 \times 100,000 = 161.5$ per 100,000.
<b>Priority Setting</b>	The process used by a planning council or consortium to establish numerical priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority
<b>Probability sample</b>	See Random sample.
<b>Prophylaxis</b>	Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has been brought under control. (Secondary prophylaxis or maintenance therapy).
<b>Proportion</b>	Ratio of a part of the whole to the whole.
<b>Prospective study</b>	See Cohort study.

ACRONYM/TERM	DESCRIPTION
<b>Protease</b>	An enzyme that triggers the breakdown of proteins. HIV's protease enzyme breaks apart long strands of viral protein into the separate proteins constituting the viral core and the enzymes it contains. HIV protease acts as new virus particles are budding off a cell membrane.
<b>Protease Inhibitor</b>	Antiretroviral drug that works by binding to and blocking HIV protease from working, thus preventing the assembly and release of new infectious viral particles from an infected white blood cell; includes indinavir, ritonavir, saquinavir, nelfinavir, lopinavir, and amprenavir.
<b>QA</b>	Quality Assurance
<b>QI</b>	Quality Improvement
<b>Random sample</b>	Sample in which all individuals have a precisely defined chance of being selected.
<b>Rate</b>	Measure of the frequency of a disease in a specified population during a specified period of time; used to compare the impact of a disease on one subpopulation compared with others; also to monitor the impact on groups across time. (See Cumulative AIDS rate, Incidence rate, and Prevalence rate)
<b>Report delay</b>	Period between the date a reportable disease is diagnosed by a physician and the date that the diagnosis is reported to public health officials; reason reliable and accurate data only available after a period of months to years after diagnosis.
<b>Retrovirus</b>	A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.
<b>Reverse Transcriptase</b>	A uniquely viral enzyme that constructs DNA from an RNA template, which is an essential step in the life cycle of a retrovirus such as HIV. The RNA-based genes of HIV and other retroviruses must be converted to DNA if they are to integrate into the cellular genome.
<b>RFA</b>	Request for Application
<b>RFP</b>	Request for Proposals An open and competitive process for selecting providers of service (sometimes called RFA or Request for Application).
<b>Risk ratio</b>	Likelihood of a particular disease occurrence among persons exposed to a given risk factor divided by the corresponding likelihood among persons not exposed.
<b>RTI</b>	Reverse Transcriptase Inhibitor. A drug that binds to HIV reverse transcriptase and blocks it from working, thus preventing the production of new functional viral particles.
<b>Salvage Therapy</b>	A therapy strategy for people for whom treatments have failed. Salvage therapy is usually a therapy of last resort.



ACRONYM/TERM	DESCRIPTION
<b>SAMHSA</b>	The Substance Abuse and Mental Health Services Administration. Agency within the Department of Health and Human Services that administers state block grant funds for substance abuse and mental health services and directs service grants to community-based organizations serving individuals living with HIV/AIDS and substance abuse or mental health issues.
<b>Sample</b>	Subset of a population that is chosen for investigation. (See Convenience sample and Random sample)
<b>SAMs</b>	Self Assessment Modules Self-assessment tools for planning councils and consortia
<b>SCSN</b>	Statewide Coordinated Statement of Need A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination. The SCSN process is convened by the Title 11 grantee, with equal responsibility and input by all programs; representatives must include all CARE Act titles and Part F managers, providers, PLWH, and public health agency(s).
<b>SDI</b>	State Disability Insurance
<b>Seroconvert</b>	Positive blood serum test indicative of HIV infection in a person with a history of having been negative at last HIV test.
<b>Serology</b>	Study of the components and properties of a patient's blood serum—for example, serum antibodies to HIV. (See below)
<b>Seroprevalence</b>	Proportion of a specified population who have antibodies to a particular organism in their blood serum—for instance, HIV.
<b>Seroprevalence Report</b>	A report that provides information about the percent or rate of people in specific testing groups and populations who have tested positive for HIV.
<b>Serorevert</b>	In an uninfected infant born to an HIV-infected mother, process in which maternal HIV antibodies that were measurable in the blood at birth disappear over time, thereby reverting to HIV negative.
<b>Serostatus</b>	Status with respect to being seropositive or seronegative for a particular antibody—for example, for HIV.
<b>Sexual risk</b>	Person is said to be at sexual risk for HIV when engaging in sexual intercourse—penile-vaginal, penile-anal, or penile-oral—with a partner who is either HIV-infected or at high risk for being HIV-infected, and without the use of a protective barrier, such as a condom.
<b>Sexually exposed</b>	Exposure to an infectious agent as a result of sexual intercourse with an infected partner.
<b>SNF</b>	Skilled Nursing Facility. SNF is a licensure category administered by the State of California.
<b>SOC</b>	Share of Cost. The payment required by individuals to receive MediCal benefits. For very low-income individuals, the share of cost is zero.

ACRONYM/TERM	DESCRIPTION
<b>SPA</b>	Service Planning Area. One of eight geographic subdivisions of Los Angeles County established to decentralize public health service administration into regional areas more responsive to local needs.
<b>SPN</b>	Service Provider Network
<b>SPNS</b>	Special Projects of National Significance A health services demonstration, research, and evaluation program funded under Part F of the CARE Act or by HOPWA.
<b>SRO</b>	Single Room Occupancy. Usually a kind of residence hotel, frequently used for temporary housing for very low-income individuals.
<b>SSDI</b>	Social Security Disability Insurance
<b>Statistical power</b>	Relative frequency with which a true difference of specified size between populations would be detected by the proposed experiment or test.
<b>Statistically significant</b>	The finding of an observed difference between two or more samples is described as statistically significant when it can be demonstrated that the probability of obtaining such a difference by chance alone, is low. It is customary to describe one's finding as statistically significant, when the observed result would occur by chance no more than 5 times out of 100.
<b>STD</b>	Sexually transmitted disease; disease spread from one sexual partner to another as a result of sexual activity—usually through sexual intercourse. Synonymous with VD, STI.
<b>STI</b>	Sexually Transmitted Infection
<b>Superinfection</b>	The recent transmission of a new and different strain of HIV to an already HIV-infected person. The risk for the superinfected person is that this new strain of HIV may have a different drug-resistance pattern than their original infection and that this may result in their HIV disease progressing more rapidly.
<b>Surveillance</b>	Systematic and ongoing collection and analysis of information about a disease within a population, followed by the timely distribution of that information to those who need to know so that action can be taken.
<b>Surveillance Report</b>	A report providing information on the number of reported cases of a disease such as AIDS, nationally and for specific sub-populations.
<b>Synergistic effect</b>	Interaction of discrete agents—for example anti-retroviral drugs, or different viruses) such that the combined effect is greater than the sum of the individual effects.
<b>Syphilis</b>	Infectious disease—spread either sexually or from infected mother to her newborn—caused by the bacterial organism <i>Treponema pallidum</i> ; also known as “lues” and “bad blood”. Syphilis is curable when treated with appropriate antibiotics.
<b>TA</b>	Technical assistance
<b>TANF</b>	Temporary Aid for Needy Families. A State of California program for low-income families. Formerly AFDC.
<b>TAR</b>	Treatment Authorization Request. A TAR authorizes a treatment or therapy for Medi-Cal reimbursement.

ACRONYM/TERM	DESCRIPTION
<b>Target Population</b>	A population to be reached through some action or intervention; may refer to groups within specific demographic or geographic characteristics.
<b>TB</b>	Tuberculosis. Disease caused by the highly infectious microorganism, <i>Mycobacterium tuberculosis</i> ; is spread through spitting and coughing of infected mucus or from ingestion of unpasteurized infected cow's milk. TB is an AIDS-defining opportunistic infection.
<b>TG</b>	Transgender at sexual risk and/or injection drug user and their partner(s)
<b>Transmission Category</b>	A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include injection drug use, men who have sex with men, heterosexual contact, perinatal transmission etc.
<b>Trichomonas vaginitis</b>	STD caused by the one-celled protozoan, <i>Trichomonas vaginalis</i> . In women, disease may produce no symptoms or cause a vaginal discharge. In men, infection is usually without symptoms, but can survive and hide in the male urethra or prostate, allowing for further sexual transmission of the organism. <i>Trichomonas vaginitis</i> often co-exists with other STDs, and is curable when treated with the appropriate antibiotic.
<b>UARP</b>	University-wide AIDS Research Program. This is a program of the University of California, with research centers and projects at multiple sites.
<b>Unique identifier</b>	A code used as a substitute for a person's identifying information—such as name, birthdate, and address—and that can be retraced to a unique person. (Compare Anonymous HIV testing and Non-name code)
<b>Unlinked HIV test</b>	Test in which all blood specimens tested for HIV are marked with a code number that cannot be linked to the patient's name. (See also Anonymous HIV testing)
<b>UR</b>	Utilization Review
<b>Urethra</b>	The canal in humans and other mammals that carries off urine from the bladder; in the mammalian male, the urethra also functions as a duct for semen transit during ejaculation.
<b>URS</b>	Uniform Reporting System. A system developed by HRSA to standardize data collected on CARE Act clients and services.
<b>VD</b>	Venereal Disease. See STD.
<b>Venue</b>	In epidemiological research, a place or location for the observation or interviewing of subjects in a study.
<b>Viral Load</b>	The amount of HIV RNA per unit of blood plasma. Indicates virus concentration and reproduction rate. HIV viral load is also used as a predictor of diseased progression. It can be measured by PCR or bDNA tests and is expressed in number of copies of or equivalents to the HIV RNA genome per milliliter of plasma.

ACRONYM/TERM	DESCRIPTION
<b>Viremia</b>	The presence of virus in blood or blood plasma. Plasma viremia is a quantitative measurement of HIV levels similar to viral load but is accomplished by seeing how much of a patient's plasma is required to spark an HIV infection in a laboratory cell culture.
<b>VNA</b>	Visiting Nurses Association. An organization (including affiliates in many parts of California) that provides home health and attendant care.
<b>Western Blot</b>	Blood test used to detect HIV antibody; most often used to confirm the results of a positive ELISA test. (See also ELISA test)
<b>WHO</b>	World Health Organization, an entity within the United Nation, headquartered in Switzerland.
<b>Window period</b>	Time period between initial infection with a disease and the time when the antibodies can be measured. In HIV infection, the window period is usually between 2 - 12 weeks after infection.
<b>WSR</b>	Women at sexual risk and their partners

**Sources:**

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## E. Description of Selected Research Studies by Priority Population

### ■ General Research

#### ***Community Health Study – (CHIPTS)***

Understanding the HIV epidemic in Los Angeles requires establishing an integrated, multilevel surveillance system for HIV, sexually transmitted diseases (STDs), and the Hepatitis C virus (HCV). Information about sexual and substance use risk behaviors, HIV seroprevalence, and public knowledge, attitudes, and norms regarding HIV are needed for public health planning. Before any comprehensive surveillance system can be established, the ability to monitor HIV in community settings and among households in neighborhoods with high rates of AIDS cases must be established. To fill this gap, a two-phase project is being initiated by the City of Los Angeles in order to assess the acceptability of HIV testing and reporting one's risk behaviors when approached: (1) in a household survey; or (2) in a neighborhood setting such as a shopping mall, grocery center, theater, or church.

#### ***The Context of HIV Infection Project or "CHIP"***

Past studies have documented that the distribution of HIV infection among risk and demographic groups in the United States has shifted over time.<sup>1,2,3</sup> The epidemic, once primarily affecting White men who have sex with men, is now a growing concern for communities of color. In 1989, African Americans and Latinos represented 40% of all AIDS cases reported in Los Angeles County. In 2000, this proportion had increased to over 60%. Since old approaches to HIV prevention are unlikely to be effective among these and other emerging risk groups in Los Angeles, there is an urgent need to study the psychological, behavioral and environmental factors associated with recent HIV infections to guide the development of salient HIV prevention programs that target the populations at the leading edge of the epidemic. Previous research has had limited success in identifying the factors associated with recent HIV infection, because methods to identify large numbers of recently infected persons have been unavailable.

Fortunately, a major advancement in laboratory testing, the Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS), makes it easier to differentiate persons with recent HIV seroconversion from those who became infected more than 12 months prior to testing.<sup>4</sup> STARHS technology has already been used successfully to estimate HIV incidence rates in clinic-based study populations using stored serum specimens.<sup>3,5,6</sup> In the "Context of HIV Infection Project" (CHIP), STARHS technology will be used to identify persons with evidence of recent HIV infection and compare them to a group of HIV seronegatives in order to identify the contextual factors associated with recent HIV seroconversion, as well as missed opportunities to prevent more recent HIV transmission.

#### ***Objectives***

There are two main objectives for the study:

- 1) To identify and understand factors associated with recent HIV infection, and
- 2) To identify missed HIV prevention opportunities that could have averted recent HIV infection.

#### ***Contact Persons***

Ekow Kwa Sey, Project Epidemiologist, 213-351-8199  
Trista Bingham, Principal Investigator, 213-351-8175.

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### **Finding and Characterizing Persons with Recent and Newly Diagnosed HIV Infection in Metro and South Service Planning Areas – (HIV Epidemiology)**

HIV incidence data are needed to prioritize resources for prevention and care. This information has not been easy to obtain using methods available in the past. Until recently, a handful of methods including back-calculation from AIDS case reports have been used to estimate HIV incidence. These methods have never provided a complete picture of the HIV epidemic; at most, they provide estimates for specific segments of the population or for people who voluntarily test for HIV. The development of the Serologic Testing Algorithm for Recent HIV Seroconversions provides a mechanism for estimating HIV incidence using cross-sectional data and blood specimen collection in a community.

By targeting research efforts on those individuals who are newly diagnosed, relevant information concerning changing behaviors and attitudes can be evaluated. In addition, the referral patterns of those recently diagnosed can be evaluated to determine if prevention services, HIV-related health care, and social support services are being accessed appropriately. By evaluating how new infections are occurring, who is becoming infected, and whether newly infected persons are receiving referrals and appropriate services, the County will be able to obtain crucial scientific information for resource prioritization.

### **Objectives**

Project One addresses these gaps in information by integrating two main study components in selected geographic areas (Chicago, Dallas, and Los Angeles). The main components are: 1) estimating HIV incidence in at-risk populations in the Los Angeles County jails and in "Skid

Row" single resident occupancy (SRO) hotels among IDUs, MSM, and HRHs; and 2) in the "Behavioral and Viral Characterization Study," the objective is to identify and describe the socio-demographic, behavioral and viral characteristics of recently infected and newly diagnosed individuals. Those found to be recently infected are subsequently referred to the "Context of HIV Infection Project".

**"HARS" (HIV/AIDS Reporting System) – (HIV Epidemiology Program)**

AIDS case surveillance is a core public health activity that has been the responsibility of the HIV Epidemiology Program since its inception. Non-AIDS HIV surveillance was mandated by California regulation starting in July 2002. These activities are supported by a grant from the State Office of AIDS and by federal funding through a cooperative agreement with the Centers for Disease Control and Prevention (CDC). HIV and AIDS surveillance activities are divided among three units, Data Acquisition Unit, Data Analysis Unit, and Pediatric HIV/AIDS Infection Reporting (PHIR).

The Data Acquisition unit is responsible for coordinating and conducting all activities relating to the identification and reporting of adolescent and adult HIV and AIDS cases. Surveillance activities are conducted through a comprehensive network of reporting sources, such as public and private hospitals and clinics, health maintenance organizations, vital registries, other disease control programs, public and private laboratories, and community-based organizations in collaboration with other counties and states. Historically, the Data Acquisition unit has reported 35% of all AIDS cases in California and 5-6% of all AIDS cases nationally. Only four states have reported more cumulative AIDS cases than Los Angeles County and only New York City has more cases among major metropolitan areas.

The Data Analysis unit is responsible for the maintenance of the AIDS case registry, analysis and dissemination of AIDS case data. The Data Analysis staff are responsible for maintaining the integrity of the database and routinely monitor the database for errors, incomplete information, and inconsistencies. AIDS surveillance data are analyzed and summarized on an ongoing basis. The HIV/AIDS Surveillance Summary is distributed semi-annually to more than 1,200 persons, including physicians, hospital infection control practitioners, laboratory personnel, representatives of community based organizations, public health officials, the news media, local government officials, and researchers. The Data Analysis unit also responds to an average of 30 requests for special analyses and summary reports each month.

PHIR includes the Enhanced Perinatal Surveillance project and works off site in close collaboration with Pediatric Spectrum of Disease project staff under the direction of Acute Communicable Disease Control (at <http://lapublichealth.org/acd/pediatric.htm>).

**Objectives:**

1. Conduct active and passive name-based surveillance of AIDS cases and non-AIDS HIV surveillance using a coded-identifier to monitor HIV/AIDS morbidity and mortality in adults, adolescents, and children and to monitor perinatal exposure to HIV.
2. Conduct follow-up investigations of cases of special epidemiologic significance.
3. Conduct interstate reciprocal notification of newly identified HIV/AIDS cases.
4. Ensure that case-finding activities and data management are conducted in a manner that ensures the security and confidentiality of HIV/AIDS surveillance data.

5. Conduct activities to evaluate and improve the quality, efficiency, and productivity of the core surveillance units to ensure that CDC criteria for reporting timeliness, completeness, and accuracy are met.
6. Report HIV/AIDS surveillance data using CDC standards and software.
7. Analyze and disseminate HIV/AIDS surveillance data and promote the use of these data in local prevention and health services planning and evaluation.
8. Implement projects to supplement the information available through HIV/AIDS case reporting to enhance HIV prevention and care planning.

### ***HIV Testing Survey 2002 - or "HITS"***

Since the AIDS epidemic was first identified in the United States in 1981, population-based AIDS surveillance has been used to track the progression of the HIV epidemic<sup>1</sup>. To monitor this epidemic, all states and territories conduct name-based surveillance of AIDS cases<sup>2</sup>. This allows for a unified and consistent method by which to track the epidemic nationally. However, HIV surveillance is not nationally conducted and, when it is, standard methods are not utilized. With the onset of highly active antiretroviral therapy (HAART), the number of AIDS cases has decreased dramatically as a result of people living longer. As a result, HIV surveillance has become necessary in order to monitor and track the disease. In January 1993, the Centers for Disease Control and Prevention (CDC) decided to evaluate the potential deterrent effect of implementing HIV surveillance on HIV testing<sup>2</sup> through the HIV Testing Survey (HITS). Between 1995 and 2001 HITS was conducted in three waves in 23 different states.

As part of its HIV/AIDS surveillance efforts, the HIV Epidemiology Program was funded by CDC to conduct HITS with persons at high risk for HIV in the City, and later in the County, of Los Angeles. The 2002 HITS was conducted in 15 cities or states across the country with men who have sex with men (MSM), injection drug users (IDU), and heterosexual STD clinic clients, using a standard protocol. Its goal was to understand the influence of HIV surveillance policies on testing behaviors and to examine other correlates of HIV testing, risk behavior, and prevention service utilization. The 2002 study focused on Black and Latino populations.

### ***Objectives***

- Assess the reasons and barriers that influence persons to seek or avoid HIV testing
- Assess knowledge of state policies for HIV surveillance
- Assess HIV testing patterns among persons at-risk for HIV
- Conduct behavioral surveillance among persons at risk for HIV
- Evaluate the representativeness of HIV surveillance data
- Examine level and types of exposure to HIV prevention services
- Collect data for local HIV prevention and community planning

### ***Contact Persons:***

Qiana R. Butler, MPH, Study Coordinator

Nina T. Harawa, MPH, PhD, Study Epidemiologist

### ***References:***

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***VIBE (Vaccine Interest and Benefit Evaluation) – (CHIPTS)***

This study examines consumers' demand for HIV vaccines (e.g., would people be willing to be vaccinated?), motivators and barriers to potential trial participation or post-trial adoption, and potential behavioral responses to vaccination, such as increases in risk behavior. The current phase of the study involves focus groups among communities at risk for HIV in Los Angeles County as well as key informant interviews.

***Street Outreach for HIV Prevention: Effectiveness of a State-wide Program. Wendell, D, Cohen DA, LeSage, D, Farley TA. International Journal of STD and AIDS, Vol. 14, No. 5, May 2003, pp. 334-340***

Street outreach is considered a key HIV prevention strategy in the United States. To determine whether street outreach to prevent HIV infection as practised by state-funded community-based organizations (CBOs) is effective in promoting condom use, we conducted an evaluation using a quasi-experimental design. Twenty-one CBOs involved in street outreach conducted cross-sectional surveys assessing risk behaviour and exposure to outreach activities in 66 intervention and 13 comparison areas in Louisiana over a 2-year period. Surveys were collected from 4950 persons at intervention sites and 1597 persons at comparison sites. After controlling for demographic characteristics and sexual risk factors, persons in intervention sites were more likely to use condoms than persons in comparison sites [odds ratio 1.37 (95% confidence interval 1.20, 1.56;  $P < 0.001$ )]. Contact with an outreach worker mediated condom use. The mechanism of effect may be related to direct contact with an outreach worker and condom distribution rather than to broader community mobilization.

***The Value of Screening for Sexually Transmitted Diseases in an HIV Clinic. Farley TA, Cohen DA, Wu SY, Besch CL. Journal of Acquired Immune Deficiency Syndrome, Vol. 33, No. 5, Aug 15 2003, pp. 642-648***

Because bacterial sexually transmitted diseases (STDs) facilitate HIV transmission, screening for and treatment of STDs among HIV-infected persons should prevent HIV spread to partners. Before screening programs for gonorrhea and Chlamydia infection should be widely established in HIV clinics, it is useful to know the prevalence of these infections. This study analyzed the results of a urine-based screening program for gonorrhea and Chlamydia in a New Orleans HIV clinic and compared the positivity rates to the prevalence in the local community. Among persons screened in the HIV clinic, 1.7% (46/2629) had gonorrhea and 2.1% (56/2629) had Chlamydia infection. Among persons aged 18-29 years, the test positivity for gonorrhea was similar in the HIV clinic to that of persons in sociodemographically similar community samples (3.1 versus 2.4%, adjusted odds ratio 1.6,  $P = 0.11$ ) and the test positivity for Chlamydia infection was lower (5.4% versus 10.5%, adjusted odds ratio 0.6,  $P < 0.01$ ). Based on a previously published mathematical model, it was estimated that treatment of all 46 gonorrhea and 56 Chlamydia infections in the HIV clinic may have averted 9 HIV infections among sex partners and saved far more in future medical costs than the cost of the screening. Routine screening for gonorrhea and Chlamydia infection should be considered in HIV clinics.

**■ American Indian / Alaskan Natives*****The American Indian/Alaskan Native Validation Project - (HIV Epidemiology)***

In Los Angeles County, race/ethnicity information for cases reported to the HIV/AIDS Reporting System (HARS) is most often obtained from reviewing patient medical records. However, race/ethnicity may be misclassified for some individuals due to health care staff not asking the patient for, or not recording their race/ethnicity, on the patient's chart. The problem with

racial/ethnic misclassification may be especially pronounced for American Indians/Alaska Natives (AI/ANs). In Los Angeles County, AI/ANs constitute 0.33% of the total population and 0.29% of the cumulative AIDS cases reported. The latter proportion may be an underestimate due to racial/ethnic misclassification of AI/ANs with AIDS.

In 2002, Los Angeles County Department of Health Services HIV Epidemiology Program collaborated with the Centers for Disease Control and Prevention on a multi-site project to evaluate the accuracy of data on race/ethnicity for AIDS cases among American Indians and Alaska Natives. The objectives of the study were 1) to estimate the accuracy of race/ethnicity data for reported AIDS cases among AI/ANs in Los Angeles County and 2) to determine the factors associated with the misclassification.

### ■ HIV Positive

#### ***Supplement to HIV and AIDS Surveillance (SHAS) Project - (HIV Epidemiology)***

Increasingly, health agencies need information about HIV/AIDS cases that HIV/AIDS surveillance data cannot provide. These questions reflect expanding knowledge about HIV-infection and AIDS, increased attention to minority health issues, concerns about the link between HIV infection and illicit drug use (both injecting and non-injecting), sexual behaviors that increase transmission of HIV infection, patterns of health care use by person infected with severe HIV disease, and the health and social status of children born to women with AIDS/HIV infection. To obtain more detailed information and to answer these questions, the SHAS Project was developed in 1990 in collaboration with the Centers for Disease Control and Prevention and eleven local and state health departments.

#### ***Objectives:***

1. To obtain additional descriptive information on persons with newly reported cases of HIV infection or AIDS that will supplement information routinely collected through national HIV and AIDS surveillance.
2. To improve our understanding of sexual and drug-using behaviors; health care access; minority issues; utilization and adherence to therapies; reproductive history and children's health of women with HIV infection or AIDS; geographic differences; and disability as related to HIV infection.

#### ***Making Decisions (MD) for Life – (CHIPTS)***

MD for Life is a study that will help health-care professionals and researchers learn how well an intervention works with people living with HIV. The intervention is designed to reduce sexual risk and substance-use behavior by increasing motivation and intention for behavior change among individuals living with HIV. This project builds on previous prevention successes and utilizes existing staff, treatment delivery settings, and new technology to deliver a brief innovative intervention that can be repeatedly delivered to a diverse population of individuals living with HIV. If successful, this program would be inexpensive and fairly effortless to implement in health clinics nationwide.

#### ***Healthy Living Project: A Multi-Institutional Collaborative Research Project – (CHIPTS)***

The UCLA Healthy Living Project is designed to promote health-related behavior changes in adults living with HIV. This project aims to reduce sexual and injection drug use risk behaviors among 1,200 HIV positive men and women in order to decrease the likelihood of secondary HIV

transmission. The research study is focused on four subgroups: women, heterosexual men, men who have sex with men, and injection drug users. The study is being conducted at four sites: Los Angeles, Milwaukee, New York, and San Francisco.

***Sex Without Disclosure of Positive HIV Serostatus in a US Probability Sample of Persons Receiving Medical Care for HIV Infection. Ciccarone DH, Kanouse DE, Collins RL, Miu A, Chen JL, Morton SC, Stall R. American Journal of Public Health, Vol. 93, No. 6, June 2003, pp. 949-954***

Objectives: We estimated the proportion of HIV-positive adults who have any sexual contact without disclosure and the proportion of their sexual partnerships that involve unprotected sex without disclosure. Methods. We drew participants from the HIV Cost and Services Utilization Study (n = 1421). Interviews assessed disclosure and sexual activities with up to 5 recent partners. Results. Overall, 42% of the gay or bisexual men, 19% of the heterosexual men, and 17% of all the women reported any sex without disclosure, predominately within nonexclusive partnerships (P < .001). Across all groups, 13% of serodiscordant partnerships involved unprotected anal or vaginal sex without disclosure, with no significant difference between groups. Conclusions. Risky sex without disclosure of serostatus is not uncommon among people with HIV.

***HIV Risk Behaviors and Their Correlates Among HIV-positive Adults with Serious Mental Illness. Tucker JS, Kanouse DE, Miu A, Koegel P, Sullivan G. AIDS & Behavior, Vol. 7, No. 1, March 2003, pp. 29-40***

HIV risk behaviors and their correlates were examined in a sample of 154 HIV-seropositive and seriously mentally ill adults (83% male, 56% sexually active). Most sexually active participants engaged in HIV risk behavior during the past 6 months, although the rates of these behaviors were generally not higher, and in some cases were lower, than those reported in studies of otherwise comparable noninfected people. Variables significantly associated with one or more HIV risk behaviors in bivariate analyses included being female, any limitation in instrumental functioning, not having a bipolar disorder, more psychotic mental health symptoms, problem drinking, and not receiving HIV counseling. The latter three variables accounted for 22% of the variance in the total number of HIV risk behaviors. Interventions to reduce risky sexual practices may be most appropriately provided through public mental health systems, given that this is the primary setting in which seriously mentally ill adults receive formal treatment.

***Brief Safer Sex Intervention for HIV Outpatient Clinics***

***Principal Investigator: Dr. Jean Richardson***

Seventy percent of HIV-infected patients are sexually active and many engage in unprotected sex while being managed on antiretroviral therapy. Providers of HIV medical care are in the best position to speak on a regular basis with their patients about safer sex and disclosure. The HIV outpatient clinic is an ideal yet under-utilized setting to integrate a prevention program for HIV positive persons into routine medical care.

The study provides the first theoretical test of the impact of gain- versus loss-framed messages on sexual behavior and disclosure on the part of HIV positive individuals who are being seen at six HIV outpatient clinics in the State of California. This is the first study to evaluate the effectiveness of provider-delivered safer sex counseling as a means to reduce transmission of HIV.

The safe sex intervention conditions are compared with an attention control intervention that addresses adherence to medication. Data were collected on 885 HIV-positive sexually active persons in care of whom 34.4% engaged in unprotected anal or vaginal sex (UAV). Follow-up data were collected from about two-thirds of the sample.

The main focus of the intervention was to address issues of safer sex, but because the attention control group addressed medication adherence, this allows us to explore hypotheses with regard to adherence. Detailed data were collected by patient interview, medical record abstracts and provider questionnaires. All field procedures are complete, and we are conducting analyses to assess interventions effects. Analysis to-date indicates the UAV decreases in the safer sex clinics and adherence increases in the adherence clinics.

This study was funded by the National Institute of Mental Health (NIMH).

***Sex Without Disclosure of Positive HIV Serostatus in a US Probability Sample of Persons Receiving Medical Care for HIV Infection. Ciccarone DH, Kanouse DE, Collins RL, Miu A, Chen JL, Morton SC, Stall R. American Journal of Public Health, Vol. 93, No. 6, June 2003, pp. 949-954***

Objectives: We estimated the proportion of HIV-positive adults who have any sexual contact without disclosure and the proportion of their sexual partnerships that involve unprotected sex without disclosure. Methods. We drew participants from the HIV Cost and Services Utilization Study (n = 1421). Interviews assessed disclosure and sexual activities with up to 5 recent partners. Results. Overall, 42% of the gay or bisexual men, 19% of the heterosexual men, and 17% of all the women reported any sex without disclosure, predominately within nonexclusive partnerships (P < .001). Across all groups, 13% of serodiscordant partnerships involved unprotected anal or vaginal sex without disclosure, with no significant difference between groups. Conclusions. Risky sex without disclosure of serostatus is not uncommon among people with HIV.

■ **IDU (FIDU; HMIDU; or MSM/IDU)**

***Substance Use and High-Risk Sex Among People with HIV: A Comparison Across Exposure Groups***

***Megan Beckett, Audrey Burnam, Rebecca L. Collins, David E. Kanouse, Robin Beckman. Reprinted with permission from [AIDS and Behavior](#), Vol. 7, No. 2 June 2003, pp 209-219. Copyright © 2003 Kluwer Academic/Plenum Publishing Corporation.***

Substance use is associated with increased risk for HIV transmission by HIV-positive people to uninfected partners through sexual contact. The largest risk groups for infection, men who have sex with men (MSM) and injecting drug users (IDUs), have high rates of substance use, but little is known about their substance use post-HIV diagnosis. We compared the prevalence of substance use between these two groups and a third group, heterosexual men and women, and tested for differential association between substance use and sexual behaviors across exposure groups in a national sample of patients in treatment for HIV. Substance use was most prevalent among MSM. Substance use and current dependence were associated with being sexually active among MSM but not IDUs; marijuana, alcohol, and hard drug use were most strongly associated with being sexually active among MSM. Whereas substance use predicted high-risk sex, there were few differences among exposure groups in these associations.

**Partner-Oriented Drug Treatment and HIV Risk Reduction (current)****PIs: Martin Iguchi, Ricky Bluthenthal**

Methadone maintenance is an effective tool for reducing HIV risk and incidence among injection drug users. All too often, however, individuals in methadone treatment continue to use opiates and other drugs, usually with a close friend or family member who is not currently enrolled in treatment. One response to this problem is to encourage at least one member of the methadone client's personal drug-using network to also enter treatment, thereby reducing the number of individuals offering drug-use opportunities. This study aims to determine whether treatment outcomes can be improved and HIV risk behaviors reduced by involving at least two network members in drug treatment simultaneously. The study will interview 268 new methadone treatment entrants, each of whom will be encouraged to recruit a drug-using partner for an interview. Half of the drug-using partners will be selected at random and offered 13 weeks of free methadone maintenance; the other half will not be offered subsidized treatment. Self-reports, clinic retention, urinalysis records, and other data will be collected from study participants at baseline and 4 months later to assess treatment outcomes, change in HIV risk behaviors, and change in personal drug-using network characteristics for both the initial methadone clients and their partner referrals.

***Sexual Relationships, Secondary Syringe Exchange, and Gender Differences in HIV Risk Among Drug Injectors. Riehmman KS, Kral AH, Anderson R, Flynn N, Bluthenthal RN. Journal of Urban Health, Vol. 81, No. 2, June 1 2004, pp. 249-259***

Injection drug use continues to place women at risk for human immunodeficiency virus (HIV) through both risky injecting practices and risky sexual behavior with male injection drug users (IDUs). Although attendance at syringe-exchange programs (SEPs) is protective against HIV, a recent study found that women attending SEPs who exchanged syringes for other people (secondary exchange) were at greater risk for HIV seroconversion, potentially through risky sexual behavior. We examined this question in a sample of 531 IDUs (175 women and 356 men) attending 23 SEPs in California in 2001. Findings indicated that women were more likely than men to engage in secondary exchange and were more likely to have IDU sexual partners. In multivariate analysis among women, secondary exchange was independently associated with distributive syringe sharing, not engaging in receptive sharing, and not exchanging sex for money or drugs. Multivariate analysis among men found that having an IDU sexual partner was associated with secondary exchange. Women's sexual risk behavior was not associated with secondary exchange, and although women's secondary exchange was associated with individual protection for injection-related behaviors, it may increase network risk. More information on network members is needed to understand gender differences in secondary exchange.

**■ Men Who Have Sex With Men*****HIV Incidence Study in Commercial Sex Venues or The Bathhouse Study – (HIV Epidemiology)***

The lack of information about HIV incidence and prevalence, risk behaviors, and psychosocial factors in bathhouse settings represents a critical gap in our understanding of the HIV epidemic as well as the specific prevention needs of this high-risk population. To close these gaps in knowledge, the HIV Epidemiology Program conducted a study consisting of five research components. In addition, because there was very little HIV risk behavior information currently available on MSM who frequent bathhouses, a supplemental risk assessment questionnaire was administered to all eligible, consenting participants. The questionnaire focused on identifying

risk behaviors and psychosocial factors associated with HIV infection among bathhouse attendees.

The lack of information about HIV incidence and prevalence, risk behaviors, and psychosocial factors in bathhouse settings represents a critical gap in our understanding of the HIV epidemic as well as the specific prevention needs of this high-risk population. To close these gaps in knowledge, we conducted a study consisting of five research components: 1) formative research; 2) a prospective, record-based incidence study; 3) a laboratory-based incidence study using the Strategic Testing Algorithm for Recent HIV Seroconversion (STARHS); 4) a Supplemental Risk Behavior Questionnaire Survey; and 5) an Exit Survey.

### ***Objectives***

The study was conducted in two phases. The objectives of the formative research were to:

1. Guide the design and implementation of HIV counseling and testing program in bathhouses.
2. Develop a risk factor questionnaire.
3. Understand the unique population segments that may exist among bathhouse patrons.

The objectives of the epidemiologic study components were to:

1. Develop standard methods for conducting HIV incidence studies in bathhouse settings.
2. Estimate HIV incidence among patrons attending bathhouses who receive multiple HIV tests.
3. Estimate HIV incidence among patrons attending bathhouses who accept HIV testing using STARHS testing methodology.
4. Estimate prevalence of HIV, syphilis and hepatitis B among those bathhouse patrons who accept HIV testing.
5. Describe HIV risk behaviors and psychosocial factors associated with a population of bathhouse attendees who seek anonymous HIV testing.
6. Monitor trends in HIV incidence among patrons attending bathhouses.
7. Monitor trends in HIV, syphilis and hepatitis B prevalence among patrons attending bathhouses.
8. Monitor trends in HIV risk behaviors among patrons attending bathhouses.
9. Describe HIV risk behaviors and psychosocial factors associated with recent HIV infection versus longstanding HIV infection versus no HIV infection among bathhouse attendees.

### ***Epidemiological HIV/AIDS Research in Black and Latino Men who have Sex with Men or Brothers y Hermanos – (HIV Epidemiology)***

Previous studies have documented the elevated incidence and prevalence of HIV infection in African American and Latino men who have sex with men (MSM) as compared to White MSM. Despite significant declines in HIV infection rates among MSM since the early years of the epidemic, MSM continue to be the group at highest risk for HIV. Young MSM, African American MSM, and Latino MSM are at particularly high risk for HIV infection.

New studies are needed to understand why some MSM of color contract HIV, while other Black and Latino MSM remain free of infection. Building upon the work of the Young Men's Survey and other epidemiological studies over the past decade, the Brothers y Hermanos study conducted formative research to identify ethnic- and race-specific psychological, social, cultural, and

environmental constructs that are associated with risk behavior within Black and Latino MSM populations.

### ***Objectives***

The objectives of the formative research phase of Brothers y Hermanos were to:

1. Identify HIV risk-promoting and risk-reducing cultural, social, environmental and psychological factors within populations of Black and Latino MSM through interviews and focus groups with key participants and systems representatives;
2. Delineate variables and specify appropriate language for questions to be used in the epidemiological survey;
3. Inform the epidemiological research phase of the study;
4. Generate preliminary in-depth knowledge of factors that can be tested in community-based HIV prevention trials.

### ***Behavioral Surveillance Study of HIV Risk and Prevention Behaviors of Men who have Sex with Men in Los Angeles County or The Los Angeles Men's Survey (LMS) – (HIV Epidemiology)***

The purpose of LMS is to collect cross-sectional HIV risk data, once every two or three years, from men 18 years and older who attend bars, cafes, parks, street locations, and other public venues throughout Los Angeles County. The study objectives are to estimate the prevalence of and trends in sexual and drug-use risk behaviors known to be associated with HIV infection on an ongoing basis. The survey will also estimate demographic, social, and behavioral correlates of HIV infection; estimate the prevalence of, and trends in, HIV testing behaviors and HIV prevention services utilization; and characterize prevention service gaps and missed opportunities for HIV prevention.

This behavioral surveillance system will provide relevant data on risk behaviors of MSM, the behavioral risk group that constitutes 70% of all reported AIDS cases in Los Angeles County. Behavioral surveillance data can be used to evaluate whether prevention efforts are reaching MSM and meeting local and national HIV prevention goals. Los Angeles County joins 24 other states and metropolitan areas in this national behavioral surveillance system.

### ***Objectives***

The purpose of LMS is to collect cross-sectional HIV risk data, once every two or three years, from men 18 years and older who attend bars, cafes, parks, street locations, and other public venues throughout Los Angeles County. The study objectives are to estimate the prevalence of and trends in sexual and drug-use risk behaviors known to be associated with HIV infection on an ongoing basis. The survey will also: estimate demographic, social, and behavioral correlates of HIV infection; estimate the prevalence of, and trends in, HIV testing behaviors and HIV prevention services utilization; and characterize prevention service gaps and missed opportunities for HIV prevention.

### ***Contact Persons***

Denise Fearman Johnson, Study Epidemiologist, 213-351-8545

Trista Bingham, Principal Investigator, 213-351-8175



## ■ Women

### ***Patterns and Correlates of HIV Testing Among Sheltered and Low-Income House Women in Los Angeles County. Tucker JS, Wenzel SL, Elliott MN, Hambarsoomian K, Golinelli D. Journal of Acquired Immune Deficiency Syndrome, Vol. 34, No. 4, December 1 2003, pp. 415-422***

This study investigated the prevalence, location, and correlates of HIV testing in a random sample of women drawn from shelters (n = 460) and low-income housing units (n = 438) in Los Angeles County. Most women (83%) had been tested for HIV, with the most common location being a clinic or physician's office (82%). Sheltered women were more likely to have ever been tested and, among those tested, to have been tested in a treatment program, mobile van, hospital or emergency department, or jail. Multivariate analyses indicated that testing was more likely among women who were sampled from shelters, younger, living with a child, had a regular source of medical care, were drug or alcohol dependent in the past year, experienced sexual violence, and were at low risk for mental health problems. Few women reported lack of money, transportation, or access to testing facilities as primary barriers to being tested. Although our results suggest that most impoverished women in our study area did not experience significant impediments to HIV testing, programs to encourage testing among older women, stably housed women who lack a regular source of care, and women at high risk for mental health problems may be warranted.

### ***Technology Translation and Transfer of Effective HIV Prevention Behavioral Interventions***

#### ***Principal Investigator: Dr. Jean Richardson***

The purpose of this CDC grant is to diffuse the intervention that was tested in the NIMH-funded study "A Brief Safer Sex Intervention for HIV Outpatient Clinics". The study developed training manuals, patient intervention materials (brochures and flyers) and clinic posters to implement and maintain the program.

Now that the efficacy of the program has been documented, the next step is to demonstrate that the program can be incorporated into routine care. To that end we will (1) improve and expand on patient education materials, (2) develop materials targeted for high-risk HIV positive individuals, (3) train HIV providers, (4) maintain the program and (5) improve the program diffusion process. The program will be diffused to three to five clinics in the Los Angeles area and a process evaluation will be conducted.

## ■ Youth

### ***Technology Transfer and Transition of an Effective HIV Prevention with Runaway Youth – (CHIPTS)***

Runaway and homeless youth have a national seroprevalence rate of 2.3%, a rate about six times higher than adolescents in the major AIDS epicenters. This intervention builds upon a previous intervention developed, implemented, and evaluated for 300 runaway youth in New York City. Over two years, the program demonstrated reductions in the number of unprotected sexual risk acts and substance use, with positive effects significantly larger for females and African American youth.

Based on these positive results, the goal of this project was to revise the program in order to develop an effective strategy for dissemination of the program to CBOs that serve high-risk runaway youth. A Community Advisory Board composed of representatives of the agencies



servicing high-risk youth in Los Angeles collaborated on revising the program and updating HIV information. The dissemination package includes a video that explains the intervention, access to ongoing consultation, and updates on implementation.

### **Youth LIGHT (Living in Good Health Together) – (CHIPTS)**

Project LIGHT was originally conducted as a multisite national prevention research trial with at-risk adults. The current Los Angeles-based pilot study will build upon the original Project LIGHT and explore if youth attending continuation school are receptive to using a self-administered computer program to access HIV prevention information. CHIPTS will modify Project LIGHT to reflect the language and experiences relevant to students at continuation schools. The computer-assisted intervention will be implemented in two phases. Phase I will explore the meaning of sex and perspectives about sexual risk behaviors held by the students targeted in the project. Phase II will document changes in the students' risk behaviors by conducting a baseline risk assessment and a three-month follow-up assessment.

In addition to the above studies, HIV Epidemiology Program staff are actively involved in publishing articles related to HIV/AIDS. Recent 2004 publications include:

- Risk of mortality associated with viral hepatitis B and C in patients with HIV infection: A cohort study. In Press.
- Changes in HIV Prevalence Among Public Sexually Transmitted Disease Clinic Attendees in the Western Region of the US (1989-1999).
- Associations of Race/Ethnicity with HIV Prevalence and HIV-Related Behaviors among Young Men Who Have Sex With Men (MSM) in Seven U.S. Centers.
- Comparing sexual behavioral patterns between two bathhouses: implications for HIV prevention intervention policy. In Press.
- Recent Increase In High-Risk Sexual Behaviors Among Sexually Active MSM Living With AIDS in Los Angeles County.

### **CLEAR (Choosing Life: Empowerment, Action, Results Intervention for Youth Living with HIV) – (CHIPTS)**

CLEAR builds upon CHIPTS' previous intervention – *Teens Linked to Care* (a CDC Effective Intervention) and provides HIV positive youth with education and skills training designed to reduce HIV transmission, increase adherence to medical treatment and regimens, and improve quality of life. CLEAR better addresses the needs of HIV-positive youth and offers two modes of delivery, one-on-one telephone sessions or one-on-one in-person sessions. CLEAR also seeks to learn more about youth living with HIV over time, their relationships and health, how they cope with problems, and how drug and alcohol use impacts sexual and other risk behaviors that may lead to the transmission of HIV.

### **Economic Evaluations for HIV Prevention Programs for Adolescents – (CHIPTS)**

While the field of HIV prevention has demonstrated that adolescents do reduce their sexual and substance use risk acts in response to intervention programs, there have been no evaluations of the cost effectiveness of these programs. This project will evaluate the cost-effectiveness of four adolescent prevention programs already mounted and compare the consistency of the cost-

effectiveness findings across studies. Because HIV sex risk acts among adolescents are usually part of a cluster of problem behaviors, this project will expand current strategies for examining cost-effectiveness to include social outcomes such as foster care, mental health institutionalization, jail, and temporary shelter.

### ***Understanding the Sexual Behavior of Adolescents***

Public health officials and educators have a long-standing interest in adolescent sexual behavior and risk prevention--an interest intensified by the spread of HIV. Unfortunately, understanding of adolescent sexuality is quite limited. Research on adolescent sexual behavior has typically concentrated on vaginal intercourse. However, adolescents who are virgins (defined as never having had vaginal intercourse) may still be sexually active and may behave in ways that put them at risk for sexually transmitted diseases (STDs).

As part of an ongoing program of research on risk behavior, Mark Schuster and his colleagues examined the range of adolescent sexual activity. They gathered data about the sexual behavior of adolescents in a socioeconomically diverse Los Angeles County school district, providing some of the first empirical information about the sexual practices of a population-based sample of high-school-aged virgins. The researchers also used this information to evaluate how a condom availability program affected adolescents attitudes and behavior.

Among the key findings from this research:

- Many high-school-aged virgins engaged in genital sexual activities that can transmit disease.
- Virgins who engaged in activities most likely to transmit STDs were more likely to have used cigarettes, alcohol, and drugs.
- Adolescents would like more information about sexual matters, but many don't know if they can trust their doctors.
- A high school condom availability program was associated with a significant increase in the percentage of males who used condoms.
- The program also appears to have significantly increased the percentage of virgins who intended to use condoms in the future.

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## F. Description of Selected Interventions by Type of Intervention

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### ■ Website Resources

The following descriptions of selected interventions was compiled by CHIPTS and the text was obtained from the following Web sites

1. HIV Prevention Toolbox - [www3.utsouthwestern.edu/preventiontoolbox/interven.htm](http://www3.utsouthwestern.edu/preventiontoolbox/interven.htm)
2. CDC Replicating Effective Programs Plus - [www.cdc.gov/hiv/projects/rep/default.htm](http://www.cdc.gov/hiv/projects/rep/default.htm)
3. CDC Compendium of HIV Prevention Interventions with Evidence of Effectiveness - [www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm](http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm)
4. Center for AIDS Prevention Studies - [www.caps.ucsf.edu/projects/curricula.html](http://www.caps.ucsf.edu/projects/curricula.html)
5. Center for HIV Identification, Prevention and Treatment Services – Intervention Manuals [chipts.ucla.edu/interventions/manuals/intervhral.html](http://chipts.ucla.edu/interventions/manuals/intervhral.html)
6. CDC National Diffusion Strategy & Technology Transfer Project - [www.effectiveinterventions.org](http://www.effectiveinterventions.org)

### ■ Intervention Descriptions

#### ***Community Level Interventions***

##### • **AIDS Community Demonstration Projects**

This intervention is based on the Social Learning and Stages of Change Theories as well as the Transtheoretical Model of Behavior Change. The intervention aims to modify attitudes and beliefs about prevention methods among the community members by providing models of successful risk reduction strategies adopted by members of the target population.

Target Population: Communities

Intervention: Peer volunteers from each target community are trained to carry out the intervention, drawing attention to and reinforcing identification with and acceptance of the intervention messages. The intervention features role model stories developed from the real-life experiences of local community members. These stories depict members of the target population moving from earlier to later stages of change. Stories are developed and selected so that the majority matched the predominant stages of change and beliefs about condoms and bleach observed in the population. The role model stories are featured in flyers distributed with condoms and bleach kits by the peer volunteers.

Findings: Individuals in the intervention communities demonstrated significantly greater achievement of consistent condom use and maintenance of consistent condom use with non-main partners than individuals in the comparison communities.

Web site: Intervention details can be found on page 6 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

- **Community PROMISE**

Community PROMISE is a community-level intervention to promote progress toward consistent HIV prevention through community mobilization and distribution of small-media materials and risk reduction supplies, such as condoms and bleach. The program is derived from the AIDS Community Demonstration Projects. The program is based on several behavioral theories, including the transtheoretical model of behavior change, which states that people move through a series of stages in the process of changing their behavior; the Theory of Reasoned Action, which explains how behaviors are guided by attitudes, beliefs, experiences, and expectations of other persons' reactions; and Social Cognitive Theory, which states that persons learn by observing other people successfully practice a new behavior.

Target Population: Injection drug users, their female sex partners, sex workers, non-gay identified men who have sex with men, high risk youth and residents in areas with high rates of sexually transmitted disease.

Intervention: Persons from the targeted at-risk communities are recruited and trained to be community advocates and to distribute role model stories and risk reduction supplies on the streets of their communities. Role model stories are personal accounts from individuals in the target population explaining how and why they took steps to practice HIV risk-reduction behaviors and the positive effects the choice has had on their lives. The messages in the role model stories are reinforced by interpersonal communication with the community advocates. Each week, community advocates distribute stories and supplies to 10 to 20 of their peers.

Findings: Communities where Community PROMISE was conducted showed:

1. Significant movement by community members toward consistent condom use with their main and non-main partners.
2. Significantly increased condom carrying among members of the communities.

Web site: <http://www.cdc.gov/hiv/projects/rep/promise.htm>

- **Real AIDS Prevention Project**

RAPP is a community mobilization program designed to reduce risk for HIV and unintended pregnancy among women in high-risk communities by increasing condom use. The program is based on the multi-site HIV Prevention in Women and Infants Demonstrations Project. RAPP is based on the transtheoretical model of behavior change, which states that people move through a series of stages in the process of changing their behavior. The program also is supported by theories of social learning and diffusion of innovation, which suggest that people are more likely to adopt new behaviors that have already been accepted by others who are similar to them and whom they respect.

Target Population: Sexually active women of reproductive age and their male partners

Intervention: The RAPP II intervention relies on a set of peer-led integrated activities:

*Outreach:* Peer network volunteers contact their neighbors on the street, at businesses and community organizations, and in residential areas. During brief, one-on-one encounters, they deliver informational brochures, referrals, and condoms. They may also engage in longer discussions in which they determine the woman's stage of change and motivate her with stage-appropriate messages and “role model” stories (project-produced brochures containing stories of community women in different stages of readiness to use condoms and describing their experiences and decisions).

*Small groups:* Peer network leaders supplement street outreach by conducting small group activities, such as safer sex parties and presentations to organized community groups. The peer networkers also represent the project in community activities promoting women's health.

*Community mobilization:* Peer networkers recruit businesses to provide in-kind services for project activities and to participate in a media campaign. The businesses display posters and distribute “role model” stories and brochures and newsletters containing information on HIV prevention, women's health and well-being, and referral sources.

Findings: After the RAPP intervention, women living in high risk intervention communities were more likely to have:

1. Initiated condom use with their steady partner
2. Negotiated condom use with steady and casual partners

Women at very high risk (sex workers) were more likely to use condoms consistently with both steady and casual partners.

Web site: <http://www.cdc.gov/hiv/projects/rep/rappii.htm>

#### • **Mpowerment**

The Mpowerment Project is a community building program designed to reduce the frequency of unprotected anal intercourse among young gay and bisexual men. Developed through an intensive social marketing process with young gay men, the Mpowerment Project is based on an empowerment model in which young gay men take charge of the project. The project draws on the theory of diffusion of innovations, which suggests that people are most likely to adopt new behaviors that have already been accepted by others who are similar to them and whom they respect.

Target Population: Young gay and bisexual men (ages 18–29)

Intervention: The Mpowerment Project is run by a “core group” of 10–15 young gay men from the community and paid staff. The young gay men from the core group, along with other volunteers, design and carry out all project activities. Ideally, the project has its own physical space where most social events and meetings are held and which serves as a drop-in center where young men can meet and socialize during specified hours. The program relies on a set of four integrated activities:

*Formal Outreach:* Teams of young gay men go to locations frequented by young gay men to discuss and promote safer sex, deliver appealing informational literature on HIV risk reduction, and distribute condoms. Additionally, the team creates their own social events to attract young gay men (e.g., dances, video parties, picnics, discussion groups) and at which safer sex can be promoted.

*M-groups:* These peer-led, 2–3 hour meetings of 8–10 young gay men discuss factors contributing to unsafe sex among the men (e.g., misconceptions about safer sex, beliefs that safer sex is not enjoyable, poor sexual communication skills). Through skills-building exercises, the men practice safer sex negotiation and correct condom use. Participants receive free condoms and lubricant and are trained to conduct informal outreach.

*Informal outreach:* Informal outreach consists of young men discussing safer sex with their friends.

*Ongoing publicity campaign:* The campaign attracts men to the project by word of mouth and through articles and advertisements in gay newspapers.

Findings: After the Mpowerment Project, young gay men in the intervention were more likely than those in the comparison community to have:

1. Significantly decreased their rates of unprotected anal intercourse

Web site: <http://www.cdc.gov/hiv/projects/rep/mpower.htm>

### **Group Level Interventions**

- **Fifteen Month Follow Up of Women Methadone Patients Taught Skills to Reduce Heterosexual HIV Transmission**

The goal of this intervention was to determine the effects of a small group intervention to reduce sexual risk behavior and HIV transmission by increasing AIDS knowledge, sexual negotiation skills, and safer sex practices.

Target Population: Female African American and Latina methadone patients

Intervention: The intervention was delivered in five 2-hour sessions<sup>§</sup> with about ten women in each group. The intervention was led by experienced female drug counselors who had received an additional 20 hours of training.

*Sessions 1-2:* Information on AIDS transmission and prevention. Trainers used video, other visual presentations, and didactic exercises to enable participants to identify their own high-risk sexual behaviors and barriers to adopting safer sex practices.

*Session 3:* Condom use. Members discussed their negative associations with condoms, practiced condom skills, and role-played scenarios that involved asking their partners to use condoms.

*Sessions 4-5:* Assertiveness training, problem solving, and communication skills. Participants practiced and personalized these skills, first by role-playing in scripted scenarios, then by selecting scenarios that reflected their own life.

Incentives included modest payments for attending the sessions.

Findings: Women who participated in the intervention significantly increased frequency of condom use with their partners compared with women in the comparison condition.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-4.htm>

- **A Randomized Controlled Trial of an AIDS Prevention Program for Low-Income African American Youths**

The intervention, developed through ethnographic research, targeted pre- and early-adolescents in their existing friendship groups. Being in such a group was a requirement of enrollment. AIDS prevention education was based on a social cognitive model, Protection Motivation Theory (PMT), that uses cost and reward constructs to explain how intentions are formed to respond to threats in either adaptive or maladaptive ways. The goal of the intervention was to determine the effects of a peer network decision-making intervention to increase condom use among sexually active youth.

Target Population: African-American youths

Intervention: The intervention consisted of 8 sessions: seven 1½-hour weekly meetings at local recreational centers and one day-long session at a rural campsite. The intervention was

delivered in a large eastern city to peer groups that consisted of 3 to 10 same-gender friends within 3 years of age of each other. The sessions were led by a pair of interventionists, at least one of whom was gender matched to the group. Most of the interventionists were African-American men and women recruited from the community.

Each session focused on one or more PMT concepts and also reviewed concepts from the prior session. Beginning in the first session and integrated throughout, a family genogram was used to illustrate the application of concepts to real-life situations.

Sessions emphasized values clarification and goal setting; presented facts regarding AIDS, STDs, contraception, and human development; and provided condoms. Multiple delivery formats were used to address individual variability in receptivity to media, e.g., videos, games, role-playing, acting, storytelling, and arts and crafts.

In the seventh session, participants developed community projects with specific target audiences and intervention messages. The eighth session included a presentation of the projects and concluded with a "graduation" ceremony.

Findings: Sexually active youth who participated in the intervention reported significantly greater condom use than sexually active youth in the comparison condition.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-24.htm>

- **AIDS and the Transition to Illicit Drug Injection**

This prevention program was based on social learning principles. The intervention was delivered in four 1- to 1½-hour sessions over a 2-week time period. The goal of the intervention was to determine the effects of a small group intervention to prevent the transition from sniffing heroin to injecting heroin.

Target Population: Male and female drug users

Intervention: The intervention was led by two trainers who encouraged a therapeutic atmosphere in which participants felt free to discuss personal problem situations and seek help from the trainers and from their peers. Reduction in non-injected use of illicit drugs was an additional goal of the program. Trainers were clear not to take a condemning/punitive attitude. The emphasis was on recognizing and admitting problems with illicit drug use and then seeking treatment to reduce/eliminate the illicit drug use.

The four sessions covered understanding AIDS, risks of drug use and drug injection, sexual behavior and AIDS, and seeking entry into drug abuse treatment programs. The trainers used presentations, group discussion, and role-play of critical situations like refusing an offer of injection or seeking entry into a treatment program when one's non-injection drug use becomes too heavy.

Findings: Men and women who participated in the intervention were significantly less likely to inject drugs than those in the comparison condition.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-3.htm>



- **Assertiveness Skills Development for Women with Severe and Persistent Mental Illness**

Target Population: Women with severe and persistent mental illness

Intervention: This intervention is based on Social Learning Theory. This is an intensive 10-session small group intervention designed to increase knowledge, risk reduction skills, and communication and assertiveness skills in order to enable clients to discuss risk behaviors with partners and take preventive action.

*Session 1 through 3:* Focuses on HIV-related information and motivation for reduction in risk behaviors, including transmission, risk behaviors, condom use and effectiveness, HIV testing; motivational strategies to enhance awareness of personal risk with each participant receiving a risk summary based on participants' self-report of risky behavior prior to intervention.

*Sessions 4 through 7:* Offers skills development and fluency building through modeling by facilitators of simulated interactions; participants practice skills and receive feedback.

*Sessions 8 through 10:* A generalization of skills learned in sessions to actual sexual interactions.

*Session 10:* A review and clarification of unanswered questions; completion of treatment acceptability questionnaire and scheduling of subsequent assessments.

Findings: Women in the intervention increased assertiveness skills, HIV knowledge and frequency of condom protected sex compared with the control group.

Web site: Intervention details can be found on page 51 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

- **Behavioral Intervention to Reduce AIDS Risk Activities**

The intervention consisted of 12 weekly group sessions, each about 75 to 90 minutes. Groups were led by 2 clinical psychologists and 2 project assistants. The goal of the intervention was to determine the effects of a small group intervention to reduce the frequency of high-risk sexual practices and increase behavioral skills for refusing sexual coercions.

Target Population: African American and Latino gay men

Intervention: The intervention used group process, lecture, and role-playing methods to deliver information and develop skills.

*Sessions 1-2:* AIDS risk reduction. This component included information about AIDS, HIV infection, and HIV-transmission methods.

*Sessions 3-5:* Behavioral self-management. Participants examined past high-risk sexual activity and identified mood, setting, substance use, and other factors associated with the risk taking. Leaders presented strategies to reduce risk.

*Sessions 6-8:* Assertion skills training. Three scenarios were used: (a) initiating discussion about one's commitment to low-risk behavior with a potential sex partner; (b) refusing pressures to engage in high-risk behavior; and (c) declining an immediate sexual proposition from a person one wanted to get to know socially.

*Sessions 9-11:* Relationship skills and social support development. This component addressed strategies for problem solving in relationships and for maintaining low-risk sexual practices, even in committed relationships.

*Session 12:* Risk-reduction review and identification of useful strategies. This session allowed each participant to address the changes he had made and the strategies he had used.

Findings: Gay men who participated in the intervention reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than the men in the comparison condition.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-17.htm>

- **Brief Behavioral Skills Intervention to Prevent HIV Infection Among Chronically Mentally Ill Adults**

This intervention is based on the Cognitive-behavioral and skills instruction model.

Target Population: Chronically mentally ill adults

Intervention: Two experienced HIV risk reduction group leaders who are the same sex as the group facilitate the interventions.

*Session 1:* Uses the film "AIDS: What Everyone Needs to Know," presentations, and discussions to review information about HIV transmission and risk behaviors. Participants are given an assignment to identify personal cues or triggers that lead to sexual risk-producing situations.

*Session 2:* Focuses on developing skills related to HIV risk reduction. Participants discuss personal risk behaviors and cures that they identified in the past week's homework. Methods of effectively cleaning drug injection equipment are discussed. Proper condom use is demonstrated and practiced and group leaders role-play effective responses to potentially risk producing problems. Participants are given an assignment to implement one or more steps toward their personally identified behavior goals.

*Session 3:* Increases skills for resisting a partner's coercion to engage in sexual intercourse without a condom and increases comfort in discussing safer sex with a sexual partner before engaging in sexual activity. Basic components of interpersonal assertiveness, refusal to engage in risk-related sexual behaviors, and negotiating safer sexual activities are modeled by group leaders and practiced by participants. Participants again practice condom placement and discuss successes and difficulties encountered in working toward their goals.

*Session 4:* Consists of a comprehensive review of the material skills covered in the previous three sessions. Repetition and reinforcement of skills are emphasized. Participants review their individual behavior goals and generate additional strategies for initiating and maintaining risk reduction.

Findings: This intervention increased risk knowledge and behavior change intentions; reduced unprotected sex; and increased condom use.

Web site: Intervention details can be found on page 67 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

- **Brief Group Counseling in HIV Risk Reduction Among Homosexual Asian and Pacific Islander Men**

This intervention is based on the Health Belief Model, Theory of Reasoned Action and Social Learning Theory.

Target Population: Asian and Pacific Islander gay men

Intervention: One trained intervention coordinator and one community leader facilitate this culturally specific intervention. It consists of four components:

*Development of positive self-identity and social support* – Topic cards are used to address issues related to having dual identities,[e.g. family, coming out, religion/tradition, stereotypes, language, gossip, immigration, community, racism and homophobia, bi-phobia,] and personal strengths.

*Safer sex education* – Involves expressing both negative and positive feelings toward safer sex; providing facts about HIV transmission; and playing a safer-sex game that addresses risk with different types of partners.

*Eroticizing safer sex* – Participants write down on slip of paper a list of erotic but safe ways of touching. Each participant reads someone else's slip describing it as erotically as he can.

*Negotiating safer sex* – Negotiation skills are taught through safe-sex negotiation scenarios and role-play demonstrations.

Findings: This intervention resulted in a significant reduction in number of sex partners and rate of unprotected anal intercourse.

Web site: Intervention details can be found on page 11 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

- **Comparison of Education versus Behavioral Skills Training Interventions in Lowering Sexual HIV Risk Behavior of Substance Dependent Adolescents**

This intervention is based on Social Learning Theory and the Theory of Reasoned Action. Substance-dependent adolescents participate in a six session intervention over six weeks to

reduce their risk of HIV infection and transmission. This is a cognitive-behavioral intervention designed to equip youth with the interpersonal and technical skills necessary to lower their risk.

Target Population: Substance dependent adolescents

Intervention: The intervention includes HIV education, training and rehearsal in correct condom use, problem solving, and self-management strategies. The groups are divided by gender, and racial and gender-matched leaders conduct the sessions.

*Session 1:* Focuses on risk reduction.

*Session 2:* Participants learn about correct condom use and then practice and demonstrate correct use on penile models.

*Session 3:* Youth view a film that focuses on issues relevant to partner negotiation and communication. They practice initiating conversations with their partners and refusing coercive advances.

*Session 4:* Emphasizes problem solving and self-management skills. Youth identify high-risk situations and practice alternative ways to manage them in the future. They also develop contracts to make changes and identify peer models from within the group. Outcomes of this intervention were increases in perceived risk, positive attitudes toward condoms and prevention, self-efficacy, and interpersonal skills.

Findings: There were decreases in sexual risk behaviors (exchanging sex for money or drugs, causal sex, and sex with high-risk partners) and the occurrence of STDs.

Web site: Intervention details can be found on page 63 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

- **Condom Skills Education and Sexually Transmitted Disease Reinfection**

This intervention was based on the premise that familiarity with condoms and skills in using condoms properly are necessary for increasing future condom use. The intervention consisted of a brief condom skills education session led by a health educator who was an African-American woman. The intervention was delivered in a single 30-minute group session to people waiting for appointments in a Los Angeles STD clinic. The goal was to determine the effects of a small group intervention on the incidence of sexually transmitted diseases.

Target Population: Male and female adults (all races/ethnicities)

Intervention: The session began with a 10- to 15-minute presentation in which the health educator emphasized 3 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 of how condoms should be used and a demonstration of how to put on a condom. The health educator referred to a poster that displayed a variety of condoms with their packaging. The presentation was followed by a 10- to 15-minute question-and-answer session.

Findings: Men and women who participated in the intervention were significantly less likely to return to the STD clinic within the next 12 months with a new STD than those in the comparison condition.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-7.htm>

- **Effects of HIV/AIDS Intervention Groups for High-Risk Women in Urban Clinics**

The intervention incorporated cognitive-behavioral and risk-reduction skills training principles and peer support elements. It consisted of 4 weekly group sessions, 90 minutes each. There were 8 to 10 women in each group. The sessions were conducted in Milwaukee, Wisconsin by 2 female group leaders. The goal of the intervention was to determine the effects of a small group intervention on high-risk behaviors.

Target Population: Women (all races/ethnicities)

Intervention: The sessions provided detailed information about HIV risk and focused on behaviors that increase risk, common misconceptions about AIDS, and steps to reduce the risk of contracting the disease. National and local HIV seroprevalence and epidemiology statistics were summarized to personalize risk situations for the women, including the possibility of encountering an infected partner.

Exercises emphasized cognitive-attitudinal areas, behavioral skills, and social factors. Participants role-played initiating discussion of concerns about AIDS and condom use with potential sex partners and resisting sexual pressure from a man whose risk history was unknown or with whom the woman did not want to have sex.

Skills-building was a critical component of this intervention. Condom demonstration and practice were provided to desensitize participants to condom use. Also, attention was directed toward recognizing, understanding, and managing one's personal triggers for high-risk behavior.

Findings: Women who participated in the intervention reported a significantly greater increase in condom use with their partners and a significantly greater decrease in their frequency of engaging in unprotected sex than women in the comparison condition.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-12.htm>

- **Enhancing Motivation to Reduce the Risk of HIV Infection for Economically Disadvantaged Urban Women**

This intervention is based on the Information-Motivation-Behavioral Skills Model (IMB) and Social Learning Theory. At risk, low-income, African-American urban women participate in a comprehensive risk reduction intervention designed to reduce HIV-related risk behaviors by enhancing motivation for behavior change. Women who are motivated to change are offered the opportunity to increase their HIV-related knowledge and sharpen interpersonal skills needed to adopt safer sexual practices.

Target Population: Women

Intervention: There are four 90-minute sessions with trained minority therapists. Women provide their own motivational statements, express concerns regarding their HIV risk, develop risk reduction action plans, view videos, and learn and practice communication and negotiation skills regarding condom use and eroticizing safer sex.

*Session 1* focuses on the development of motivational statements and risk sensitization.

*Session 2* focuses on women's perceptions of community problems, their HIV knowledge and personal risk situations, and preparation of risk reduction action plans. Videotape is used in each of the first two sessions.

*Session 3* introduces the pros and cons of behavior change, the development of risk reduction plans, and skills training related to condom usage and eroticizing safer sex.

*Session 4* enhances communication and interpersonal skills, using extensive role-play rehearsal and feedback.

Findings: Results indicate that women who participated in the intervention increased their knowledge and risk awareness, strengthened their intentions to adopt safer sexual practices, communicated their intentions with their partners, reduced substance use just prior to sexual activities, and engaged in fewer acts of unprotected sex.

Web site: Intervention details can be found on page 25 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

- **Healthy Relationships**

Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. The sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

Target Population: Men and women living with HIV/AIDS

Intervention:

The core elements of Healthy Relationships are:

1. Defining stress and reinforcing coping skills across three life areas: disclosing to family and friends, disclosing to sexual partners, and building healthier and safer relationships.
2. Using modeling, role-play, and feedback to teach and practice skills related to coping with stress.
3. Teaching decision-making skills about disclosure of HIV status.

4. Providing personal feedback reports to motivate change of risky behaviors and continuance of protective behaviors.
5. Using movie clips to set up scenarios about disclosure and risk reduction to stimulate discussions and role-plays.

Findings: Implementation of Healthy Relationships produced the following results:

1. Participants reported greater self-efficacy for suggesting condom use with new partners.
2. Participants reported intentions to consider the pros and cons of HIV status disclosure to partners.
3. Participants reported intentions to engage in safer sex with partners who did not know their HIV status.
4. Participants were significantly more likely to have followed through on their earlier intentions at the three-month and six-month follow-up.
5. Participants reported less unprotected intercourse, more protected intercourse, and fewer sexual contacts at the six-month follow-up.
6. Participants reported less sexual intercourse and less unprotected intercourse with non-HIV-positive partners at the three-month and six-month follow-up.
7. Participants were significantly more likely to refuse to engage in unsafe sex at the six-month follow-up.

Web site: Click on Healthy Relationships at [www.effectiveinterventions.org](http://www.effectiveinterventions.org).

- **HIV Risk Reduction Among African-American Homosexual and Bisexual Men**

This intervention is based on the AIDS Risk Reduction Model.

Target Population: African American gay and bisexual men

Intervention: Two trained African-American homosexual male facilitators lead this culturally specific intervention. It consists of four components:

*Self-identity and development of social support* -Participants view segments of the video 'Tongues Untied' about African-American homosexual men and then discuss their experiences associated with being members of both racial and sexual minorities and perceptions of their HIV risks as sexual minorities.

*AIDS risk education* - Participants are divided into teams to play the 'AIDS Jeopardy Game' that demonstrates their knowledge of HIV risk activities and then discuss them. During the 'Condom Games', participants examine their positive and negative emotions about low-risk activities.

*Assertiveness training* - Participants form groups of two to engage in role-plays designed to practice initiating low-risk sexual behaviors or refusing high-risk activities with a current sexual partner and with a potentially new sexual partner.



*Behavioral commitment* - Participants share strategies they have used for risk reduction and make a verbal commitment before the group to change their risk behaviors.

Findings: This intervention significantly reduced the frequency of unprotected anal intercourse and participants were more likely to test for HIV.

Web site: Intervention details can be found on page 18 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

- **Holistic Harm Reduction**

The Holistic Harm Reduction Program (HHRP) is a 12-session, manual-guided, group level program to reduce harm, promote health, and improve quality of life. The primary goal of HHRP is to provide group members with the resources (i.e., knowledge, motivation, and skills) they need to make choices that reduce harm to themselves and others.

The program is based on the Information, Motivation, Behavior (IMB) model of behavior change. In addition to providing substance abuse treatment, HHRP addresses medical, emotional, and social problems that may impede harm reduction behaviors. Treatment goals could include abstinence from illicit drugs or sexual risk behavior, but reduced drug use, reduced risk of HIV transmission, and improved medical, psychological, and social functioning are also acceptable.

Target Population: HIV-positive injection drug users

Intervention: HHRP activities are designed to address clients as complex human beings in search of physical, emotional, social, and spiritual well-being.

The core elements of HHRP are:

1. Deliver a 12-session multi-modal, manual-guided group intervention.
2. Focus on reducing drug use and high-risk behaviors.
3. Address medical, emotional, and social problems that may be associated with disease progression.
4. Respect clients' spiritual and religious beliefs, help clients cope with stigma and grief, teach stress management techniques, and address fears of death and dying.

Follow the IMB model so clients gain the skills to attain and realize treatment goals. Use multiple presentation strategies (e.g., slides, games) to increase understanding and retention of materials.

Findings: Implementation of HHRP produced the following results:

1. Decrease in addiction severity after three months.
2. Decrease in risk behavior after three months.
3. Significant improvement in behavioral skills, harm reduction knowledge and behaviors, motivation, and quality of life.

Web site: Click on Holistic Harm Reduction at [www.effectiveinterventions.org](http://www.effectiveinterventions.org)



- **Many Men, Many Voices**

Many Men, Many Voices (3MV) is a six- or seven-session, group level STD/HIV prevention intervention for gay men of color. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia.

Target Population: The 3MV intervention targets gay men of color. The intervention also targets men on the ‘down low’ with or without female partners (i.e., men of color who have sex with other men but do not identify as gay or bisexual).

Intervention: 3MV is designed to be facilitated by a peer in groups of 6-12 clients. The 2-3 hour sessions aim to foster positive self image; educate participants about their STD/HIV risks; and teach risk reduction and partner communication skills. The sessions are highly experiential, incorporating group exercises, behavioral skills practice, group discussions, and role play.

The sessions address specific influencing factors in a sequence including:

*Session 1:* The Dual Identity of Gay Men of Color

*Session 2:* STD/HIV Prevention for Gay Men of Color – Sexual Roles and Risks

*Session 3:* STD/HIV Risk Assessment and Prevention Options

*Session 4:* Intentions to Act and Capacity to Change

*Session 5:* Sexual Relationship Dynamics – Partner Selection, Communication, and Negotiation

*Session 6:* Social Support and Problem Solving to Maintain Change

*Session 7 (optional):* Building a Healthy Community

The intervention can also be adapted to 12 sessions of 75-90 minutes each, or condensed into a weekend retreat, covering the 18-21 hours of intervention curriculum.

The core elements of 3MV include:

1. Educate clients about HIV risk and sensitize to personal risk.
2. Develop risk reduction strategies.
3. Train in behavioral skills.
4. Train in partner communication and negotiation.
5. Provide social support and relapse prevention.

Findings: After implementation of the original intervention (12 sessions of 75-90 minutes each), participants reduced their frequency of unprotected anal intercourse and increased their use of condoms significantly more than men who did not participate in the intervention.

Web site: Click on Many Men, Many Voices at [www.effectiveinterventions.org](http://www.effectiveinterventions.org)

- **Outcome of Intensive AIDS Education for Male Adolescent Drug Users In Jail**

The intervention was based on a problem-solving therapy model. It consisted of four 60-minute sessions focusing on health education issues relevant to male adolescent drug users, with emphasis on HIV/AIDS. The intervention was delivered at the New York City Department of Corrections Adolescent Reception and Detention Center on Rikers Island. The goal of the intervention was to determine the effects of a small group intervention to reduce HIV drug- and sex-related risk behaviors.

Target Population: Incarcerated, young, male drug users

Intervention: Sessions used interactive methods and a small group format with 8 adolescents and one male counselor. Counselors were guided by a written curriculum. Topics included general health knowledge, HIV and AIDS knowledge, factors associated with initiation and continuance of drug abuse, types of sexual behavior and HIV risk, the relationship of drug use and sexual behavior, and strategies to access services and drug abuse treatment in the community. Counselors adapted topics to the needs of the participants. Counselors used techniques based on the problem-solving therapy model:

*Problem orientation* - group members share and discuss facts and beliefs about HIV/AIDS

*Problem definition and formulation* - members define specific high-risk attitudes and behaviors that must be modified to protect themselves and others against HIV/AIDS

*Generation of alternative solutions* - members suggested and compiled possible courses of action for risky behaviors

*Decision-making* - members critiqued and evaluated the alternative solutions

*Solution implementation* - participants used role play and rehearsal techniques to practice alternative solutions.

The young men received \$5 for each group session they attended.

Findings: After release from jail, youth who participated in the intervention were significantly more likely to use condoms during vaginal, oral, and anal sex and had fewer high-risk sex partners than youth in the comparison condition.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-5.htm>

- **Project LIGHT**

Project "light" is a small group intervention based on the NIMH Multisite HIV Prevention Trial and has the goals of decreasing unprotected sexual intercourse and increasing condom use. Grounded in behavioral theory, the program targets three primary factors that mediate sexual risk acts 1) outcome expectancies, 2) skills, and 3) self-efficacy. The small group format allows group members to gain knowledge and to enhance and practice risk reduction

skills, and the group dynamic encourages the promotion of new social norms within a safe, supportive environment.

Target Population: Ethnically diverse adult men and women, who are seeking initial or follow-up treatment at STD clinics and low-income women seeking treatment at neighborhood health care clinics.

Intervention: Nurses or health care educators employed by the clinic facilitate gender specific groups of 5 to 12 people in a private room within the clinic. Each of the seven 90-minute sessions begins with goal review and discussion of success and barriers, review of the previous session, preview of the current session, introduction of a skill-building exercise, skill practice and discussion, session review, and goal setting. Male and female condoms are made available to participants at all sessions.

*Session 1* introduces HIV knowledge and risk personalization.

*Session 2* identifies personal risk triggers.

*Session 3* focuses on problem-solving triggers.

*Session 4* discusses and demonstrates the use of male and female condoms.

*Sessions 5 and 6* develop assertive communication and negotiation skills.

*Session 7* reviews the previous session's skills and develops plans for risk reduction behavior maintenance, and participants receive a certificate of completion.

Findings: The "light" intervention produced the following results among program participants:

1. Significant decrease in the reported number of unprotected intercourse acts.
2. Significant increase in reported condom use over time.

Web site: <http://www.cdc.gov/hiv/projects/rep/light.htm>

- **Project TLC: Teens Linked to Care**

Project TLC was a 31-session skills-building intervention designed to help youth living with HIV reduce transmission risk behaviors and increase their treatment adherence. Social Learning Theory was the theoretical foundation for the intervention.

Target Population: Youth living with HIV between 14-21 years old

Intervention:

*Module I:* improve the youths' health status

*Module II:* reduce transmission acts among youth

*Module III:* improve the youths' quality of life.

Findings: Youth assigned to Project TLC's intervention condition reported more positive lifestyle changes and demonstrated more positive coping styles, more social support, and were better at keeping their medical appointments regardless of their stage of illness, as compared to youth in the standard care condition.

Decreases in the number of unprotected sexual risk acts, including 45% fewer sex partners and 50% fewer HIV-negative sex partners, were observed among youth assigned to the intervention condition as compared with youth in the standard care condition. Also, marijuana use and hard drug use decreased by 6% and 22% respectively among youth in the intervention condition as compared with youth in the standard care condition. Finally, youth in the intervention condition reported fewer mental health and physical symptoms than youth in the standard care condition.

Rotheram-Borus, MJ; Lee, M; Murphy, D.; Futterman, D.; Duan, N.; Birnbaum, J. & The Teens Linked to Care Consortium. (2001). Efficacy of a preventive intervention for youth living with HIV. *American Journal of Public Health*, 91, (8), 400-405.

Rotheram-Borus, MJ; Murphy, D.; Wight, R; Lee M; Lightfoot, M; Swendeman, D; Birnbaum, J; & Wright, W. (2001). Improving the quality of life among young people living with HIV. *Evaluation and Program Planning*.

Web site: <http://chipts.ucla.edu/interventions/manuals/intervtlc1.html>

- **Reducing Inner-City Women's AIDS Risk Activities**

The intervention was based on theories of social learning, conservation of resources (including coping strategies and support skills), and communal support. The goal of the intervention was to determine the effects of a small group intervention to enhance AIDS knowledge, attitudes, and skills and, as a result, to influence behavior change.

Target Population: Women (all races/ethnicities)

Intervention: The intervention consisted of 4 sessions, 1½- to 2-hours each, for groups of 2 to 8 women. Trained group leaders were female psychologists and health educators whose ethnic backgrounds were similar to those of the participants.

Sessions featured videos using actors from the target population illustrating assertiveness, negotiation skills, planning skills, and specialized skills (e.g., cleaning drug works). Women discussed the videos and role-played risk scenarios. Participants created health plans.

Women learned negotiation skills and assertiveness skills. They developed a sense of mastery and positive expectations of success. The sessions also included an activity in which women imagined an unhealthy behavior and then imagined a healthy behavior. The final session addressed relapse prevention.

Incentives included cash, partial reimbursement for transportation and child care costs, and participation in a lottery for a color television.

Findings: Women who participated in the intervention increased their use of condoms with their partners more than women in the health promotion condition and significantly more than women who received no intervention.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-10.htm>

- **Safety Counts**

The intervention is aimed at reducing high-risk drug-use and sexual behaviors of injecting and non-injecting drug users that are related to transmission of HIV and viral hepatitis. The intervention is a behaviorally focused, seven-session intervention, which includes both structured and unstructured activities in group and individual settings over four to six months. It employs a stages-of-change framework and draws on behavior change principles articulated in the theory of reasoned action, social cognitive theory, and the health belief model.

Target Population: Individuals who are currently using drugs, injectors and non-injectors.

Intervention: With HIV testing as a core element of the intervention, Safety Counts works well with CDC's Advancing HIV Prevention initiative as staff discusses the importance of knowing your status upon program enrollment and in each session offers testing and counseling services to clients. The intervention addresses the needs of both HIV-negative and HIV-positive clients.

Original program developers identify the five core elements as:

1. Group Session One and Group Session Two (identify client's HIV risks and current stage of change, hear risk-reduction success stories, set personal goal, identify first step to reduce HIV risk, and make referrals to C&T and medical/social services)
2. One (or more) Individual Counseling Session (discuss/refine risk-reduction goal, assess client's needs, and provide needed referrals to C&T and medical/social services)
3. Two (or more) Social Events (share meal and socialize, participate in a planned HIV-related risk-reduction activity, and receive reinforcement for personal risk reduction)
4. Two (or more) Follow-up Contacts (review client's progress in achieving risk-reduction goal, discuss barriers encountered, identify concrete next step and discuss possible barriers/solution, and make referrals to C&T and medical/social services)
5. HIV/HCV Counseling and Testing (offer the client this service either through referrals or at the implementing agency)

Findings: Clients who were enrolled in Safety Counts were about 1.5 times more likely to reduce their drug- and sex-related risks compared with clients in the standard intervention. Clients who were enrolled in Safety Counts were more than 2.5 times more likely to self-report an increase in condom use compared with clients in the standard intervention.

Clients who were enrolled in Safety Counts were significantly more likely to self-report a reduction in the number of times they inject and more likely to test negative for opiates through urinalysis.

Web site: Click on Safety Counts at [www.effectiveinterventions.org](http://www.effectiveinterventions.org)

- **Street Smart**

Street Smart is an HIV/AIDS and STD prevention program for runaway and homeless youth. Your staff may use this skills-building program to help groups of young people reduce their unprotected sex acts, number of sex partners, and substance use. It is based on social learning theory, which links feelings, attitudes, and thoughts to behavior change.

Target Population: Runaway and homeless youth, ages 11 to 18.

Intervention: Street Smart is conducted over a six- to eight-week period with 10-12 youth. The program consists of eight 1 1/2 to 2 hour group sessions, one individual counseling session, and one visit to a community-based organization that provides healthcare. Each session has specific goals on HIV/AIDS, STDs, pregnancy prevention, coping and negotiation skills, personalized risk behaviors and reducing drug and alcohol use. Group members participate in scripted and non-scripted role plays, activities, and video production.

The core elements of the Street Smart program include:

1. Enhancing affective and cognitive awareness, expression, and control;
2. Teaching HIV/AIDS risk hierarchy and its personal application;
3. Identifying personal triggers, using peer support and small group skills-building sessions; and
4. Building participant's skills in problem solving, personal assertiveness, and HIV/AIDS harm reduction.

Findings: After Street Smart was implemented, it yielded these results:

1. Participants reported lower rates of substance use and unprotected sex acts.
2. After the group sessions, young women self-reported greater reductions in substance abuse and unprotected sex acts than young men.
3. African-American youth self-reported less substance use than youth of other ethnic groups.

Web site: Click on Street Smart at [www.effectiveinterventions.org](http://www.effectiveinterventions.org) or go to <http://chipts.ucla.edu/interventions/manuals/intervstreetsmart.html>

## 2. The SISTA Project

The SISTA project is a social skills training intervention for African-American women aimed at reducing HIV sexual risk behavior. It is comprised of five two-hour sessions delivered by peer facilitators in a community-based setting. The sessions are gender- and culturally-

relevant and include behavioral skills practice, group discussions, lectures, role play, a prevention video, and take-home exercises.

Target Population: African-American women

Intervention:

The core elements of the SISTA project are:

1. Convening five group sessions facilitated by a peer health educator;
2. Educating participants about condoms through hands-on exercises;
3. Emphasizing gender and ethnic pride as a means to reduce HIV risk behaviors;
4. Educating participants about HIV and other STDs; and
5. Teaching sexual assertiveness and communication.

Findings: Participants in the social skills intervention demonstrated increased consistent condom use, sexual behavior self-control, sexual communication, and sexual assertiveness skills. Additionally, the partners of participants in the social skills intervention were more likely to adopt and support consistent condom use.

Web site: Click on SISTA at [www.effectiveinterventions.org](http://www.effectiveinterventions.org)

#### • **VOICES/VOCES**

Health educators convene groups of 4-8 clinic patients in a room that allows privacy for discussions. Groups are gender-and-ethnic specific, so that participants can develop prevention strategies appropriate for their culture. Information on HIV risk behavior and condom use is delivered by videos, facilitated group discussion, and a poster board presenting features of various condom brands in English and Spanish. Two culturally specific videos are used: one for African- American participants and a bilingual video for Latinos. Skills in condom use and negotiation are modeled in the videos, then role -played and practiced by participants during the discussion that follows. At the end of the single, 45-minute session, participants are given samples of the types of condoms they have identified as best meeting their needs.

Target Population: African- American and Latino adult men and women

Intervention:

The core elements of VOICES/VOCES include:

1. Viewing culturally-specific videos portraying condom negotiation;
2. Conducting small group skill-building sessions to work on overcoming barriers to condom use;
3. Educating program participants about different types of condoms and their features; and
4. Distributing samples of condoms identified by participants as best meeting their needs.

Findings: After the VOICES/VOCES intervention, the following results were displayed:

1. Participants increased knowledge about the transmission of HIV and other STDs.
2. Participants had a more realistic assessment of their personal risk.
3. Participants had a greater likelihood of getting condoms and intending to use them regularly.
4. Participants presented fewer repeat STD infections.

Web site: Click on VOICES/VOCES at [www.effectiveinterventions.org](http://www.effectiveinterventions.org)



### ***Individual Level Interventions***

- **Popular Opinion Leader**

Popular Opinion Leader (POL) is an intervention based on a program that identifies, trains, and enlists the help of key opinion leaders to change risky sexual norms and behaviors in the gay community. The program is based on diffusion of innovation/social influence principles, which states that trends and innovations are often initiated by a relatively small segment of opinion leaders in the population. Once innovations are visibly modeled and accepted, they then diffuse throughout a population, influencing others.

Target Population: Men who frequent gay bars

Intervention: A cadre of trusted, well-liked men who frequent gay bars are trained to endorse safer sexual behaviors in casual, one-on-one conversations with peers at the bars and other settings. During these conversations, the “popular opinion leader” corrects misperceptions, discusses the importance of HIV prevention, describes strategies he uses to reduce his own risk (e.g., keeping condoms nearby, avoiding sex when intoxicated, resisting coercion for unsafe sex), and recommends that the peer adopt safer sex behaviors. Popular opinion leaders wear buttons displaying the project logo, which also is on posters around the bars, as a conversation-starting technique. Each leader agrees to have at least 14 such conversations and to recruit another popular opinion leader.

Findings: The POL intervention produced the following results among patrons of bars where the program was conducted:

1. Unprotected anal intercourse decreased from between 15 to 29 percent
2. Condom use increased
3. Numbers of sex partners decreased

Web site: <http://www.cdc.gov/hiv/projects/rep/pol.htm>

- **Efficacy of Risk Reduction Counseling to Prevent HIV and STDs**

The Enhanced and Brief Counseling interventions were based on the Theory of Reasoned Action and Social Cognitive Theory. Sessions were interactive and designed to change factors that could facilitate condom use, such as self-efficacy, attitudes, and perceived norms. The study was conducted in Baltimore, Denver, Long Beach, Newark, and San Francisco. The goal of the intervention was to determine the effects of enhanced and brief interactive counseling interventions to reduce high-risk behavior and to prevent new STDs.

Target Population: Men and women (all races/ethnicities)

Intervention: Health department staff, trained to conduct HIV counseling, delivered the intervention. The Enhanced Counseling intervention consisted of 4 sessions, a total of 200 minutes, and was completed in 3-4 weeks.

*Session 1:* Assessed personal risk, identified barriers to risk reduction, and negotiated a small risk-reduction step achievable in the next week.

*Session 2:* Explored condom use attitudes, discussed prior week's behavior change successes and barriers, and devised a strategy for taking a risk-reduction step before the next session.

*Session 3:* Received HIV test results, discussed prior week's behavioral goal and condom use barriers and facilitators, built condom use self-efficacy, and devised a strategy for taking another risk-reduction step.

*Session 4:* Explored social norms and support for condom use, discussed prior week's behavioral goal successes and barriers, and devised a long-term strategy for consistent condom use.

The Brief Counseling intervention consisted of 2 sessions, a total of 40 minutes, and was completed in 7-10 days. It was based on the HIV Prevention Counseling recommended by CDC for use with HIV testing since 1993.

*Session 1:* Identical to Session 1 above.

*Session 2:* Received HIV test results, discussed changes, support for changes made, and barriers and facilitators to change, and developed a long-term plan for risk reduction. Incentives included cash for intervention sessions, follow-up visits, and STD exams.

Findings: Participants in both counseling interventions reported significantly higher condom use than participants in the comparison condition. Of the counseling participants, 30% fewer had new STDs than participants in the comparison condition. In the counseling interventions, benefits accrued equally to men and women, and STD reduction was higher among adolescents than older participants.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-11.htm>

- **Reduction of High-Risk Sexual Behavior Among Heterosexuals Undergoing HIV Antibody Testing**

The intervention was offered to clients of an STD clinic in Los Angeles. The goal of the intervention was to evaluate the effects of HIV education and testing on sexual risk behavior.

Target Population: Heterosexual adult men and women (all races/ethnicities)

Intervention: The intervention consisted of an educational component and an HIV blood test. The educational component included (a) a written pamphlet that explicitly discussed safer and unsafe sexual acts and explained condom use; (b) a 15-minute video that examined HIV-risk behavior and promoted condom use as well as discussing the risk with sex partners; and (c) a 10-minute, one-on-one counseling session with a physician.

The counseling session focused on assessing personal risk, discussing the elements of HIV testing, and answering any questions about HIV/AIDS or testing. [NOTE: See Summary for Kamb, et al. for current HIV testing and counseling protocols.]

After completing the educational module, intervention participants had blood drawn for an HIV test. Test results were revealed to intervention participants approximately 2 weeks after study entry and were accompanied by the same risk-reduction message as during the pretest counseling (for seronegative results) or in-depth counseling (for seropositive results).

Findings: Participants who received the HIV education and testing intervention reported significantly fewer occurrences of unprotected intercourse than did those in the comparison condition.

Web site: <http://www.cdc.gov/hiv/pubs/hivcompendium/section1-15.htm>

- **STD and HIV Risk in Heterosexual Adults Attending a Public STD Clinic**

This intervention is based on the AIDS Risk Reduction Model. High-risk heterosexual adults in an urban STD clinic participate in a skills-building intervention consisting of 4 individual, 60-minute, multi-component sessions over 4 consecutive weeks.

Target Population: Heterosexual adult men and women

Intervention: Ethnically diverse, trained intervention counselors facilitate the sessions. Participants learn about transmission modes and prevention of HIV/AIDS, assess their personal risk, practice condom-use skills, and develop a risk reduction plan. They also develop effective communication and self-efficacy skills.

*Session 1* includes a video, discussion of STDs, risk assessment, diagrams, and anatomical models to practice condom use.

*Session 2* includes a risk-reduction plan, vignettes, risk scenarios, communication and self-efficacy skill building, and referrals as needed.

*Session 3* reinforces and enhances session 2 skills and includes vignettes and risk scenarios.

*Session 4* is a follow-up on the risk-reduction plan and identifies sources of social support.

Findings: In this study, the intervention did not have an impact on STD acquisition or on women in general, but men reported increased condom use and a lower number of sexual partners without condom use.

Web site: Intervention details can be found on page 22 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

- **Cognitive and Behavioral Adaptations to HIV/AIDS Among Gay and Bisexual Adolescents**

This intervention is based on Social Learning Theory. Predominantly gay male youth participate in a cognitive and behavioral-based intervention designed to reduce sexual risk-

taking behavior and drug use associated with sexual situations. There are individual as well as group-level activities.

Target Population: Gay and bisexual adolescents

Intervention: The program begins with an initial two-hour interview for individualized HIV/AIDS risk assessment and risk-reduction counseling. Youth then participate in a 90-minute interactive peer education program designed to provide factual information about HIV transmission, testing, and the adverse effects of substance use on risk reduction. Behavioral components include avoidance of substance use in sexual situations, communication with sexual partners and friends, risk reduction strategies, and consistent condom use. The peer education program is provided in an atmosphere of mutual support. The program's lessons are reinforced in an educational video. Optional peer support groups meet weekly. Finally, there is a one hour follow-up visit for reassessment and referrals to medical and social services, as needed.

Findings: Outcomes were a decrease in unprotected anal sex, an increase in more frequent condom use, and a reduction in substance abuse.

Web site: Intervention details can be found on page 53 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

- **Factors Mediating Changes in Sexual HIV Risk Behaviors Among Gay and Bisexual Adolescents**

This intervention is based on Social Learning Theory. This intervention is based on programs that have been successful in changing sexual risk behaviors in adult gay men, runaway youth, and adolescents who engage in other types of risky, non-sexual behavior. The program is intensive and includes components with demonstrated effectiveness in social skills training, behavioral self-management, and group and social support from peers. It also addresses youths' needs for comprehensive care.

Target Population: Gay and bisexual adolescents

Intervention: The 20-session intervention rotates in a 3-week sequence, with youths joining the sessions at various points, as they choose (youth attended an average of 11 sessions in this study). The sessions are typically conducted 2 or 3 days per week and last from 90 to 120 minutes each. A small group format is preferred. The HIV intervention activities address five main components:

- 1) Facts about HIV are communicated in artistic venues;
- 2) Coping skills training addresses youths' unrealistic expectations regarding their emotional and behavioral responses in high-risk situations;
- 3) Access to health care and other resources is addressed through a visit to a health care agency;
- 4) Individual barriers to safer sex are reviewed in a private counseling session; and
- 5) Prejudice against gay youth and positive attitudes toward homosexuality are addressed as potential mediators of safer sex attitudes.

Findings: Youth who participated in this intervention reported a 60% increase in protected sexual acts, with the highest number of protected acts occurring immediately following the intervention. Assessments were also conducted at 3, 6, and 12 months. In general, there were significant reductions in unprotected sex and the number of partners. African-American youth maintained their reductions over the one-year period, whereas Hispanic youth returned to baseline levels at the one-year mark.

Web site: Intervention details can be found on page 60 of the \*.pdf document posted at <http://www3.utsouthwestern.edu/preventiontoolbox/interven/Final%20IFS%20Document.pdf>

## G. Focus Group Raw Data for Targeted BRGs

### BRG Focus Group Comments for MSM/W, August 2002

Key Successes	Key Challenges	Recommendations
<ul style="list-style-type: none"> <li>• Clients are modifying behaviors through the intervention. Individuals show intent to change through trans-theoretical models. MSM/W are able to adopt behavior change, reduce sex, and increase condom use.</li> <li>• Participants within the program recognize themselves as MSM/W and are able to bring in others.</li> <li>• Recruiting and training MSM/W has been successful. Outreach has been successful.</li> <li>• Through 1:1 session, individuals able to disclose.</li> <li>• Community involvement.</li> <li>• Collaborations with other agencies have been successful including the cross-implementation of staff.</li> <li>• Individuals' openness.</li> <li>• Attendance at events.</li> <li>• Outreach in open places such as shopping centers.</li> <li>• Providing referrals and incentives.</li> <li>• Having many events (i.e., Café, Carnival, talent show, BBQs).</li> <li>• Having a diverse staff.</li> <li>• Calling our clients "family members" has created a more comfortable environment.</li> <li>• Diverse methods in attracting members.</li> <li>• Able to reach in Recovery and Halfway homes.</li> <li>• Able to identify MSM/W through pre-test.</li> <li>• MSM/W that are involved in workshops are receptive.</li> <li>• Disclosure – openness to sexual orientation.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify issues faced by this population are very challenging. Identifying MSM/Ws is difficult because of culture, family, and social pressure. We are unable to distinguish between gays versus straight. The clients don't identify with behavior. Clients consider themselves heterosexual. Clients are not receptive to these interventions because of how they identify.</li> <li>• Clients want to remain anonymous and are therefore paranoid about having their identity exposed. Trying to earn and gain trust of clients is challenging.</li> <li>• Dealing with issues of homophobia is challenging in reaching this populations.</li> <li>• This population doesn't consider themselves as at-risk. They don't see that they need to be responsible for their behavior because they don't see themselves as bisexual.</li> <li>• Recruiting MSM/Ws because of culture and religious barriers is challenging. Dealing with cultural issues such as Machismo is challenging.</li> <li>• There is a stigma or label to being MSM/W.</li> <li>• It is difficult finding clients because of immigrant mobility.</li> <li>• Finding MSM/Ws, locating MSM/Ws.</li> <li>• Attitude of client is challenging. They will have sex with men if they can't get women.</li> <li>• Limited conduct of outreach face-to-face.</li> <li>• Language is a barrier.</li> <li>• Social/networks</li> <li>• Some settings are not conducive for reaching clients – we need to cater to their comfort zone.</li> </ul>	<ul style="list-style-type: none"> <li>• Need more social marketing and recruitment methods (billboards, magazines) to reach this population.</li> <li>• Streamline paperwork for various interventions (PCM, workshops, etc.).</li> <li>• Need more staff training on how to reach and work with MSM/Ws.</li> <li>• Need more training and information regarding the MSM/W population including how to reach them.</li> <li>• Need research or a study to develop methods on how to reach MSM/W populations (i.e., personality, habits).</li> <li>• Contract should not be just MSM/W specific.</li> <li>• Create a hotline and brochures specific for this population.</li> <li>• Modify contract to allow for internet accessibility.</li> <li>• More opportunities to share information with other agencies on their methods, plans, etc. for working with this population.</li> <li>• More staff.</li> <li>• Integrate STD/HIV testing with prevention education.</li> <li>• Relax standards for PCM.</li> <li>• More outreach diversity.</li> <li>• Diversity of staff.</li> <li>• Sensitivity training for staff.</li> <li>• Contract not to be BRG specific.</li> <li>• Need training to clarify the difference between identification and behavioral risks and assistance in developing strategies to reach persons that identify in varying ways but share the same behavioral risk (BRG).</li> <li>• Increase funding.</li> </ul>

Key Successes	Key Challenges	Recommendations
<ul style="list-style-type: none"> <li>• Outreach in the form of general medical check-ups.</li> <li>• Reaching out to other facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• MSM/W doesn't relate to MSM.</li> <li>• Need to relate to family setting to remain in comfort zone. Make sure that they remain anonymous in order to get information.</li> <li>• Attendance of individuals to return to post-testing.</li> <li>• Clients require time to become comfortable with the program.</li> <li>• Paperwork – complicated</li> <li>• More training of staff – attitude tends toward homophobia, do not understand the behavior of MSM/W.</li> <li>• Recovery House – clients leave and do not stay in contact.</li> <li>• Lack of participation by this population transfers into low numbers.</li> <li>• Timeline – workshop, follow -up, risk assessment.</li> <li>• This is a needy and mobile population.</li> <li>• Sexual behavior – need to implement safe sex methods.</li> <li>• Anonymous testing limits ability to follow -up.</li> </ul>	

## BRG Focus Group Comments for IDUs, August 2002

Key Successes	Key Challenges	Recommendations
<ul style="list-style-type: none"> <li>• Successful newsletter</li> <li>• Outreach workers able to identify IDU youth through partnering with IDU adults</li> <li>• Positive relationship with methadone clinics has made outreach easier</li> <li>• Outreach workers have begun communicating with the police regarding their presence and outreach activities to contact IDUs</li> <li>• IDUs sharing information on how to contact them for follow-up activities</li> <li>• Incentives have been useful in getting IDUs to come back to the program</li> <li>• Increased collaborations and partnerships with other agencies have brought mobile HCT and syringe exchange services on the spot</li> </ul>	<ul style="list-style-type: none"> <li>• Follow-up with clients is challenging; it is sometimes impossible or unrealistic to expect 6-month follow-ups.</li> <li>• Younger crowd and MSM not into injecting drugs. They are more into speed and cocaine, not heroin. This makes it difficult to find these populations.</li> <li>• Short attention span of working with multi-diagnosed clients makes even a risk assessment difficult as it seems too long for them.</li> <li>• Some clients only go through detox twice a year, making it difficult to reach them for HE/RR during the times they are not in treatment.</li> <li>• It is difficult getting the homeless and transient population to consistently participate in group sessions (incentives have helped).</li> <li>• Clients asking for information regarding Hepatitis C. Agencies need more access to programs or services that provide HEP C screening and treatment.</li> <li>• Finding clients over time. Wherever the dope moves, the clients move.</li> <li>• Consistent communication with police is sometimes challenging as they do sweeps of particular areas. When they do this, IDUs are dispersed and it is difficult to find them, often for several months.</li> <li>• The MSM/IDU population is difficult to find. Finding IDUs that admit to MSM behavior is difficult.</li> <li>• Communicating with this population is difficult. They often don't want to give you the time.</li> <li>• Our forms require a lot of signatures and that deters clients.</li> </ul>	<ul style="list-style-type: none"> <li>• Having our own or immediate availability to detox would provide the first step towards "getting clean."</li> <li>• Need more incentives. They are big in getting IDUs to return.</li> <li>• Need funding to conduct hepatitis C screening.</li> <li>• Availability to provide HCT on the spot when doing outreach.</li> <li>• A shelter in our community.</li> <li>• Flexibility to target a broader population to target non-IDU as well.</li> <li>• Increased funding. Limited funding makes it difficult for the same person to do all aspects of the program (e.g., outreach, PCM, groups, and risk assessments)</li> <li>• Gather input and feedback from frontline staff when doing scopes of work.</li> <li>• Eliminate 6-month follow-up and do 1-month and 3-month follow-ups for evaluations.</li> <li>• Longer peer-educator program beyond 3-months is needed in order to have an opportunity to implement other components such as social skills, job skills, etc.</li> </ul>



## BRG Focus Group Comments for Transgenders, May 2002

Key Successes	Key Challenges	Recommendations
<ul style="list-style-type: none"> <li>• There is good attendance at transgender support groups.</li> <li>• Transgenders have become a united community.</li> <li>• Transgender staff at agencies have become positive role models for other transgenders.</li> <li>• Many transgenders have taken the initiative to start their own support groups.</li> <li>• A good example that demonstrates that the transgender community wants to change is when you see transgenders teaching each other skills such as typing, computer, etc.</li> <li>• There are more transgenders attempting to obtain a higher education.</li> <li>• Sex workers are using condoms.</li> <li>• Transgenders are returning for services.</li> <li>• Transgenders can be reached through other transgenders.</li> </ul>	<ul style="list-style-type: none"> <li>• There aren't any plans for new studies that include transgenders.</li> <li>• There are many homeless transgenders and housing shortages for transgenders.</li> <li>• There are not enough appropriate and quality medical services available for transgenders.</li> <li>• There are less services available for a transgender who is HIV – negative than for a transgender who is HIV -positive.</li> <li>• Services are more scarce for female to male transgenders.</li> <li>• It is difficult to reach transgender youth.</li> <li>• Transgenders have relationship issues, i.e. how to have healthy relationships.</li> <li>• Transgender sex workers do not carry condoms because of police harassment.</li> <li>• Transportation is a problem for transgenders since many agencies can't provide it.</li> <li>• Transgenders must decide between entry-level positions at minimum wages or entry level pay versus sex work. It is difficult for transgenders to obtain jobs.</li> <li>• There needs to be more education for transgenders.</li> <li>• A consistent problem has been having transgenders complete any type of information on forms that are required for reporting to funders.</li> </ul>	<ul style="list-style-type: none"> <li>• Subcategories for Transgenders should be added to BRG model.</li> <li>• Additional focus groups for Transgenders who are monolingual recent immigrants should be conducted to find out their needs.</li> <li>• More studies should be conducted on Transgenders. This will assist in determining appropriate interventions.</li> </ul>