

SAN GABRIEL VALLEY

Service Planning Area **SPA**

3

Chapter 3: Community Assessment

Overview

This chapter:

- Discusses community needs, including findings from the Los Angeles Coordinated HIV Needs Assessment (LACHNA), focus groups, and key informant interviews;
 - Presents a brief description of needs by priority population;
 - Provides information on available community resources (i.e., AIDS Education and Training, Community Coalition Building, HIV prevention and related resources, etc.);
 - Offers information on web-related resources; and
 - Includes the LACHNA protocol, a facilitator guide for the focus groups/key informant interviews, and recommendations from the PPC's 2006 Venue Based Task Force, African American MSM Task Force, and the Crystal Methamphetamine Task Force.
-

With a population over 10 million, Los Angeles is the most populous county in the United States (U.S.) covering a region of 4,084 square miles. The sheer size of Los Angeles County and the diversity of its residents contribute to the challenges faced when developing a comprehensive continuum of HIV prevention and care services. The Centers for Disease Control and Prevention's (CDC) *2003-2008 Community Planning Guidance* states that the Community Services Assessment section of the HIV prevention plan "*describes the prevention needs of populations at risk for HIV infection, the prevention activities/interventions implemented to address these needs, and service gaps.*" Thus, a major responsibility of the Los Angeles County HIV Prevention Planning Committee (PPC) is to assess both the HIV prevention-related needs of the community as well as the resources available to address them. This chapter provides the most current information available regarding both community needs and resources, shedding light on how best to target limited funding.

Assessing Community Needs

Los Angeles County utilizes a multi-pronged approach to assess the HIV prevention and related needs of its diverse communities. The Los Angeles County Department of Public Health, Office of AIDS Programs and Policy (OAPP) and the PPC are jointly responsible for completing this work, and they collaborate closely with the Los Angeles County Commission on HIV (COH). Assessing community needs is not a static process. It is a dynamic, ongoing process. Needs assessment occurs formally at the County level but also occurs on a daily basis through the many agencies and community based organizations that develop programs and services to meet the needs of their distinct target populations. It is sometimes through these grassroots efforts that the needs of smaller communities -- such as transgender women, Native Americans, Asian and Pacific Islander communities, African American gay men, crystal methamphetamine users, sex workers, and many others have a voice within the larger planning process.

As part of the process to develop the 2009-2013 HIV Prevention Plan, Los Angeles County has gathered information regarding community needs through multiple avenues. The County's earliest efforts began with the formation of several ad hoc task forces to examine community needs related to HIV testing, African American or Black men who have sex with men (MSM), crystal methamphetamine use, and high risk sex venues. The PPC established these four task forces/work groups to gather specific information regarding community needs in these areas. The findings and recommendations from three of the four task forces (i.e., African American MSM Task Force, Crystal Methamphetamine Task Force, and the Venue-based Task Force) were included in the County's *HIV Prevention Plan Addendum 2006*. Findings and recommendations from all task forces were approved by the PPC and informed the needs assessment process.

In May 2007, the PPC formed a Prevention Plan Work Group (PPWG) to be responsible for developing a new prevention plan for 2009 through 2013. As part of this work, PPWG members examined multiple data sources in order to determine the extent of need in the County for HIV prevention and related services. These data sources included:

- HIV epidemiologic studies;
- HIV/AIDS surveillance systems;
- Los Angeles Coordinated HIV Needs Assessment (LACHNA);
- Focus group and key informant interviews with agency staff providing services to persons at-risk for HIV/AIDS; and
- Resource Inventory survey

The *Community Assessment* chapter presented here expands upon the quantitative data presented in *Chapter 2: HIV Epidemiologic Profile*. The epidemiologic profile includes a general picture of Los Angeles County, estimates of current HIV and AIDS prevalence, as well as key information related to the specific priority populations and co-morbid communicable diseases (e.g., STIs, TB). This chapter presents both quantitative and qualitative data that describe the specific HIV risk behaviors that exist within the County that put individuals of a population at risk for HIV. Examining both the quantitative and qualitative data together provides a more comprehensive picture of community needs. When these needs are overlaid with available resources, this information helps service providers, policymakers, government representatives, faith communities, and other community and county stakeholders identify existing gaps. It also helps these stakeholders gain a comprehensive understanding of the current and potential HIV prevention challenges facing Los Angeles County.

■ **The 2007 Los Angeles Coordinated HIV Needs Assessment**

The 2007 Los Angeles Coordinated HIV Needs Assessment (LACHNA) was Los Angeles County's first effort to examine both HIV prevention and care related needs through a single needs assessment process. OAPP, the PPC, and the COH coordinated their efforts to gather survey data from people living with HIV/AIDS (PLWHA) and individuals at risk for HIV. LACHNA provided a county profile of HIV risk. It also helped assess the service needs and service utilization patterns of PLWHA and individuals at risk for HIV. The LACHNA survey was developed to gather data on existing target populations as well as to identify emerging populations. OAPP and the PPC formed a LACHNA prevention work group consisting of OAPP staff, PPC subcommittee members, and a COH representative. The objectives of this workgroup were to develop a survey instrument and an implementation plan. The workgroup designed the survey instrument by modifying previous needs assessment (Countywide Risk Assessment Survey) and gaps analysis tools as well as constructed new questions to address new and

emerging populations/issues. Simultaneously, OAPP and COH developed a care workgroup to craft questions specific to HIV treatment and care. The care workgroup modified questions from previous COH care assessments (H-CAP). OAPP staff participated in both workgroups to construct the final data collection instrument which included both HIV prevention and care questions.

Specific survey topics included the following core areas:

- Demographic information
- HIV care/testing
- HIV knowledge
- Drug and alcohol use
- Sexual risk behaviors
- Perceptions of risk for acquiring/transmitting HIV
- HIV prevention service utilization
- Mental status/mental health service utilization
- Oral health
- Care service utilization (HIV/AIDS, primary medical health, housing, case management, substance use).
- Health insurance/benefits utilization

OAPP developed the survey to be administered on a hand-held personal digital assistant (PDA). Project principal investigators assembled and trained a team of interviewers to conduct the survey. Using PDAs systematized and facilitated data collection in a way not previously experienced. The compact size of the PDAs allowed LACHNA staff to discretely conduct surveys in a wide variety of venues including bars, clubs and street corners, without the need to carry a clipboard or paper documents. Administering the survey using a PDA greatly increased accuracy and efficiency as the data collector did not have to worry about following skip patterns or recalling previous responses. As a result, the interviewer was able to go through more than 300 questions relatively easily.

❖ **LACHNA PROTOCOL**

For the detailed account of the LACHNA Protocol, please see Attachment 1 at the end of this chapter.

A. Background:

In an effort to enhance our understanding of both prevention and care services needs for individuals living with or at risk for HIV in Los Angeles County, the Office of AIDS Programs and Policy (OAPP), the Los Angeles County HIV Prevention Planning Committee (PPC) and the Commission on HIV (COH) have developed a needs assessment questionnaire.

The evaluation has the following major objectives:

1. To describe the populations receiving HIV services;
2. To assess populations not receiving services;
3. To identify where risky behavior is occurring;
4. To identify what services are needed;
5. To determine where services are needed.

B. Methods:

Approximately 2,000 interviews were conducted throughout Los Angeles County and in all eight Service Planning Areas (SPAs). It was anticipated that two thirds of the participants would be HIV negative or unaware of their HIV status and one-third would be HIV positive.

All individuals ages 13 years of age or older were eligible to participate. Youth under 12 years of age were excluded. Individuals who, at the time were incarcerated were also excluded from participation. Systematic sampling was used to select which clients were eligible to participate in the survey.

The primary goal of LACHNA was to obtain data from five distinct populations:

1. HIV negative individuals currently receiving HIV prevention services,
2. HIV negative individuals or individuals who do not know their HIV status and have not ever received HIV prevention services,
3. HIV positive individuals who are not receiving HIV medical care services (out of care),
4. HIV positive individuals who are currently receiving HIV care services (in care), and
5. HIV positive individuals who are currently receiving care services but did not access services in the prior 12 months (return to care).

In addition, there were specific sections for homeless, crystal methamphetamine users, adult film stars, and parents or guardians of children. Multiple layers of skip patterns were embedded within the survey. For this reason the survey took approximately 15 to 60 minutes to complete. Therefore, LACHNA utilized a two-tiered compensation method. Participants were compensated with an item valued at \$20.00 for an interview lasting 45 minutes or less and \$30.00 for an interview longer than 45 minutes. The length of the survey was dependant on HIV status and whether the client was currently accessing care services. There was no client follow-up after the survey.

Data collection took approximately twenty eight weeks (starting June 10, 2007). The needs assessment was anticipated to take approximately one year to complete, which included instrument development, implementation, analysis, and dissemination of results. Data was collected using hand-held computing devices (PDAs) which employed handheld assisted personal interview software (HAPI; developed by Nova Research, Bethesda MD). This system completely eliminated data entry and dramatically increased accuracy.

Data was obtained through the LACHNA survey which was available in English and Spanish language. Data was collected at venues, clinics, and sites randomly selected throughout all eight SPAs in Los Angeles County.

❖ RECRUITMENT GOALS

OAPP, the PPC, and COH worked collaboratively to establish recruitment goals. Geography and behavioral risk were identified as the two recruitment goals and the number and types of survey sites were established based on the present Geographic Estimate of Need (GEN) for both prevention and care. After establishing recruitment goals, the workgroups identified over 300 sites for surveying potential participants which included high-risk sites such as street corners, bars/clubs, and commercial sex venues, as well as other sites including HIV treatment providers. They obtained information from several sources, including:

- Los Angeles County HIV Epidemiology Program data
- Community Organizations
- Los Angeles County Commission on HIV members
- The PPC's Prevention Plan Work Group members

From the more than 300 potential sites, OAPP randomly selected 162 sites by Service Planning Area (SPA) to match recruitment goals, and out of these, surveys were collected from 133 sites. The remaining 29 sites either chose not to participate or logistics could not be adequately addressed to ensure the safety of the data collectors. Sites ranged from parks and truck stops to day labor sites to bars and clubs. LACHNA staff interviewed a total of 1,937 participants. Of the 1,937 surveys, 49 surveys were not included in the final analysis due to ineligibility or early termination. Table 3.1 presents a summary on the total number of participants by outreach location.

Table 3.1 Total Number and Proportion of Participants by Type of Outreach Site

OUTREACH SITE	NUMBER OF PARTICIPANTS	PERCENTAGE
Special Event	149	7.9%
Bar/Club	420	22.2%
Day Labor Site	40	2.1%
Street	157	8.3%
HIV Treatment Providers	779	41.3%
Park or Beach	165	8.7%
Non-high Risk Venue	84	4.4%
Commercial Sex Venue	37	2.0%
Needle Exchange	40	2.1%
School/University	7	0.4%
Truck Stop	3	0.2%
Re-Entry (from correctional facility)	7	0.4%
TOTAL	1,888	100.0%

❖ DATA COLLECTION

Surveys were collected at 91 non-clinic sites between June and October 2007, and clinic surveys were conducted between August and December 2007.

❖ PARTICIPANT CHARACTERISTICS

Table 3.2 below describes basic demographic characteristics of LACHNA participants. A majority of participants were male (71.6%) and the Latino or Hispanic population formed the largest proportion (43.3%) of participants among all racial/ethnic groups followed by African-Americans or Blacks (24.8%) and Whites (14.7%). In regards to sexual identity, a high percentage of participants (46.2%) self-reported as being straight or heterosexual and 39.7% self-reported identifying as gay or homosexual. Among all participants, the primary language spoken was either English (81.1%) or Spanish (17.2%), with only a small percentage reporting an alternate primary language. Approximately three-fourths of all participants had completed high school and a little less than half had finished at least one to two years of college or trade school. Note that educational characteristics of recent immigrants may not have been accurately measured due to differing school systems. A high percentage of participants (78.2%) reported having a stable living situation (defined as owning or renting property). Additionally, about half of the sample reported being unemployed. 29.6% of all participants were born outside of the United States. Of those born outside the U.S., 90.7% were recent immigrants (immigrated to the U.S. less than five years ago) and 39.4% were not legal residents or U.S. citizens.

Table 3.2 Demographic Characteristics of LACHNA Participants

LACHNA PARTICIPANTS (N = 1,888)	
Sexual Identity	
Straight/Heterosexual	46.2%
Gay/Homosexual	39.7%
Lesbian	2.5%
Bisexual	10.5%
Age	
13-17	2.5%
18-25	22.4%
26-29	12.2%
30-39	22.2%
40-49	23.9%
50-59	12.9%
60+	3.7%
Primary Language Spoken	
English	81.1%
Spanish	17.2%
Education ¹ (n = 1,415)	
Completed 9 th grade	94.6%
Completed high school	75.8%
Completed 1-2 yrs. of college/trade school	42.3%
Completed 4-yr. college degree	15.5%
Completed graduate/professional degree	4.0%
Living Situation	
Stable ²	78.2%
Transitional ³	12.7%
Homeless ⁴	9.0%
Current Work Status	
Full-time (≥ 35 hrs.)	33.2%
Part-time (< 35 hrs.)	14.0%
Unemployed	47.9%
Retired	4.0%
Residency Status	
Among non-U.S. born:	29.6%
Not a U.S. Resident or U.S. Citizen	39.4%
Recent Immigrant	90.7%

¹ Includes only individuals greater than 25 yrs. of age.

² Stable living situation is defined as living in a house, condo, or apartment that is owned or rented.

³ Transitional living situation is defined as living in transitional housing, halfway house, substance abuse residential program, assisted living or board and care facility, renting a room from a family member or friend, living with a family member or friend and not paying rent, single room occupancy hotel with a lease, hotel without a lease, hospital or institution, or residential hospice or nursing facility.

⁴ Homeless living situation is defined as living in a car or other vehicle, an abandoned or vacant building, outside on the street, park, beach or underpass, or an emergency shelter or mission.

Table 3.3 Comparison of Gender, and Race/Ethnicity between 2004-2006 AIDS Surveillance, 2006 HIV Counseling and Testing Data and 2007 Los Angeles Coordinated HIV Needs Assessment Participants

CHARACTERISTICS	2004-2006 AIDS Surveillance ^A (N = 3,629)	2006 HCT ^B (N = 31,650)	2007 LACHNA (N=1,888)
Gender			
Male	86.9%	67.7%	71.6%
Female	13.1%	31.6%	20.1%
Transgender	N/A	0.7%	7.9%
Race/Ethnicity			
Latino or Hispanic	44.0%	38.2%	43.3%
White	27.8%	28.5%	14.7%
African-American or Black	23.5%	22.2%	24.8%
Native American/Alaskan Native	N/A	1.1%	3.5%
Asian/Pacific Islander	3.9%	6.0%	5.7%
Mixed Race/Other	N/A	4.0%	8.0%

^A Data Source: Recent AIDS cases, 2004-2006: Table 4 - HIV/AIDS Semi-Annual Surveillance Summary, July 2007, Los Angeles County HIV Epidemiology Program.

^B Data Source: HIV Counseling and Testing, 2005-2006 Data, Los Angeles County Office of AIDS Programs and Policy (data came from publicly funded counseling and testing programs).

Table 3.3 above compares the gender and race/ethnicity breakdown of LACHNA participants with 2006 HCT data and 2004-2006 AIDS surveillance data. It is important to note that HCT data consists of tests (which may contain replicates of the same individual) and AIDS surveillance and LACHNA data consists of individual people, and therefore, may not be appropriate to compare against each other. In terms of gender, AIDS surveillance data has a higher percentage of males compared to both HCT and LACHNA data. HCT data has the highest percentage of females out of the three data sources. Although 32% of testers in Los Angeles County are female, the burden of the HIV/AIDS epidemic falls primarily on males. Data on transgender individuals was not available for AIDS surveillance. Compared to HCT data, transgender individuals comprised a larger percentage of the total LACHNA sample. After consulting and collaborating with community members and members of the Prevention Planning Committee (PPC), venues were identified and transgender individuals were specifically targeted for LACHNA recruitment, oversampling this population relative to the total sample.

The racial/ethnic breakdown was similar for all three datasets. The Latino or Hispanic population comprised the highest percentage, followed by Whites, and then African-Americans or Blacks. The only significant difference can be seen in the LACHNA group, where Whites made up a much smaller percentage of the racial composition of the LACHNA group compared to both AIDS surveillance and HCT data. The reason for this disparity was that a majority of recruiting for LACHNA participants occurred at non-traditional sites, where higher proportions of minority populations (particularly Latino or Hispanic and African-American or Black populations) were present. LACHNA also had a higher percentage of Native American/Alaskan Native and Mixed Race/Other participants compared to the other two samples. This is important to note given the small absolute numbers, since the Native American/Alaskan Native population have high prevalence rates of AIDS in the County as compared to most other racial/ethnic groups.

Table 3.4 below presents the average, median age of participants by specific target population.

Table 3.4 Average (Median) Age by Target Population

TARGET GROUP	AVERAGE AGE
HIV+ Positive	41.0
Gay Men	32.0
Non Gay-Identified Men	33.0
Latino Men	31.5
African American Men	40.0
Caucasian Men	38.0
Women	36.0
Transgender	30.0
Youth	21.0
Sex Workers	29.0
Drug Users	37.0

❖ RESULTS BY TARGET POPULATION

After LACHNA was conducted, the PPC adopted a new set of priority populations described in *Chapter 4: Priority Populations*. Although the original survey tool was designed to reflect Los Angeles County’s previously-approved behavioral risk group populations and not the County’s new priority populations, the following data (Tables 3.4 through 3.8) have been organized by the current priority populations (i.e., HIV positive individuals, men, women, transgender individuals, youth, and people who share injection paraphernalia). The PPC also adopted *critical target populations* within each priority population. Most significant are “gay men” and “non-gay identified men who have sex with men” (MSM). These designations take into account important issues of identity. The PPWG and the PPC acknowledged that how an individual self-identifies may result in a barrier to services if a person does not see himself or herself as a member of a particular “target population.” This is most acutely experienced among men who have sex with other men but do not identify as gay, bisexual, queer or any identity that connotes homosexuality. Some men, for example incarcerated men, men who participate in commercial sex work or sex exchange, or victims of sexual violence may identify as “straight.” As a result, they may not feel comfortable attending an HIV prevention program targeting MSM. Research has also shown that identity serves as a protective factor against HIV for gay men who identify and embrace their gay identity. Thus, the distinction between these *critical target populations* is important for understanding HIV risk within these populations. Lastly, the PPC also recognized disparities across race/ethnicity. Thus, it is important to examine priority populations by race/ethnicity to see the differences in HIV risk behaviors across racial/ethnic groups. The populations presented below include:

- TABLE 3.5 HIV Positive Individuals
- TABLE 3.6 Men: Gay Men & Non-Gay Identified MSM;
- TABLE 3.7 Men: Latino, African American, and White;
- TABLE 3.8 Women, Transgender Individuals, and Youth; and
- TABLE 3.9 Sex Workers and Drug Users (includes people who inject as well as those who use other substances).

Although not a priority population, the PPC identifies “sex work” and “drug use” as contributing co-factors for HIV risk. Specific information was collected from individuals impacted by these co-factors (see Table 3.8) in order to better identify their unique needs.

When reviewing the information on the following tables, the sample size of the population (n) is provided. This is important as the detailed information is provided in percentages. Also, it is important to note that the data from Tables 3.5 to 3.9 include only those individuals who self-reported that they were sexually active (responded that they had sex in the past six months), and therefore, at sexual risk for HIV infection or transmission.

Table 3.5 LACHNA 2007 Data for HIV Positive Individuals

HIV+ POSITIVE INDIVIDUALS (N = 275)		
Sexual Identity		
	Gay	58.9%
	Heterosexual ("Straight")	32.0%
	Bisexual	8.4%
Gender of Sex Partners		
	Male	77.5%
	Female	16.7%
	Transgender	0%
	Multiple Genders	5.8%
Behavioral Risk		
Sexual	Casual Partner (at least 1 in past 6 months)	48.0%
	Inconsistent condom use (past 6 months)	36.7%
	Serodiscordant partner (past 6 months)	46.6%
	Used a needle for any purpose (past 6 months)	10.2%
	Among those using needles, shared a needle	21.4%
	Perception of Risk of Transmission: Low Susceptibility	40.0%
Co-Factors		
	Drugs used in past 6 months: Methamphetamine	14.9%
	Cocaine, Crack, Heroin, or Meth	21.8%
Access to Prevention Services		
	Did not receive services during past 6 months	6.6%
	Willing to participate: Individual intervention	11.1%
	Group intervention	27.8%

Table 3.6 LACHNA 2007 Data for Men: Gay and Non-Gay Identified MSM

MEN		GAY (N=384)	NON-GAY IDENTIFIED MSM (N=30)
Racial/Ethnic Profile			
Latino or Hispanic		49.7%	36.7%
Caucasian		18.8%	10.0%
African American or Black		16.7%	33.3%
Asian or Pacific Islander		6.8%	0%
Native American or Alaskan Native		2.1%	3.3%
Mixed Race/Other		6.0%	16.7%
Gender of Sex Partners			
Male		91.7%	13.3%
Female		0.5%	0%
Transgender		0.5%	0%
Multiple Genders		7.3%	86.7%
Behavioral Risk			
Sexual	Casual Partner (at least 1 in past 6 months)	56.8%	46.7%
	Used Internet to find sexual partner (past 6 months)	26.6%	13.3%
	Inconsistent condom use (past 6 months)	32.3%	23.3%
	Serodiscordant partner (past 6 months)	23.4%	3.3%
	Sex while under the influence of "meth"	11.7%	25.0%
Used a needle for any purpose (past 6 months)		5.7%	6.7%
Among those using needles, shared a needle		18.2%	0%
Perception of Risk for Acquiring HIV: Low Susceptibility		40.1%	35.3%
Co-Factors			
Drugs used in past 6 months: Methamphetamine		14.1%	13.3%
Cocaine, Crack, Heroin, or Meth		17.7%	20.0%
Sexually Transmitted Infection (in past 6 months)		13.3%	3.3%
Unemployed		31.3%	46.7%
Education – less than high school		10.4%	20.0%
Unstable living condition or homelessness		12.0%	30.0%
Access to Prevention/Testing Services			
Did not receive services during past 6 months.		14.8%	46.7%
Willing to participate: Individual intervention		19.3%	7.1%
Group intervention		22.8%	7.1%
Tested for HIV		96.1%	66.7%
Among those tested: Received results		98.4%	100%
Among those that received their results: HIV negative		57.0%	85.0%
HIV positive		42.2%	15.0%
HIV+ that did not pursue medical care		3.9%	33.3% ¹
Non-HIV+ not willing to test in own neighborhood		23.8%	23.5%

¹ Percentage unstable due to small numbers (n = 3).

Table 3.7 LACHNA 2007 Data for Men: Latino or Hispanic, African American or Black, White

MEN		LATINO or HISPANIC (N=334)	AFRICAN AMERICAN or BLACK (N=181)	WHITE/ CAUCASIAN (N=112)
Sexual Identity				
	Gay	57.2%	35.4%	64.3%
	Heterosexual (i.e., Straight)	31.7%	53.0%	27.7%
	Bisexual	11.1%	10.5%	8.0%
	Did not report	0%	0%	0%
Gender of Sex Partners				
	Male	58.7%	40.3%	68.8%
	Female	29.6%	48.1%	25.9%
	Transgender	0.6%	0%	0%
	Multiple Genders	11.1%	11.6%	5.4%
Behavioral Risk				
Sexual	Casual Partner (at least 1 in past 6 mos.)	46.7%	52.5%	59.8%
	Inconsistent condom use (past 6 mos.)	26.4%	28.2%	42.0%
	Serodiscordant partner (past 6 mos.)	22.5%	13.8%	17.9%
	Sex while under the influence of "meth"	10.2%	3.3%	16.1%
	Trading sex	7.5%	7.7%	8.0%
	Used Internet to find sexual partner (past 6 mos.)	15.0%	13.8%	32.1%
	Used a needle for any purpose (past 6 mos.)	8.1%	4.4%	13.4%
	Among those using, shared a needle	22.2%	12.5%	6.7%
	Perception of Risk for HIV: Low Susceptibility	41.8%	56.5%	41.9%
Co-Factors				
	Drugs used in past 6 mos.: Methamphetamine	12.9%	5.0%	19.6%
	Cocaine, Crack, Heroin, or Meth	19.8%	19.3%	25.0%
	Treated for STD (in past 6 mos.)	11.7%	7.2%	8.0%
	Unemployed	35.6%	46.4%	39.3%
	Education – less than high school	18.9%	12.2%	8.9%
	Unstable living condition or homelessness	13.5%	26.5%	25.9%
	Among non-U.S. born:			
	Not a U.S. Resident or U.S. Citizen	41.9%	20.0%	0%
	Recent Immigrant	89.4%	90.0%	100%
Access to Prevention/Testing Services				
	Did not receive services during past 6 mos.	18.0%	17.7%	26.8%
	Willing to participate: Individual intervention	40.0%	31.3%	23.3%
	Group intervention	38.3%	34.4%	16.7%
	Tested for HIV	88.9%	89.0%	90.2%
	Among those tested: Received results	98.7%	96.9%	97.0%
	HIV negative	62.1%	69.2%	63.3%
	HIV positive	37.5%	30.1%	36.7%
	HIV+ that did not pursue medical care	6.4%	4.3%	2.8%
	Non-HIV+ not willing to test in own neighborhood	13.7%	16.5%	27.4%

Table 3.8 LACHNA 2007 Data for Women, Transgender Individuals, and Youth

SUBPOPULATION		WOMEN (N=218)	TRANSGENDER (N=80)	YOUTH (N=255)
Sexual Identity				
	Gay	1.8%	40.0%	39.2%
	Lesbian	15.6%	2.5%	5.9%
	Heterosexual (i.e., Straight)	74.8%	41.3%	39.6%
	Bisexual	7.8%	10.0%	14.1%
	Did not report / Not clear	0%	6.3%	1.2%
Gender of Sex Partners				
	Male	75.2%	85.0%	61.6%
	Female	17.0%	3.8%	25.5%
	Transgender	0%	1.3%	0.8%
	Multiple Genders	7.8%	10.0%	12.2%
Behavioral Risk				
Sexual	Casual Partner (at least 1 in past 6 mos.)	22.0%	65.0%	47.8%
	Inconsistent condom use (past 6 mos.)	20.2%	50.0%	31.0%
	Serodiscordant partner (past 6 mos.)	11.5%	26.3%	10.6%
	Sex while under the influence of "meth"	7.3%	17.5%	9.8%
	Trading sex	6.4%	30.0%	12.2%
	Used Internet to find sexual partner (past 6 mos.)	3.2%	26.3%	18.4%
	Used a needle for any purpose (past 6 mos.)	10.6%	31.3%	5.1%
	Among those using, shared a needle	17.4%	8.0%	7.7%
	Perception of Risk for HIV: Low Susceptibility	64.1%	26.7%	46.2%
Co-Factors				
	Drugs used in past 6 mos.: Methamphetamine	9.6%	18.8%	13.7%
	Cocaine, Crack, Heroin, or Meth	20.6%	27.5%	18.4%
	Treated for STD (in past 6 mos.)	5.5%	21.3%	15.3%
	Not employed	53.7%	40.0%	43.5%
	Education – less than high school	21.6%	23.8%	18.4%
	Unstable living condition or homelessness	26.2%	18.8%	20.4%
	Among non-U.S. born:			
	Not a U.S. Resident or U.S. Citizen	44.8%	35.3%	49.1%
	Recent Immigrant	100%	82.4%	70.9%
Access to Prevention/Testing Services				
	Did not receive services during past 6 mos.	21.6%	10.0%	21.6%
	Willing to participate: Individual intervention	23.4%	37.5%	30.9%
	Group intervention	17.0%	37.5%	23.6%
	Tested for HIV	85.3%	92.5%	78.0%
	Among those tested: Received results	94.1%	97.3%	97.0%
	HIV negative	81.1%	62.5%	89.6%
	HIV positive	18.9%	37.5%	10.4%
	HIV+ that did not pursue medical care	6.1%	14.8%	15.0%

Table 3.9 LACHNA 2007 Data for Subpopulations - Drug Users and Sex Workers

SUBPOPULATION		DRUG USERS (N=219)	SEX WORKERS (N=97)
Racial/Ethnic Profile			
Latino or Hispanic		40.6%	37.1%
Caucasian		21.5%	17.5%
African American or Black		23.7%	26.8%
Asian or Pacific Islander		3.2%	5.2%
Native American or Alaskan Native		3.7%	5.2%
Mixed Race/Other		7.3%	8.3%
Gender of Sex Partners			
Male		55.7%	61.9%
Female		33.3%	14.4%
Transgender		0.9%	0%
Multiple Genders		10.1%	23.7%
Behavioral Risk			
Sexual	Casual Partner (at least 1 in past 6 months)	60.7%	100%
	Inconsistent condom use (past 6 months)	49.8%	73.2%
	Serodiscordant partner (past 6 months)	20.1%	24.7%
	Sex while under the influence of "meth"	41.7%	40.2%
Used a needle for any purpose (past 6 months)		35.6%	29.9%
Among those using needles, shared a needle		20.5%	17.2%
Perception of Risk for HIV: Low Susceptibility		40.0%	26.7%
Co-Factors			
Drugs used in past 6 months:			
Cocaine		28.3%	20.6%
Methamphetamine		58.9%	44.3%
Crack		35.2%	22.7%
Heroin		19.6%	5.2%
Sexually Transmitted Infection (in past 6 months)		13.2%	14.4%
Unemployed		59.8%	54.6%
Education – less than high school		23.3%	22.7%
Unstable living condition or homelessness		45.2%	49.5%
Access to Prevention/Testing Services			
Did not receive services during past 6 months		10.1%	5.2%
Willing to participate: Individual intervention		36.4%	40.0%
Group intervention		36.4%	20.0%
Tested for HIV		95.0%	95.9%
Among those tested: Received results		94.2%	93.6%
HIV negative		68.9%	69.0%
HIV positive		30.6%	31.0%
HIV+ that did not pursue medical care		13.3%	74.1%

■ Focus Groups & Key Informant Interviews

The PPC's Standards & Best Practices subcommittee members and OAPP staff conducted seven focus groups in order to gain information from agency staff regarding their experiences recruiting, retaining, and providing HIV prevention services to specific target populations. Although there were nine priority populations and various emerging populations of interest as described in the *Los Angeles County 2004-2008 HIV Prevention Plan and 2006 Prevention Plan Addendum*, data were collected through other projects/studies for some of the populations. Therefore, this series of focus groups targeted (1) men who have sex with men (MSM), including African American or Black MSM; (2) men who have sex with men and women (MSM/W); (3) transgenders at sexual risk and transgender injection drug users (TSR/TIDU); (4) women at sexual risk (WSR); (5) people living with HIV and AIDS (PLWHA); and (6) injection drug users (IDU).

To augment the focus group data, OAPP conducted eight key informant interviews with service providers. The key informants worked at agencies targeting other non-behavioral risk group (BRG) populations (i.e., Native Americans and Incarcerated), as well as with programs funded to provide structural HIV prevention interventions (i.e., faith-based and school-based HIV prevention programs, and social marketing campaigns). OAPP developed a *Focus Group & Key Informant Questions: Facilitator Guide* (see Attachment 2 at the end of this chapter for questions) to ensure a consistent process for gathering information.

❖ FOCUS GROUP PROCESS

OAPP mailed an invitation letter to all of their HE/RR-funded agencies that provided services to the identified BRG priority populations listed above. Agencies selected one staff member to attend the focus group using the following criteria:

1. Works primarily with the identified BRG;
2. Has thorough knowledge of Health Education/Risk Reduction programs;
3. Able to articulate program successes, challenges, and recommendations; and
4. Has worked with the organization for at least six months.

The size of each focus group was limited to six to eight participants to ensure that each participant had an opportunity to speak.

Discussions centered around four areas: (1) general information about the target populations and specific services provided; (2) successes and challenges in recruiting and retaining participants; (3) prevention services and HIV testing needed; and (4) successes and challenges in changing behavior, attitudes, and beliefs (see Appendix for *Facilitator Guide*). Data collection began in August and was completed in September 2007. Findings were presented to the PPWG and were considered in the priority setting process (see Chapter 4). Findings from the focus groups and key informant interviews are provided but are only a starting point in addressing the four topic areas since they represent the opinions and experience of a small number of service providers in Los Angeles County.

❖ **FOCUS GROUP RESULTS**

In reviewing the information across target populations, several themes emerged that are common for all target populations. This information is presented below in order to gain insight regarding community needs from the service provider perspective.

Common Themes Shared by All Target Populations

- Building rapport with clients is critical;
- Establishing trust with clients may determine their level of participation and disclosure;
- Having peer health educators facilitates learning because clients believe that the educator has a sense of understanding of the challenges they face;
- Agencies must design interventions that address clients' immediate needs, while also addressing their HIV prevention needs;
- Incentives need to be appropriate for the target population (e.g., a gift card may not be appropriate for IDUs or movie ticket may not be appropriate for homeless individuals);
- Social networking is achievable through existing client bases; and
- Collaboration between agencies is essential for successful client-centered interventions.

Common Challenges Facing HIV Prevention Program Participants

- Participants move frequently and maintaining accurate contact information is difficult;
- Transportation to attend programs continues to be problematic, making it hard for participants to maintain regular attendance throughout multiple intervention sessions;
- The community still faces numerous challenges with stigma and shame, including:
 - a. Fear of being identified as HIV positive;
 - b. Concern about what peers may think of them;
 - c. Not wanting to identify as "MSM" or "MSMW;" and
 - d. Personal safety is an issue facing transgender individuals particularly on group outings.
- Male participants will often disclose their drug use behavior(s) before disclosing their sexual behavior(s) with other men.

In addition to the themes and challenges shared by multiple target populations, there were several unique themes that emerged specific to each target population. The information presented below represents the information provided by OAPP-funded agency staff who participated in a focus group. This information is based upon the experience of these agency staff and is intended to supplement needs assessment information obtained directly from consumers and persons at risk for HIV in Los Angeles County.

Table 3.10 Provider Focus Group Themes and Ideas for Future Strategies by Target Population

Target Population	Unique Themes	Future Ideas
PLWHA	<ul style="list-style-type: none"> • Use participants' feedback to improve programs • "Closed group" formats guard confidentiality and clients do not need to worry about disclosing their status • Gift cards and food are good incentives • Outreach efforts need to include agencies that are not HIV-specific so that they may refer HIV positive participants for other appropriate services • More recruitment and referrals during HIV testing is needed 	<ul style="list-style-type: none"> • Have intervention groups online, and post the pre and post tests online
MSM	<ul style="list-style-type: none"> • Provide access to other life skill services such as resume building workshops and job seeking • Gift cards or theme park tickets are good incentives • Outreach at bars and clubs is effective 	<ul style="list-style-type: none"> • Do outreach on the Metro • Use phone cards as incentives for incarcerated MSM
MSM: African American or Black	<ul style="list-style-type: none"> • Obtain input from every client on what their specific needs are; addressing immediate needs first is crucial as it will impact how they respond to the HIV intervention • Good communication and follow through on promises is important so that the relationship is maintained • Meals are good incentives • Youth specific events help • Agency staff needs to be at an event or appointment when participants expect to see them. Otherwise, it negatively impacts the relationship • Agencies tend to frequent the same venues yearly, yet African American MSM frequent other places as well 	<ul style="list-style-type: none"> • Have a more gay-friendly "urban" facility that targets African American and Latino communities
MSMW	<ul style="list-style-type: none"> • Clients must feel comfortable with the staff • The staff needs to be friendly, non-judgmental, competent • Assurance that confidentiality will be maintained is vital • Outreach may be conducted at: transgender venues, day laborer sites, bathhouses, or parks 	<ul style="list-style-type: none"> • Use the internet as a medium to deliver the intervention to MSMW • Have a chat room specifically for MSMW
IDU	<ul style="list-style-type: none"> • Target clients where they are located • Target the whole population and not distinct sub-groups • Building trust is important • Flexibility is necessary for this population • Provide certificates of completion for participants • Drug treatment/methadone clinics are effective outreach sites • Developing a partnership with direct service providers and needle exchanges is useful for referring and linking clients to other resources 	<ul style="list-style-type: none"> • Offer hygiene kits to IDUs • Provide needles as incentives • Target all IDUs in the same group
TSR/TIDU	<ul style="list-style-type: none"> • Having friendly and approachable staff is important • Flexible hours are helpful • Effective outreach requires partnerships with venue owners and managers 	<ul style="list-style-type: none"> • Have a dance group for transgender performers
WSR	<ul style="list-style-type: none"> • Be upfront about the amount of time that is necessary to commit to an intervention • Go where the clients are located • Grocery store gift cards are good incentives 	<ul style="list-style-type: none"> • Have transit TVs that play on the Metro with HIV advertising • Public service announcements on the Metro about getting tested for HIV

❖ **KEY INFORMANT INTERVIEWS: PRELIMINARY RESULTS**

As noted, facilitators used the same questions to guide the eight key informant interviews. A key informant interview is a one-on-one dialogue with an expert or someone who has experience in the area of interest. The following two tables outline the themes that emerged during the interviews with agency staff serving Native Americans and the incarcerated population, and those agencies delivering other structural and community level HIV prevention strategies. The findings presented below only represent the opinions or perspectives of one or two individuals per population or prevention strategy.

Table 3.11 Unique Themes for Native Americans

WHAT WORKS
<ul style="list-style-type: none"> • Collaboration with Native American community based organizations is key • Have posters or give out cards with meeting dates and times
CHALLENGES
<ul style="list-style-type: none"> • Native Americans live across the whole County rather than in distinct communities • The race/ethnicity of Native Americans is often misclassified on intake forms • Individuals migrate back to the reservation for ceremony or seasonal harvest times
FUTURE IDEAS
<ul style="list-style-type: none"> • Develop agreements with other organizations to conduct outreach and HIV testing • Develop more relationships with Native American organizations • Target clients at their residences • Address the spiritual development of HIV positive clients in programs

Table 3.12 Unique Themes for Incarcerated Individuals

WHAT WORKS
<ul style="list-style-type: none"> • Men complete risk assessments in holding cell • Women complete risk assessments in housing areas • HIV 101 and individual interventions • Get contact information before they are released • Provide incentives if they participate in a community advisory board (CAB)
CHALLENGES
<ul style="list-style-type: none"> • There are multiple issues related to the jail environment that will always be challenging (e.g., lock-downs, court dates, and release dates) • Lack of or limited private space for individual interventions is problematic • Once an individual approaches his or her release date, there are competing priorities
FUTURE IDEAS
<ul style="list-style-type: none"> • Increase funding for incentives and follow-up visits • Tailor curriculum to Transgender population • Conduct HIV Testing

Los Angeles County provides funding for structural HIV prevention strategies including, faith-based, school-based, and social marketing campaigns. There are important lessons learned through the implementation of these strategies. These are outlined in the following series of tables.

Table 3.13 Unique Themes for Faith-Based Interventions

WHAT WORKS
<ul style="list-style-type: none"> • Networking with fellow clergy • Clergy being part of the Board of Directors • AIDS monument is a catalyst for safe discussion • Community Advisory Board makes recommendations on which churches to target • Trusting relationship between HIV faith-based prevention providers and the church • Sensitivity to church teachings • Follow-up with phone calls, letters, and meetings
CHALLENGES
<ul style="list-style-type: none"> • HIV/AIDS is not a priority for faith community • Stigma around HIV • Belief that HIV is a "homosexual" disease; stigma around gay issues • Secrets and denial in churches • Clergy move from church to church • No buy-in from Senior Pastor
FUTURE IDEAS
<ul style="list-style-type: none"> • Have a conference on Latinos, Faith, Culture & HIV • Use the Arts and put on a play for the congregation • More creativity with advertising • Shift assumption about churches • Better recruitment of men

Table 3.14 Unique Themes for School-Based Interventions

WHAT WORKS
<ul style="list-style-type: none"> • Have three meetings per year with HIV coordinators • Free updated curriculum • Contact school principals • Tap into existing parent groups • Host a workshop on a topic like school bullying and integrate the subject of gay youth
CHALLENGES
<ul style="list-style-type: none"> • Teachers, administrators & parents have competing priorities • HIV is a sensitive issue and hotly debated • There are no students during the summer months
FUTURE IDEAS
<ul style="list-style-type: none"> • Translate curriculum into Spanish • Have an independent evaluator test the efficacy of new HIV interventions • Address teachers and parents' fear about discussing HIV/AIDS • Have a school-wide presentation

Table 3.15 Unique Themes for Social Marketing Campaigns

WHAT WORKS
<ul style="list-style-type: none"> • Listening to the community by having focus groups • Reaching the community through advertisement
CHALLENGES
<ul style="list-style-type: none"> • Designing an effective social marketing campaign
FUTURE IDEAS
<ul style="list-style-type: none"> • Putting advertisements on coffee cup holders • Small posters in front of workout stations at gyms • Target social marketing by age and group • Universal messages • Expand efforts to SPAs 2 & 6

LACHNA, focus group, and data from the key informant interviews are only a few sources of data considered in the needs assessment. Existing HIV/AIDS and STD surveillance data, HIV counseling and testing data, and results from recent research studies/projects were also assessed. The strength of each data source was discussed as the PPWG tried to identify the HIV prevention needs in Los Angeles County based on best-evidence.

■ Assessing HIV Risk and Prevention Needs Across Priority Populations

Understanding risk for acquiring or transmitting HIV among Los Angeles County's priority populations requires putting all the pieces together, the quantitative epidemiologic data with the qualitative needs assessment data, as well as a description of the co-factors that contribute to risk for each population. As all of this information merges, a picture begins to form. What follows is an attempt to bring these three critical elements together in order to describe risk for HIV within specific populations and begin to examine their specific needs for prevention.

The PPC recognizes there are co-factors that contribute to a person's risk of acquiring or transmitting HIV shared by all priority populations. These co-factors include:

- Sex Work
- Mental Health Issues
- Substance Use
- Sexually Transmitted Infections (STIs)
- Poverty
- Stigma and Discrimination
- Racism
- Immigration Status
- Language
- Educational Level
- Violence and Sexual Assault
- Incarceration
- Homelessness

The presence of co-factors in itself does not constitute risk for HIV, but they are important as they heighten one's risk for acquiring or transmitting HIV. For example, an individual who is engaged in sex work or exchange of sex for money, drugs, housing, etc. may be at increased risk for HIV if that person is engaging in unprotected sex. Decision making is impaired among individuals

using drugs and a person may engage in high-risk sex or share injection paraphernalia while high. Stigma and discrimination perpetuate a climate of fear and sometimes shame, within which individuals do not feel empowered to make healthy behavioral choices. Thus, it is always important when describing a population to understand how these co-factors contribute to HIV risk behaviors, as well as how they contribute to or impede a person's access to services.

❖ **HIV POSITIVE INDIVIDUALS**

In Los Angeles County, HIV transmission occurs primarily when a person engages in sexual risk behavior or shares injection paraphernalia with an HIV positive individual. Thus, targeting HIV prevention interventions to HIV positive individuals can reduce the risk among this population for transmitting HIV.

Under the *HIV Positive Individuals* priority population, the Prevention Plan Work Group identified four *critical target populations* for focusing resources and services. These include:

1. Gay men,
2. Non-gay identified men who have sex with men/transgenders/multiple genders (e.g., men and women),
3. Transgenders, and
4. Women at risk for transmitting HIV.

As reported through June 30, 2007, there were 21,973 persons living with AIDS (PLWA) in Los Angeles County and 15,275 persons reported with non-AIDS HIV (PLWH) [1]. The total estimated number of persons living with HIV and AIDS (PLWHA) is much higher, given the fact that many do not know their HIV status. Los Angeles County HIV/AIDS surveillance data reports mode of transmission and not issues of identity. Thus, this data does not differentiate between gay men and non-gay identified MSM. As reported through June 2007, there were 23,222 male PLWHA who reported sex with men as their exposure category. An additional 2,034 male PLWHA reported sex with men and sharing injection paraphernalia (referenced as injection drug use in the surveillance data) as their exposure category. Thus, 67.8% of male PLWHA reported sex with men or sex with men and injection drug use as their exposure category [1]. Through June 2007, there were 4,636 female PLWHA in Los Angeles County. Although not reported here due to small numbers, the HIV Epidemiology Program estimates there are 926 transgender PLWHA living in the County (see Table 2.11 in *Chapter 2: Epidemiologic Profile*).

Among HIV positive individuals, services should target all races/ethnicities. However, a minimum of 23% of services should target African American or Black HIV positive men. This recommendation is based on the extensive work of the African American MSM Task Force (see Attachment 3 at the end of this chapter for recommendations). The key issues that emerged included the following:

1. In the 2004 Los Angeles Men's Survey, the Los Angeles County HIV Epidemiology Program found that African American or Black MSM had the highest prevalence of HIV (36%) and previously undiagnosed HIV infection (75%) compared to other racial/ethnic groups;
2. Ninety-one percent (91%) of African American or Black MSM (ages 23-29 years) who tested HIV positive were unaware of their infection [2].
3. Identified risk factors for African Americans or Blacks include substance use, sexually transmitted diseases, denial, socioeconomic challenges, stigma, late diagnosis, and inadequate infrastructure.

As seen in the LACHNA data (Table 3.5), HIV positive individuals are engaged in a variety of behaviors that increase their risk for transmitting HIV. Nearly half (46.6%) of HIV positive respondents reported that they had had sex with an HIV negative individual during the past six months (i.e., serodiscordant partner). Over one-third (36.7%) reported that they had inconsistent condom use and 48.0% had at least one casual sexual partner. Among HIV positive individuals who had used a needle to inject drugs or other substances, a high percentage (21.4%) second only to Latino males had shared injection paraphernalia. Overall, 40.0% of HIV positive individuals perceived their own risk for transmitting HIV as low.

The PPC recognizes that risk behavior does not occur in a vacuum. There are important co-factors that contribute and heighten risk across populations. For HIV positive individuals, there are unique co-factors that need to be assessed when designing services, and include:

- Methamphetamines and Other Substance Use
- Undiagnosed HIV
- Homophobia
- Transphobia
- Age

❖ **MEN**

Under the *Men* priority population, the Prevention Plan Work Group identified two *critical target populations* for focusing resources and services. These include:

1. Gay men, and
2. Non-gay identified men who have sex with men/transgenders/multiple genders.

As reported through June 30, 2007, there were 32,340 men living with HIV and AIDS in Los Angeles County. Of this number, 25,256 (78%) reported sex with men or sex with men and injection drug use as their exposure category [1]. This highlights the importance of targeting gay men and non-gay identified MSM within this priority population. According to the 2007 LACHNA data, 32.3% of gay men and 23.3% of non-gay identified MSM (see Table 3.6) reported inconsistent condom use during the past six months. Crystal methamphetamine use is a particular problem within this population where 11.7% of gay men and 25.0% of non-gay identified MSM reported having sex while under the influence of crystal meth (see also *Attachment 2: PPC Task Force Recommendations* for the PPC's Crystal Methamphetamine Task Force's recommendations).

In addition to the contributing co-factors shared across all populations, among men, there are specific co-factors that uniquely heighten their risk for acquiring HIV. These include:

- Individuals who engage in Day Labor
- Methamphetamines and Other Substance Use
- Internet for Anonymous Sex
- Homophobia

A total of 26.6% of gay male LACHNA respondents noted that they had used the internet to find a sexual partner. The PPC's Venue Based Task Force (see *Attachment 2: PPC Task Force Recommendations*) examined the relationship between internet use and high risk sexual behavior.

These studies documented increased levels of high risk sexual behavior and sexually transmitted diseases (STDs) among gay men using the internet for seeking sex.

Among men, services should target all races/ethnicities. For the same reasons described above for HIV positive individuals, a minimum of 23% of services should target African American or Black men. The HIV Epidemiology Program estimates there are 5,555 African American or Black gay men or men who have sex with multiple genders who are HIV positive in Los Angeles County (see *Chapter 2: HIV Epidemiologic Profile – Table 2.11*). Among male 2007 LACHNA respondents (see Table 3.7), 28.2% of African American or Black males and 26.4% of Latino or Hispanic males reported inconsistent condom use. African American or Black males were more likely to report their perceived risk for acquiring HIV as low (56.5%) than White males (41.9%) and Latino or Hispanic males (41.8%). Thus, although African American or Black gay/non-gay identified MSM have the highest seroprevalence rate in the County (36.9%; see *Epidemiologic Profile Table 2.11*) across all populations, they are the least likely among racial/ethnic groups to recognize their risk.

According to the 2007 LACHNA data, White men were the most likely to report having sex with a casual partner (59.8%) and inconsistent condom use (42.0%) across racial/ethnic groups. White men were also more likely than other racial/ethnic groups to report using the internet to seek sexual partners (32.1%). White men reported the highest incidence of having sex while under the influence of crystal methamphetamine (16.1%) as compared to other racial/ethnic populations. Among all men who used needles, Latino or Hispanic men were the most likely to share injection paraphernalia (22.2%) compared to 12.5% among African American or Black men and 6.7% of White men.

❖ **WOMEN**

Under the *Women* priority population, the Prevention Plan Work Group identified one *critical target population* for focusing resources and services:

1. Women who have sex with partners of unknown HIV status/risk and/or in highly impacted geographical areas/zip codes based on HIV surveillance, HCT data and other relevant data (e.g., STD data, partners with a history of incarceration).

Through June 30, 2007, there were 4,636 women living with HIV/AIDS in Los Angeles County [1]. Although women comprise only 12.5% of PLWHA in Los Angeles County, there are significant differences across racial/ethnic populations.

As seen in Table 2.11, the HIV Epidemiology Program estimates there is a 4.3% seroprevalence among African American or Black women, followed by 2.4% seroprevalence among Native American women, and 1.8% seroprevalence among Latinas or Hispanic women. Thus, although services to women should target all races/ethnicities, the PPC recommends that a minimum of 70% of services for women target African American or Black, and Latina or Hispanic women.

Based on the algorithm used for estimating the number of women at sexual risk among all African American or Black and Latina or Hispanic women, the calculated HIV prevalence estimates for these two groups appear higher than expected. The methodology for calculating the proportion of women who are at sexual risk across all racial and ethnic groups was determined by women's reported individual behaviors. More realistic population size estimates of women at sexual risk in Los Angeles County should probably take into account the differences in observed HIV/AIDS prevalence of women's heterosexual and bisexual male partners. Assuming that women's sexual exposure is primarily from men of the same racial/ethnic background, future

estimates may incorporate this type of information (i.e., the background HIV prevalence of male partners) to produce more realistic HIV prevalence estimates for women.

According to the 2007 LACHNA data, women were the most likely across all populations to report a self-perceived risk of acquiring HIV as low (64.1%). Although women were less likely than other populations to report having a casual partner (22.0%) or inconsistent condom use (20.2%), these behaviors are still significant within this population (see Table 3.8).

❖ **TRANSGENDER INDIVIDUALS**

Under the *Transgender Individuals* priority population, the Prevention Plan Work Group recommended and approved that all transgender individuals are themselves a *critical target population*. Among transgender individuals, services should target all races and ethnicities.

The HIV Epidemiology Program estimates that there are 926 transgender PLWHA in Los Angeles County (see *Chapter 2: Epidemiologic Profile Table 2.11*). This translates into a 21% seroprevalence within this smaller population. Although the HIV Epidemiology Program has lowered its estimate of total transgender individuals in the County from a previous estimate of 10,000 used in the *Los Angeles County HIV Prevention Plan 2004-2008* to 4,400 based upon current information. Nevertheless, this population remains disproportionately impacted.

In addition to the general co-factors common to all populations, transgender individuals have several co-factors that are of importance to this population, including:

- Methamphetamines and Other Substance Use
- Lack of Employment
- Transphobia

The 2007 LACHNA dataset is one of only a few in Los Angeles County that contains a significant sample (n = 80) of transgender individuals. According to the LACHNA data, transgenders were the most likely population to report having sex with a casual partner (65.0%), other than sex workers (see Table 3.8). They also reported high rates of inconsistent condom use during the past six months (50.0%). Among respondents, 30.0% of transgenders reported trading sex. The lack of employment, one of the contributing co-factors within this population, may lead to transgenders becoming involved in sex exchange for food, money, housing, and/or drugs.

❖ **YOUTH**

Under the *Youth* priority population, the Prevention Plan Work Group identified five *critical target populations* for focusing resources and services. These include:

1. Gay/Bi/Questioning (GBQ) males,
2. Non-gay identified young men who have sex with men (MSM),
3. Transgenders
4. Sex workers
5. Young women who have sex with partners of unknown HIV status/risk and/or in highly impacted geographical areas/zip codes based on HIV surveillance, HCT data and other relevant data (e.g., STD data, partners with a history of incarceration).

Among youth, services should target all races/ethnicities. However, a minimum of 23% of services should target African American or Black male youth.

In the 2007 LACHNA data (see Table 3.8), 47.8% of youth reported having sex with at least one casual partner during the past six months. Thirty-one percent of youth reported inconsistent condom use, and 9.8% of youth reported having sex while under the influence of crystal methamphetamine. Among respondents, 46.2% of youth reported a self-perceived risk of acquiring HIV as low.

❖ **PEOPLE WHO SHARE INJECTION PARAPHERNALIA**

Under the *People Who Share Injection Paraphernalia* priority population, the Prevention Plan Work Group recommended and approved that all *people who share injection paraphernalia* are themselves a *critical target population*. Among *people who share injection paraphernalia*, services should target all races and ethnicities.

Through June 30, 2007, there were 2,004 PLWHA who reported IDU as their exposure category for acquiring HIV. As noted above under men, another 2,034 gay and non-gay identified MSM reported IDU as an additional exposure category.

Although the 2007 LACHNA data did not separate people who share injection paraphernalia from other substance users, the risk behaviors among drug users (n=219) was significant (see Table 3.9). A total of 60.7% of drug users reported sex with a casual partner during the past six months. About half of all drug users (49.8%) reported inconsistent condom use; 41.7% reported having sex while under the influence of crystal methamphetamine. Approximately 35.6% of total drug users reported using a needle for some purpose during the past six months. Among these individuals, 20.5% shared injection paraphernalia.

❖ **OTHER RECOMMENDATIONS – NATIVE AMERICANS**

The Prevention Plan Work Group also recommended that a minimum of one percent (1%) of available funding target Native Americans to ensure that HIV prevention services reach this disproportionately impacted population. They further recommended that any services targeting Native Americans should target multiple populations.

As reported through June 30, 2007, there were 154 Native Americans living with HIV and AIDS in Los Angeles County. The HIV Epidemiology Program further estimates that there are 228 total PLWHA in the County (see *Chapter 2: Epidemiologic Profile Table 2.11*). Second only to African Americans, Native Americans are the most disproportionately impacted racial/ethnic group in Los Angeles County. As seen in *Chapter 2: Epidemiologic Profile-Figure 2.35*, there is a 3.1% seroprevalence rate among Native Americans.

The 2007 LACHNA dataset also collected a significant number of interviews (n = 66) from the Native American/Alaska Native population. Compared to the priority populations, a smaller percentage of Native Americans reported high risk behaviors. Only 27.3% of Native Americans/Alaska Natives reported sex with a casual partner in the last six months and a low percentage (16.7%), reported inconsistent condom use. Additionally, 4.6% reported having sex under the influence of crystal methamphetamine and 12.1% reported using either cocaine, crack, heroin, or crystal methamphetamine in the past six months. A total of 46.7% (of those who were HIV-negative) reported a self-perceived risk of acquiring HIV as low and 15.1% self-reported receiving a HIV-positive test result.

■ Resource Inventory

A community assessment is not complete without a resource inventory to gather information about the prevention activities and interventions currently being carried out to address the needs of populations at risk for acquiring or transmitting HIV. Thus, in order to provide a comprehensive picture of Los Angeles County's HIV prevention funding resources and programs, the Operations Subcommittee of the PPC developed a resource inventory survey which was distributed to organizations providing any type of HIV service in Los Angeles County.

❖ SUMMARY

The Operations Subcommittee of the PPC developed and utilized an online resource inventory survey tool to query agencies providing HIV prevention and care related services. The tool included a variety of questions regarding: (1) the specific services or interventions provided by agencies (e.g., HIV counseling and testing, substance use, mental health, dental care, etc.); (2) how the services were funded (i.e., federal, State, or local funding), including actual dollar amounts; and (3) cost-effectiveness of their services by asking the number of agency clients in general as compared to the number of clients supported with the specified funds. Lastly, survey questions asked agencies about the time period for funded services.

The resource inventory was sent to approximately 189 different agencies across Los Angeles County in early October 2007. Thirty-two (32) surveys were begun and 14 were completed (7.4% response rate of the 189 surveys sent). Possible reasons for the low response rate may include (1) the survey did not reach the most appropriate person to complete it, (2) the survey may have been too long and burdensome to complete as it required detailed information that may have to be pieced together from multiple sources, and (3) a fear that agency responses would negatively impact potential funding from the health department.

Since a community assessment is an ongoing activity, OAPP staff and the PPC will continue this activity in 2008. Based on the response rate, the Operations Subcommittee will revise the survey instrument and continue data collection throughout the first half of 2008. Once data are analyzed the results will be incorporated into the Gaps Analysis.

To augment the resource inventory and provide a more comprehensive community assessment, funding information regarding CDC directly funded grants to OAPP and community agencies, and other federal and private funding sources such as Office of Minority Health and Health Disparities, The California Endowment, and the Substance Abuse and Mental Health Services Administration were obtained.

■ Geographical Assessment of HIV Risk and Service Needs

Because of its large size and the diversity of populations that reside within Los Angeles County's boundaries, allocating HIV prevention and care resources within the County remains a challenging task. In order to maximize the efficiency by which these resources target specific populations within the County that exhibit high risk behaviors, a geographic assessment of HIV risk was conducted using two different sources: Los Angeles Coordinated HIV Needs Assessment (LACHNA) data and HIV Counseling and Testing (HCT) data.

Geographic data were collected in LACHNA and included where participants live, work, and socialize. Clients' home zip code was also collected in the HIV counseling and testing reporting system. A composite HIV risk profile was developed which included HIV prevalence as well as a number of high-risk drug and sexual behaviors. The composite risk profile was analyzed by zip code and those zip codes with the highest raw numbers within each SPA were identified. One should take caution when comparing these high risk ("hot spot") zip codes across SPAs. For instance, a "hot spot" zip code in SPA 1 may not be comparable to a "hot spot" zip code in SPA 4 (where the population density and HIV risk is higher). Therefore, a high-risk zip code should only be considered high risk within each respective SPA.

Figure 3.1 shows high risk ("hot spot") zip codes within each SPA of Los Angeles County identified by LACHNA and/or HCT data. High risk individuals include LACHNA participants who reported inconsistent condom use, drug use (crystal methamphetamine, crack, cocaine, and/or heroin), sharing injection paraphernalia, and/or who are living with HIV or AIDS. Figure 3.1 indicates the "hot spot" zip codes based on LACHNA data (pink areas), 2006 HCT data (green areas) and areas identified as a "hot spot" from both data sources (gold).

While there are some zip codes that were identified as high risk by both LACHNA and HCT data, there were several conflicting outcomes that included: West Hollywood (HCT), Hollywood (LACHNA), SPA 6 (LACHNA), Pacoima (LACHNA), El Monte/Baldwin Park (HCT), and Pomona (LACHNA). For example, HCT data identified West Hollywood as a "hot spot" but West Hollywood was not a "hot spot" for LACHNA. However, the surrounding areas to the east, including much of Hollywood, were LACHNA "hot spots". These differences could be attributed to differences in recruitment sites.

As noted above this analysis was based on the prevalence of high risk behavior and HIV status. Frequency counts were assessed rather than rates by zip code because it is difficult to estimate the size of the high risk population in each SPA. Since rates were not used, it is important to note that high risk areas in one SPA may be reflective of fewer cases than in other SPAs, due to population size differences. However, Figure 3.1 provides a good starting point to understand where target populations live and where some HIV prevention services may be directed. Other geographic data from LACHNA, including where individuals socialize, are currently being analyzed and the results will inform future recommendations for geographic targeting of HIV prevention services.

The table below identifies the “hot spot” zip codes by service planning area as of December 2007. Although not all clients may want to receive HIV counseling and testing in the same neighborhood that they reside, these “hot spots” may be good locations to conduct outreach, mobile testing, community level interventions, or social marketing activities.

Table 3.16 “Hot Spot” Zip Codes by Service Planning Area (SPA)

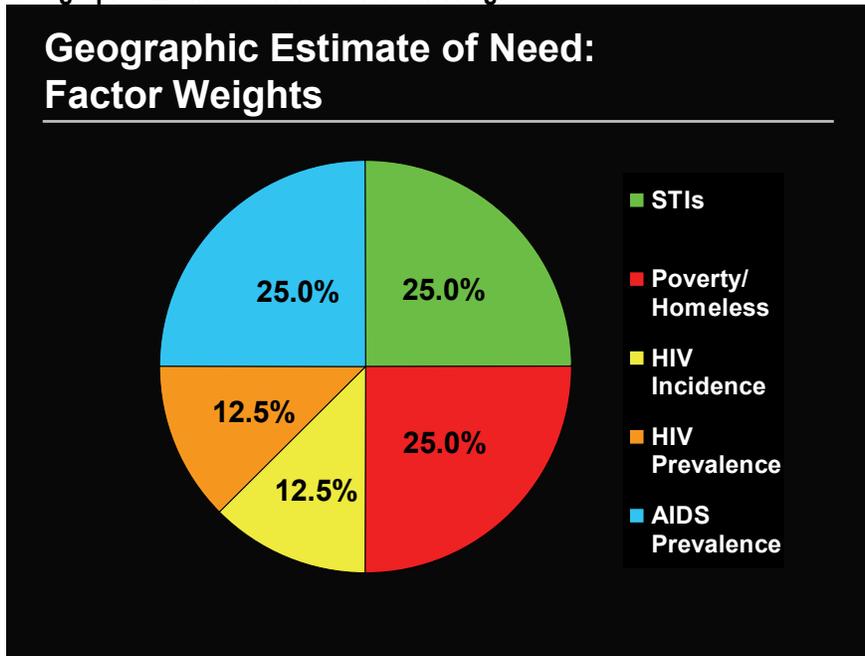
SERVICE PLANNING AREA (SPA)	"Hot Spot" Zip Codes		
SPA 1: Antelope Valley	93534	93535	93550
	91331	91356	91601
SPA 2: San Fernando Valley	91335	91401	91602
	91342	91405	91605
	91352	91406	91606
	91104	91732	91767
SPA 3: San Gabriel Valley	91706	91766	91768
	90005	90026	90046
SPA 4: Metro	90006	90027	90068
	90013	90028	90069
	90017	90038	
	90019	90042	
	90035	90210	90404
SPA 5: West	90064	90272	
	90003	90018	90044
SPA 6: South	90008	90037	90059
	90011	90043	
	90022	90255	90650
SPA 7: East	90201		
	90044	90804	90813
SPA 8: South Bay	90802	90805	
	90803	90806	

As this Prevention Plan is a dynamic, evolving document movement and changes in communities and geographic areas may occur. OAPP is committed to conducting routine geographic assessments and will provide updated information in future addenda as needed.

One other geographic assessment that OAPP completed for the 2009-2013 HIV Prevention Plan was the Geographic Estimate of Need (GEN). Based on the following factors: homelessness/poverty, HIV incidence, HIV prevalence, AIDS prevalence, and STIs (primary and secondary syphilis, gonorrhea, chlamydia) OAPP determined what percentage of prevention resources would be allocated to each SPA.

All factors were not equally weighted in the geographic estimate of need formula. HIV incidence and HIV prevalence were weighted less than other factors because they were not as reliable as the other data sources. The geographic estimate of need was calculated using the following factor weights as depicted in Figure 3.2.

Figure 3.2 Geographic Estimate of Need: Factor Weights



Each weight was applied to the total number of cases in each SPA. The adjusted number of cases in each SPA was totaled across all eight SPAs. Finally, the adjusted number of cases in each SPA was divided by the total to obtain the percent allocation.

Figure 3.3 Geographic Estimate of Need: Percent Allocations for each SPA

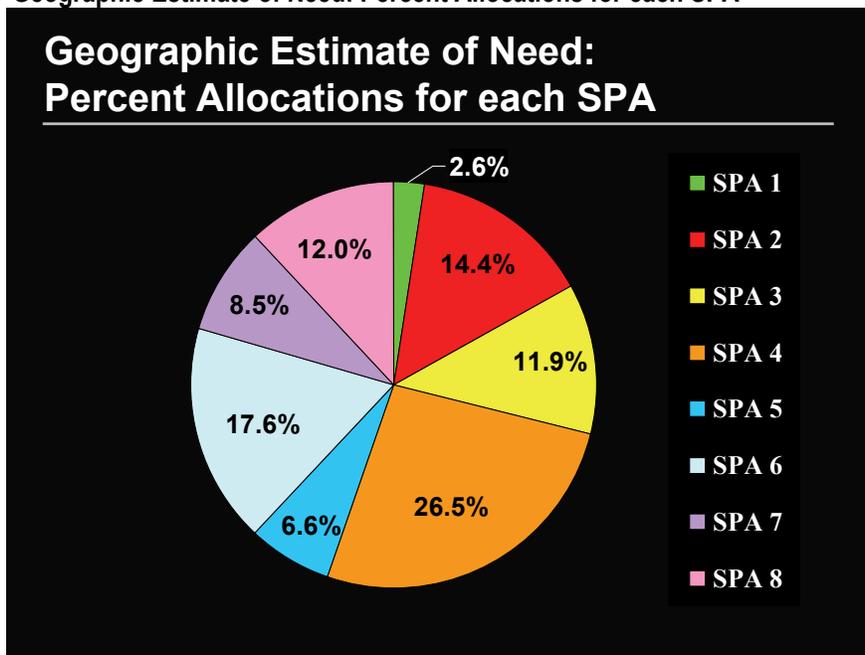


Figure 3.4 Summary of CDC's Community Assessment Requirements

Community Services Assessment (CSA)		
	Purpose	Activities
1. Needs Assessment:	To assess the prevention needs of populations at risk for HIV.	LACHNA Focus Group/Key Informant Interviews Review of existing surveillance and epidemiologic data
2. Resource Inventory:	To gather information about the prevention activities/interventions and fiscal resources currently available in Los Angeles.	Resource Inventory Survey
3. Gaps Analysis:	To compare the needs (needs assessment) and available resources (resource inventory) to determine if any gaps in services exist.	To be conducted in 2008-2013.

■ Gaps Analysis

The gaps analysis is the final requirement of the Community Services Assessment (CSA), whose purpose is to analyze met and unmet needs for prevention services. This analysis uses and compares:

- Information about the relative proportions of specific at-risk target populations based on HIV/AIDS data from the epidemiologic profile.
- The assessment of the HIV prevention needs of these target populations from the needs assessment.
- The availability of existing HIV prevention resources for these populations from the resource inventory.

Ideally, the gaps analysis identifies and describes the level and types of unmet HIV prevention needs for specific target populations. While the analysis identifies unmet service needs for specific populations, it also indicates the relative size of the service gap.

❖ **NEXT STEPS in 2008-2013**

OAPP in collaboration with the PPC will identify activities to complete the gaps analysis starting in 2008. Although the list is not complete, some of the gaps analysis activities include evaluating the linkage between the recommended allocations identified in this plan with funding awards, the health department's application for funding, and services delivered. Other activities planned to identify met and unmet need will include a web-based research project and additional focus groups.

Community HIV Prevention & Related Resources

In addition to HIV prevention funding supported directly through OAPP, including its cooperative agreement with the CDC, State of California Office of AIDS, and Net County Cost, there is a broad array of other resources that support HIV prevention and related activities within the County. These resources include epidemiological and behavioral research; organizations funded directly through both local and federal sources, including but not limited to: the City of Los Angeles, the City of Pasadena, the City of West Hollywood, the City of Long Beach, the CDC, Substance Abuse Mental Health Services Administration (SAMHSA), and the Office of Minority Health (OMH). A brief description of selected resources follows. This information is organized by type of resource, with a brief description of programs, and contact information where available.

■ AIDS Education & Training

❖ THE PACIFIC AIDS EDUCATION AND TRAINING CENTER

The Pacific AIDS Education and Training Center (PAETC) provides HIV/AIDS-related training, education, and information services to health care providers. PAETC has three sites in Southern California. PAETC is an affiliate of the University of California, San Francisco AIDS Research Institute, and is funded by HRSA under the Ryan White CARE Act. PAETC's mission is:

- To provide health care professionals with the knowledge and skills necessary to care for HIV-infected patients in underserved and vulnerable populations;
- To increase the numbers of trained health care professionals working with HIV-infected patients; and
- To respond to the needs of high-risk populations and the changing face of the epidemic.

PAETC offers education and training programs specifically designed for medical personnel including physicians, nurses, physician assistants, nurse practitioners, dentists, dental hygienists, pharmacists, and other health care professionals. Their secondary target audience includes paraprofessionals and other allied professionals.

There are three PAETC sites located within Los Angeles County:

1. Drew University AETC
Charles R. Drew University of Medicine & Science
1731 E. 120th Street, M.P. #11
Los Angeles, CA 90059
Phone: (310) 668-4757
2. UCLA AETC
Center for Health Promotion & Disease Prevention
10833 Le Conte Ave., CHS, Room 61-236
Los Angeles, CA 90095-1772
Phone: (310) 794-7130

3. USC AETC
 School of Medicine
 1420 San Pablo Street, PMB B205
 Los Angeles, CA 90089-9049
 Phone: (323) 442-1846
www.paetc.com

Table 3.17 Additional AIDS Education Training Center Resources

TRAINING CENTER	WEB SITE
AETC National Resource Center The AETCs conduct targeted, multidisciplinary education and training programs for health care providers treating persons living with HIV/AIDS. This website provides a central repository for AETC program and contact information and for training materials developed within the AETC network.	www.aidsetc.org
AETC National Evaluation Center The National Evaluation Center is led by a multidisciplinary team of researchers from the AIDS Policy Research Center (APRC) within the AIDS Research Institute (ARI) at the University of California, San Francisco (UCSF).	www.ucsf.edu/aetnec/
HIV/AIDS Bureau, Health Resources and Services Administration (HRSA) The AIDS Education and Training Centers (AETCs) Program is a network of regional and national centers that train health care providers to treat persons with HIV/AIDS. It is a component of the Ryan White Program.	hab.hrsa.gov
National Minority AIDS Education and Training Center (NMAETC) A training and technical training center based out of Howard University.	www.nmaetc.org
National Pediatric and Family HIV Resource Center (NPHRC) A database where articles about HIV and STDs may be accessed.	www.pedhivaids.org
TARGET CENTER (Technical Assistance Resources, Guidance, Education, and Training Center) Technical assistance includes onsite help, training, technical assistance products, national conference calls, conferences, and other tools.	careacttarget.org

■ Capacity Building & Technical Assistance

❖ CDC CAPACITY BUILDING

Capacity building is a key strategy for the promotion and sustainability of prevention programs. The Capacity Building Branch (CBB) within the CDC Division of HIV/AIDS Prevention provides and coordinates capacity building assistance and related resources. The Capacity Building Branch focuses on improving the performance of the HIV prevention workforce by increasing the knowledge, skills, technology, and infrastructure to implement and sustain science-based and culturally appropriate interventions and HIV prevention strategies. To accomplish its mission, CBB provides national leadership, capacity building assistance, and also funds capacity building partnerships.

CBB works through the activities of its teams, including:

- **Branch Operations Support Services Team** - Provides administrative, editorial, personnel, budget, procurement and data management service and assists other CBB teams in accomplishing their respective goals.
- **Partnerships Team** - Provides national leadership and oversight to capacity building partnerships and advancing HIV prevention among populations at high risk for HIV infection.

- **Science Application Team** - Helps agencies and health departments improve the science base of HIV prevention services by applying the techniques of behavioral and social science and evaluation.
- **Training and Development Team** - Develops, delivers, and coordinates capacity building activities related to training, health education and professional development.

Capacity Building Assistance (CBA) assists in implementing and sustaining science-based and culturally proficient HIV prevention behavioral interventions and HIV prevention strategies. CBA includes:

- **Technology transfer** – the process by which innovations are diffused among HIV prevention providers to improve how intervention effectiveness and scientific research is translated into programs and practice.
- **Technical assistance** – the provision and/or facilitation of culturally relevant and expert programmatic, scientific, and technical advice (mentoring/coaching) and support. CBB members provide assistance to grantees in areas such as organizational infrastructure development, program implementation, adaptation and tailoring of behavioral interventions, and evaluation.
- **Training** – the process of curricula development, delivery of curricula and coordination of training activities to increase the knowledge, skills and abilities of trainers, educators and service providers. Training focuses on the delivery of effective HIV prevention interventions and strategies, such as: (1) prevention counseling; (2) partner counseling, testing and referral services; (3) comprehensive risk counseling services; and (4) implementation of rapid testing.

Training activities also include facilitation skills, recruitment strategies, adaptation and tailoring guidance that increases knowledge, skills, and abilities required to implement HIV prevention interventions, and programs and services. Trainings are provided directly to service providers for implementation or to educators/trainers in a Train-the-Trainer format for further dissemination. Facilitation of trainings is available in English and Spanish.

- **Information dissemination** – the process of distribution and sharing of relevant and current HIV prevention information (reviewed by peer materials review committees prior to dissemination) through print materials, presentations, websites, and mass media.

In 2005, CBB funded 31 CBA providers through cooperative agreements. Two Los Angeles County agencies were funded by the CDC to provide CBA:

- **Acción Mutua** (<http://www.apla.org/accionmutua/cba/index.html>) - a division of AIDS Project Los Angeles assists organizations and health departments in implementing effective HIV behavioral interventions targeting Latinos in the Western region of the United States.

- **Black AIDS Institute** (<http://www.blackaids.org>) - provides national capacity building services to organizations working with at-risk African American communities by increasing knowledge and participation to reduce HIV/AIDS, including increased access and utilization of HIV testing and other services.

❖ **COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH, OFFICE OF AIDS PROGRAMS & POLICY (OAPP)**

OAPP will continue to support and enhance the capacity of governmental and non-governmental providers of HIV prevention and care services. Overall, OAPP's capacity building activities will focus on:

- Adoption and adaptation of evidence-based prevention interventions, including the development of appropriate prevention materials;
- Implementation of best practices for increasing the number of individuals who know their HIV status and are connected to care services (HIV Counseling and Testing);
- Building and sustaining the capacity of providers to address the HIV prevention needs in African American and Latino communities; and
- Adherence to sound management and collaborative practices that ensure the sustainability of HIV prevention efforts.

OAPP's capacity building assistance is delivered through 1) individualized provider-specific technical assistance; 2) trainings, seminars and workshops for front-line service providers and program coordinators / managers; and 3) OAPP's HIV/AIDS Resource Center which provides access to a wide range of materials and other tools that can be adapted and used by service providers in their HIV prevention efforts.

Evidenced-Based Interventions: Building on the lessons learned over the last 25 years of implementing HIV prevention efforts, OAPP provides a series of trainings for community-based providers to enhance their knowledge and skills based on the lessons learned from interventions that have demonstrated to be effective. OAPP's Provider Support Services and Prevention Services Divisions work closely together in the delivery of these services with a focus on providers funded under the Health Education/Risk Reduction program. Training topics include, but are not limited to:

- Basic HIV/AIDS Prevention (for new front line providers);
- Making the Connection: Developing a Comprehensive Curriculum;
- Bridging Theory & Practice - Applying Behavioral Theory to HIV/STD Prevention (in collaboration with the Prevention Training Center (PTC));
- Integrating HIV and STD Prevention (for community-based providers)

HIV Counseling and Testing: Helping individuals know their HIV status and connecting those who are HIV positive to care is critical to reducing the numbers of new HIV infections, and a high priority for OAPP. To this end, and in partnership with the California Office of AIDS, OAPP provides ongoing trainings and seminars for new and current HIV counselors across the County. OAPP's portfolio of trainings in this area includes, but is not limited to:

- HIV Prevention Counseling and Skills Certification Training (in collaboration with the State Office of AIDS);
- Counselor I Training (in collaboration with the California Office of AIDS);
- Counselor II Training (in collaboration with the California Office of AIDS);

- Comprehensive Risk Counseling and Services Training;
- Rapid Test Certification Training;
- HIV Counselor Update (in collaboration with providers and programs who are experts in the topics offered);
- HIV Information Resources System (HIRS) Training;
- Integrating HIV and STD Counseling and Testing Training (for Public Health Investigators in collaboration with the STD Program);

Sustainability of HIV Prevention Efforts: OAPP continuously strives to ensure that HIV prevention and care services are effective, of high quality, and sustainable. To this end, OAPP has implemented a robust quality assurance program to ensure adherence to not only contractual obligations, but also with sound management and programmatic practices. Program managers in OAPP's Prevention Services Division conduct regular reviews of HIV prevention contracts to monitor progress, identify potential problems, and provide technical assistance as needed. If providers need additional or specialized capacity building assistance, program managers engage Provider Support Services Division staff to provide additional capacity building assistance.

In addition to the topics above, OAPP will provide a series of trainings and seminars on topics such as:

- Perinatal HIV Transmission Prevention (for Public Health Nurses);
- HIV/AIDS Prevention and Counseling (for Physicians and Nurses);
- HIV/AIDS Case Management Certification Training;
- Partner Counseling & Referral Services Training;
- LAC HIV/AIDS Prevention Counselor Update;
- Case Management Refresher;
- Skills Building Workshops: Enhancing Documentation, Avoiding Burnout, HIV and Women Issues and Concerns, Motivational Interviewing, Co-Occurring Disorders: Issues and Concerns, Youth and HIV Issues and Concerns, Addressing Barriers to Care: Intervention Tools For Providers.

In addition to these focused trainings, OAPP offers individualized technical assistance directly to agencies to assist with curriculum development, educational materials development, and other prevention intervention design and implementation needs.

❖ **OFFICE OF MINORITY HEALTH**

The mission of the Office of Minority Health (OMH) is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. OMH was established in 1986 by the U.S. Department of Health and Human Services (HHS). It advises the Secretary and the Office of Public Health and Science (OPHS) on public health program activities affecting American Indians and Alaska Natives, Asian Americans, Blacks or African Americans, Hispanics or Latinos, Native Hawaiians, and other Pacific Islanders.

OMH operates the OMH Resource Center (OMHRC), which serves as a free information and referral service on minority health issues for community groups, consumers, professionals, and students. OMHRC assists OPHS and OMH in distributing scientifically valid and culturally-competent health information, encourages public participation in HHS programs, and assists in conducting health campaigns. The resource center (1) maintains a minority health knowledge

center and database; (2) helps link people to HHS health services and resources; (3) distributes publications; (4) manages exhibits; (5) publishes funding opportunities; (6) maintains a list of volunteer resource experts available to the public; and (7) conducts literature searches.

The OMHRC Capacity Building Division provides an array of technical assistance and capacity building activities to health care agencies and programs throughout the United States and its territories and jurisdictions. The purpose of capacity building is to increase the strength and competence of an organization. The Capacity Building Division defines technical assistance as providing short-range, acute care to agencies and organizations. Capacity building activities are considered to be more long-range activities where services are provided typically over a 2-year time period.

The purpose of the capacity building program is to stimulate and foster the development of effective and durable service delivery capacity for HIV prevention and treatment among organizations closely linked with the minority populations impacted by HIV/AIDS. Specifically, the goals of the program are to: (1) provide administrative and programmatic technical assistance to enable minority-serving CBOs to enhance their delivery of necessary services; and (2) assist those minority-serving CBOs, through an ongoing mentoring relationship, in the development of their capacity as fiscally viable and programmatically effective organizations thereby allowing them to successfully compete for federal and other resources. Currently, there are two programs in Los Angeles County receiving funds from this OMH initiative.

- Bienestar Human Services, Inc. (2005-2008 Grantee) <http://www.bienestar.org>;
- Guam Communications Network. (2006-2009 Grantee) <http://www.guamcomnet.org>;

❖ **STATE OF CALIFORNIA OFFICE OF AIDS**

In 2003, the California Department of Health Services, Office of AIDS awarded AIDS Project Los Angeles a grant to provide training and technical assistance to California organizations currently providing or desiring to provide Prevention with Positives activities or programs targeting people of color. The purpose is to strengthen and build the capacity of agencies in the areas of program planning, development, and evaluation. Program activities include a 2-day interactive training, entitled “Laying the Foundation” and one-on-one technical assistance. The training covers the fundamentals of program planning, development, and evaluation.

❖ **CENTER FOR HIV IDENTIFICATION, PREVENTION, & TREATMENT SERVICES**

The Center for HIV Identification, Prevention, and Treatment Services (CHIPTS) is a collaboration of researchers from UCLA, Charles Drew University of Medicine and Science, Friends Research Institute, and RAND working with the broader Los Angeles community toward a common goal: *to enhance our collective understanding of HIV research and to promote early detection, effective prevention, and treatment programs for HIV.* Funded by the National Institute of Mental Health (NIMH), CHIPTS serves as a bridge among researchers, government, service providers, and people living with HIV in responding to the changes in the HIV epidemic and in shaping sound public policy.

CHIPTS offers a range of services including consultation on the development of new research projects and assistance with obtaining funds for these initiatives. CHIPTS provides technical assistance in HIV program development and evaluation, and sponsors an annual conference for developing researchers to present their work. In addition, CHIPTS hosts an annual policy forum for researchers, government officials, and the HIV community to discuss emerging HIV policy issues, as well as hosts a research colloquia series.

■ Community & Coalition Building

❖ COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH, OFFICE OF AIDS PROGRAMS & POLICY (OAPP)

Los Angeles County organizes health care services in each of eight geographic Service Planning Areas (SPAs). OAPP has created community collaborations and networks, to develop and strengthen the community infrastructure in Los Angeles County.

- **Service Provider Networks.** To best plan and manage HIV/AIDS services throughout the County, OAPP contracts with a lead agency in each SPA to coordinate a Service Provider Network (SPN). Each SPN is a formally organized group of providers, consumers, and community representatives that regularly convene in an effort to facilitate and improve the coordination of HIV prevention and services in their respective geographic area. The SPNs create a linked system of care that is client-centered in an effort to expedite service delivery across all SPAs. SPNs reduce duplication of efforts through formal, ongoing and mutual relationships that manage service delivery.

The following are the lead agencies with whom OAPP currently contracts by SPA:

SPA 1:	Antelope Valley Hope Foundation
SPA 2:	El Proyecto del Barrio
SPA 3:	AIDS Service Center
SPA 4:	JWCH Institute, Inc.
SPA 5:	Common Ground
SPA 6:	Watts Healthcare Corporation
SPA 7:	AltaMed Health Services
SPA 8:	City of Long Beach Department of Health & Human Services

■ HIV Prevention and Related Resources

❖ CDC'S HEIGHTENED NATIONAL RESPONSE

In March 2007, the CDC announced its Heightened National Response to address the growing impact of HIV/AIDS among African Americans. The CDC, in consultation with a wide range of African American leaders, developed this heightened response in order to take action against this devastating epidemic. This response will help to inform prevention and care service providers and provide a guideline for maximizing the efficiency of available resources targeting this population. As part of the heightened response, the CDC outlined its plans to intensify programs in the following four key areas over the next three years:

1. Expanding the reach of prevention services;
2. Increasing opportunities for diagnosing and treating HIV;
3. Developing new, effective prevention interventions; and
4. Mobilizing broader community action

To facilitate this mobilization, the CDC has made available the Heightened Response Plan, fact sheets, a Morbidity and Mortality Weekly Report (MMWR) highlighting HIV trends among African Americans, and other helpful information that can be found on the CDC website:

<http://cdc.gov/hiv/topics/aa/>.

In the fall of 2007, the CDC awarded \$35 million over a three year period for Program Announcement PS07-768 (pertaining to the Heightened National Response) to health departments across the country.

❖ **CDC'S HIV PREVENTION FOR COMMUNITY-BASED ORGANIZATIONS**

The CDC directly funds a number of Los Angeles-based organizations through two program announcements (PA 04064 and PA PS06-618). Funds total nearly \$1.8 million to provide a variety of HIV testing and prevention services throughout the County.

Community organizations funded by the CDC under Program Announcement 04064 include:

- AIDS Healthcare Foundation. Type of intervention: CTR through the Men's Wellness Center. Offers a wide array of testing and treatment services to the MSM targeted client population.
- AltaMed Health Services Corporation. Type of intervention: Lifesmart and CRCS. A youth arts program for Latino gay and questioning youth between the ages of 13 to 24 designed to educate and empower participants to reduce HIV infection.
- Bienestar Human Service, Inc. Type of intervention: Healthy Relationships targeting HIV positive Latinos and their sexual and/or needle sharing partners in SPAS 2, 4, and 7.
- JWCH Institute, Inc. Type of intervention: Healthy Relationships with rapid testing. Serve HIV positive African American and Latino Men having Sex with Men (MSM) of age 18 and above who are homeless or at risk for homelessness in and around downtown Los Angeles.
- Tarzana Treatment Centers, Inc. Type of intervention: Safety Counts. Target population: active injection drug users (IDU) and crack cocaine smokers and their sex partners. Goal: to prevent HIV and hepatitis.

Community organizations funded by the CDC under Program Announcement PS06-618 include:

- Bienestar Human Services, Inc. Type of intervention: Latino Mpowerment "Sabores" with rapid testing (YMSM).
- Childrens Hospital Los Angeles. Type of intervention: TG AIM (adapted for a Latino population). CHLA funded to adapt and tailor Project AIM an HIV prevention program for middle school youth based on the Theory of Possible Selves, for MTF transgender youth of color.
- JWCH Institute, Inc. Two year funding (9/06-8/08) to conduct outcome monitoring of Healthy Relationships and assess changes in client behavior, and factors associated with those changes. Title of Project: Community Based Outreach Monitoring Project (CBOP).
- Tarzana Treatment Center, Inc. Type of intervention: Popular Opinion Leader. Target population: Young Latino men who have sex with men (YLMSM).

- Friends Research Institute, Inc. Type of intervention: Information Technology (IT) communication intervention. Funded to conduct formative work to assist the development of an IT communication intervention for reducing methamphetamine use and high risk sexual behaviors among out of treatment MSM. Project title: Project Tech Support: Reducing Methamphetamine Use and HIV Sex-risk Behaviors in Out-of-Treatment MSM.

❖ **CDC HIV PREVENTION DEMONSTRATION PROJECTS FOR HEALTH DEPARTMENTS**

In addition, the CDC has funded OAPP for three special projects: (1) Rapid Testing Algorithm, (2) HIV Rapid Testing Program in the Los Angeles County Sheriff's Department, and (3) an Adult Viral Hepatitis Prevention Coordinator.

Program funded by the CDC under Program Announcement PS06-002 :

- Evaluation of a Rapid HIV Test Algorithm for Improved Predictive Value and Linkage to Care: The HIV Rapid Testing Algorithm (RTA) Study. The HIV Rapid Testing Algorithm Study is a two-year project that will evaluate the feasibility, performance, and cost-effectiveness of implementing a rapid HIV testing algorithm in publicly funded HIV counseling and testing sites in Los Angeles County. OAPP is partnering with AIDS Healthcare Foundation, AltaMed Health Services, and Tarzana Treatment Center for an 18-month study period. These three sites will implement a rapid HIV testing algorithm that will consist of the use of up to three different types of FDA approved CLIA-waived rapid HIV tests for HIV infection diagnosis and linkage to care all within the same visit. (Contact: Jacqueline Rurangirwa, jrurangirwa@ph.lacounty.gov)

Program funded by the CDC under Program Announcement PS07-768:

- Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African Americans. The Los Angeles County Department of Public Health, Office of AIDS Programs and Policy (OAPP) is increasing collaboration with the Sexually Transmitted Disease Program (STDP) and the Los Angeles County Sheriff's Department (LASD) to implement an expanded HIV/STD screening program within one of the largest jail systems in the world by routinely offering rapid HIV testing to inmates who may have an elevated risk for HIV through predictors established by a recent HIV testing research study. The primary objective of the program is to identify at least 240 new HIV positive individuals, provide partner and referral counseling services for all confirmed new positive inmates, provide linkage to care while inmates are in the jail system, and provide linkage to care upon release through transitional care management services. (Contact: Sophia F. Rumanes, srumanes@ph.lacounty.gov)

Program funded by the CDC under Program Announcement PS09-801:

- Los Angeles Adult Viral Hepatitis Prevention Coordinator. On behalf of the Los Angeles County Department of Public Health, OAPP will administer the funds and take the programmatic lead to address the viral hepatitis problem using the HIV disease management model that integrates HIV prevention and care services, and engages community partners and community planning councils in HIV prevention and care

planning, policy, and standards development for coordinating viral hepatitis services in LAC. The designated Adult Viral Hepatitis Prevention Coordinator (AVHPC) is responsible for working with key DPH programs to 1) enhance viral hepatitis surveillance system to include chronic cases, 2) increase viral hepatitis screening, prevention, and education activities, and 3) improve and track the viral hepatitis referrals to care and treatment within LAC. The five year grant was funded for implementation from November 1, 2007 through November October 30, 2012. (Contact: Pierre Wasolua Nsilu, pnsilu@ph.lacounty.gov)

❖ **CITY OF LONG BEACH HEALTH DEPARTMENT**

The City of Long Beach is Los Angeles County's second largest city and has its own health department. The health department receives \$804,912 in HIV prevention funding directly from the California Office of AIDS. Funds support social marketing, school-based programs, and HIV counseling and testing, and other STD screening. Additional local funds are also allocated in the amount of \$208,955 to support HE/RR programs.

❖ **CITY OF LOS ANGELES**

Since 1989, the AIDS Coordinator's Office (ACO) of the City of Los Angeles has played a vital role in framing the delivery of services for people living with HIV/AIDS as well as those at risk for acquiring or transmitting HIV.

With the largest share of the epidemic of all eighty-eight cities in Los Angeles County, the ACO seeks to ensure that programs are funded and administered to provide the highest quality of service to its residents. The structure of the ACO enables it the flexibility to easily focus HIV/AIDS prevention efforts towards underserved populations in the city.

The ACO funds approximately \$850,000 to \$900,000 in prevention services each year through the release of an RFP every two to three years. Generally half of this funding is dedicated to syringe exchange programs. 2008-2011 funded organizations include:

- AIDS Healthcare Foundation
- AIDS Project Los Angeles
- Asian Pacific AIDS Intervention Team
- Asian American Drug Abuse Program, Inc.
- Bienestar Human Services, Inc.
- Childrens Hospital Los Angeles
- Clean Needles Now
- Common Ground
- East Los Angeles Women's Center
- Homeless Health Care Los Angeles
- Los Angeles Gay & Lesbian Center
- Reach LA
- Tarzana Treatment Centers
- Women Alive Coalition

❖ **SPECIAL NEEDS STUDIES**

The ACO also dedicates \$50,000 to support studies on relevant HIV/AIDS issues. Among the ACO studies conducted are:

- The relationship between crystal methamphetamine use and HIV risk behavior among gay and bisexual men.
- Risk behaviors of heterosexual men who sometimes have sex with other men or transgender individuals.
- The feasibility of post-exposure prophylaxis for people with recent sexual or intravenous drug use exposure to HIV.

- The effectiveness of prevention messages aimed at women, particularly African-American women.
- Prevention and outreach efforts to men who frequent bathhouses.
- HIV risk and HIV service needs among gang affiliated young people.
- The attitudes and beliefs of City of LA Neighborhood Council members and their willingness to participate in the delivery of HIV prevention messages. (In progress)
- The acceptability and feasibility of offering Pre-Exposure Prophylaxis as a bio-medical prevention intervention in Los Angeles. (In Progress)

The ACO also develops social marketing materials, and funds numerous awareness and educational events through a technical assistance mini-grant program.

On November 30, 2007, the ACO launched the City's HIV Testing Initiative through a series of public and private partnerships to facilitate an increase in HIV testing with the goal that one million people in the City know their status by 2011.

❖ **CITY OF PASADENA**

The City of Pasadena HIV & STD Prevention Programs provides a wide range of education and prevention services related to sexually transmitted infections. The programs aim to increase awareness of STIs and to empower Pasadena residents to protect themselves through risk-reduction behavior. Some of the services offered by the HIV & STD Prevention Programs include:

- HIV/STD Clinic
- Mobile HIV counseling and testing
- Community PROMISE
- HIV & STD Information sessions
- STD Community Intervention Program (SCIP)

The HIV & STD Prevention Programs staff works closely with the Andrew Escajeda Clinic, which provides free HIV/AIDS medical outpatient services to uninsured and Medi-Cal insured HIV positive individuals residing in Los Angeles County.

❖ **CITY OF WEST HOLLYWOOD**

Although small in size, the City of West Hollywood continues to have the highest AIDS case rate of any city in Los Angeles County. With the significant political power of the gay and lesbian community, the City has funded HIV prevention programs since the early years of the epidemic. It currently invests nearly one million dollars annually to prevention projects, which currently funds programs at UCLA, AIDS Healthcare Foundation, the Los Angeles Gay and Lesbian Center, Van Ness Recovery House, AIDS Project Los Angeles, and Being Alive LA.

❖ **LOS ANGELES UNIFIED SCHOOL DISTRICT**

The Los Angeles Unified School District (LAUSD) receives funding from CDC's Division of Adolescent and School Health (DASH) to develop and implement an asthma prevention program, provide HIV prevention education, and conduct the Youth Risk Behavior Survey (YRBS). The 2005 report published in the *Morbidity and Mortality Weekly Report* is available at: <http://www.cdc.gov/mmwr/PDF/SS/SS5505.pdf>. The goal of LAUSD's HIV/AIDS Prevention Program is to prevent AIDS by providing information and resources to students, parents, and employees.

❖ SAMHSA'S HIV/AIDS & HEPATITIS PROGRAMS

The primary purpose of SAMHSA's HIV/AIDS and Hepatitis programs are to provide access and increase use of mental health and substance abuse prevention and treatment services to prevent HIV and hepatitis transmission among high-risk populations, including minority populations. These programs are particularly important as the proportion of people living with HIV/AIDS and hepatitis is high. Approximately one in three persons infected with HIV annually will also be coinfecting with viral hepatitis from similar modes of transmission. The goals of these programs include:

1. To make an impact on curbing the nation's HIV/AIDS epidemic.
2. To disseminate knowledge about the mental health aspects of HIV/AIDS and the ethical issues of providing services to people living with or affected by HIV/AIDS.
3. To identify effective approaches for delivering mental health services to people living with HIV/AIDS and disseminate these findings to health care providers who serve those infected with HIV/AIDS .
4. To improve the health outcomes of people living with HIV/AIDS who also have a mental and/or substance use disorder.

Among programs funded by SAMHSA in Los Angeles County are the following:

- Tarzana Treatment Centers, Inc, Project Period: 09/30/2006 - 09/29/2009. Tarzana Treatment Centers (TTC) and Northeast Valley Health Corporation (NEVHC), two organizations based in the San Fernando Valley of Los Angeles (SPA 2), will strengthen their integrated and coordinated multidisciplinary models of HIV care and support services by filling gaps in mental health services for persons with co-occurring HIV, mental health and substance abuse treatment needs. Clients of both agencies with co-occurring HIV, mental health and substance abuse treatment needs include a majority who are male and Latino or African American, persons recently released from prison or jail, and persons who self-identify as transgender. At both sites, psychiatric, therapeutic, and case management services will be more readily available through increases in psychiatrists, therapists and case management staffing to provide more intensive and responsive mental health care that is integrated and closely coordinated through individualized case planning.
- Childrens Hospital Los Angeles, Project Period: 9/20/2006-9/29/2009. The purpose of the program is to establish and sustain evidence-based clinical treatment and trauma informed services for runaway and homeless youth in the Hollywood community and to transform the service delivery system so that the entire system of care is more educated about trauma and its impact, and more able to effectively respond to these needs. The major goals of the project are: 1) To continue meaningful collaborative planning regarding critical service needs of runaway and homeless youth in Hollywood; 2) To select, evaluate, and adopt an evidence-based trauma intervention in the runaway and homeless youth service delivery system; 3) To develop and implement coordinated training approaches to ensure fidelity to the model and effective interventions with runaway and homeless youth; 4) To develop and disseminate treatment and service products locally and nationally; 5) To sustain trauma services for runaway and homeless youth in Hollywood.

- Substance Abuse Foundation of Long Beach, Project Period 09/30/2006 - 09/29/2011. The Integrated Service Approach (ISA) project at the Substance Abuse Foundation of Long Beach (SAF) is a culturally and linguistically competent response to the mental health needs of the increasing number of economically disadvantaged African-Americans and Hispanics impacted by the HIV epidemic in Long Beach, California—a city that is highly impacted by poverty and HIV/AIDS and consistently has one of the highest per capita AIDS incidence rate in both the metropolitan Los Angeles area and in the State of California. African-Americans or Blacks and Latinos or Hispanics account for half (50%) of all new AIDS cases in Long Beach. The ISA project will serve 164 adults, ages 18 to 65, with HIV/AIDS per year (114 African-Americans or Blacks and 50 Latinos or Hispanics), and a total of 820 clients over the 5-year period (570 African-Americans or Blacks and 250 Latinos or Hispanics).

■ Early Intervention Services

In Los Angeles County, a broad array of community-based primary care clinics offer directly-funded HIV early intervention services through Ryan White CARE Act Part C and the California Office of AIDS. Like the CDC's AHP initiative, one purpose of Early Intervention Services (EIS) is to identify high-risk individuals of unknown HIV serostatus, get them tested for HIV, and link those individuals testing HIV positive into the HIV continuum of care and prevention services. The resources below represent the County's EIS programs.

❖ **RYAN WHITE PROGRAM PART C: EARLY INTERVENTION SERVICES**

The Part C Early Intervention Services (EIS) program funds comprehensive primary health care for individuals living with HIV disease. Part C services include, among others, risk-reduction counseling on prevention, antibody testing, medical evaluation, and clinical care, as well as case management, to ensure access to services and continuity of care for HIV-infected clients. The Health Resources and Services Administration (HRSA) is responsible for administering Ryan White Program funds. HRSA funds 12 EIS programs in Los Angeles County; they include:

- The Catalyst Foundation for AIDS Awareness & Care (SPA 1)
- Northeast Valley Health Corporation/HIV/AIDS Programs (SPA 2)
- Tarzana Treatment Centers, Inc. (SPA 2)
- AltaMed Health Services (SPA 3)
- Los Angeles Gay and Lesbian Center/Jeffrey Goodman Clinic (SPA 4)
- University of Southern California, Maternal Child Adolescent HIV Clinic (SPA 4)
- Venice Family Clinic (SPA 5)
- L.A. County-Martin Luther King, Jr.-Drew Medical Center, OASIS Clinic (SPA 6)
- To Help Everyone (T.H.E.) Clinic, Inc. (SPA 6)
- Watts Health Foundation South L.A. Community AIDS Program (SPA 6)
- El Proyecto Del Barrio (SPA 7)
- Catholic Healthcare West/C.A.R.E. Program/St. Mary Medical Center (SPA 8)

❖ **CALIFORNIA OFFICE OF AIDS – EARLY INTERVENTION PROGRAM**

The California Office of AIDS supports Early Intervention Programs (EIP) in 35 California counties, including Los Angeles County. EIP is dedicated to prolonging the health and productivity of persons with HIV and preventing the transmission of HIV. EIP clients receive medical treatment, transmission risk reduction counseling, case management, psychosocial assessment, and health education, delivered in a team-based setting. They include:

- Hubert Humphrey Comprehensive Health Center/Main Street Clinic
- Charles Drew University of Medicine and Science
- Prototypes (LA East and LA West)

■ Research and Academic Partners

Los Angeles County is home to a significant amount of HIV prevention and related research. UCLA's Center for HIV Identification, Prevention, and Treatment Services (CHIPTS), California State University at Long Beach, as well as the Santa Monica-based RAND Corporation conduct ongoing research in the areas of HIV prevention, substance abuse, sexually transmitted diseases, public policy, and more. The University of Southern California and the Charles Drew University of Medicine and Science also contribute to the wealth of research-related resources in the county. The following list identifies a selected portion of the research being conducted through CHIPTS and the RAND Corporation, which have implications for HIV prevention services county-wide (see Appendix for selected names and brief details about the interventions.).

For purposes of this section, the following acronyms (CDC, NIAID, NIMH, NIDA, NIAAA, NICHHD, HAART, TMP, HCSUS) will be used with frequency and their definitions can be found in the appendix in Chapter 8.

❖ CALIFORNIA STATE UNIVERSITY AT LONG BEACH (CSULB)

CSULB has been a national leader in HIV prevention for more than two decades through its Center for Behavioral Research and Services. CSULB's innovative research includes all races/ethnicities, multiple priority risk groups including MSM and IDUs, and multiple interventions. A few of their recent studies are:

- HIV Risk Behaviors and Depression Among Drug Users
Funded by NIDA
- Multiple Morbidities Testing Program
Funded by Los Angeles County Office of AIDS Programs and Policy
- Gay RESPECT
Funded by Los Angeles County Office of AIDS Programs & Policy
- Counseling and Food Program
Funded by City of Long Beach Department of Health and Human Services
- Early Detection of HIV/AIDS in Greater Los Angeles Region Women
Funded by California Community Foundation
- Integrated Services Approach-Evaluation Subcontract
Funded by Substance Abuse Foundation of Long Beach. Grant from SAMHSA
- Methamphetamine Prevention Demonstration
Funded by Los Angeles County Office of AIDS Programs & Policy

❖ CENTER FOR HIV IDENTIFICATION, PREVENTION, AND TREATMENT SERVICES

As a research collaborative, CHIPTS is involved in a number of research activities, which have strong implications for HIV prevention and related services locally. The following briefly summarizes a sample of relevant research projects:

- CLEAR (Choosing Life: Empowerment, Action, Results) Intervention for Youth Living with HIV. CLEAR builds upon CHIPTS's previous intervention – *Teens Linked to Care* (a CDC Effective Behavioral 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. (Contact: Dr. Scott Comulada, scomulad@ucla.edu)
- Economic Evaluations for HIV Prevention Programs for Adolescents. 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 evaluates 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. (Contact: Dr. Arleen Leibowitz, arleen@ucla.edu)
- Making Decisions (MD) for Life. 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 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 an inexpensive and fairly effortless program to implement in health clinics nationwide. (Contact: Dr. Marguerita Lightfoot, mal@ucla.edu)
- Street Smart: Technology Transfer and Transition of an Effective HIV Prevention with Runaway Youth. Runaway and homeless youth have a national seroprevalence rate of 2.3%, a rate about six times higher than adolescents in 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. (Contact: Dr. Heather Teavendale, hteavendale@mednet.ucla.edu)

- VIBE (Vaccine Interest and Benefit Evaluation). 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. (Contact: Dr. Jae Lee, sjlee@mednet.ucla.edu)
- Youth LIGHT (Living in Good Health Together). Project LIGHT was originally conducted as a multi-site national prevention research trial with at-risk adults. The current Los Angeles-based pilot study will build upon the original Project LIGHT and explore whether 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 explores the meaning of sex and perspectives about sexual risk behaviors held by the students targeted in the project. Phase II documents changes in the students' risk behaviors by conducting a baseline risk assessment and a three-month follow-up assessment. (Contact: Dr. Marguerita Lightfoot, mal@ucla.edu)

❖ **COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH, HIV EPIDEMIOLOGY PROGRAM (HEP)**

This Los Angeles County Public Health program ensures that accurate, timely and complete surveillance and epidemiologic information on the HIV epidemic in Los Angeles County is readily available and used effectively to reduce the spread and impact of HIV throughout the County. To support this vision, the mission of the HIV Epidemiology Program (HEP) is to collect, analyze, and disseminate 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.

Among the many past or current studies conducted by the HIV Epidemiology Program are:

- Adult/Adolescent Spectrum of Disease Study (ASD). This study evaluated trends in clinical course, treatment, and health care utilization of 6,195 HIV positive patients 13 years and older at four Los Angeles County clinics. The study period occurred from 1990-2004. (Contact: Dr. Amy Wohl, awohl@ph.lacounty.gov)
- African American Mens' Health Study (AAHP). The African American Men's Health Study was conducted in 1994-1997 with 510 HIV positive and HIV negative African American Men ages 18-55. This case-control study assessed neurobehavioral and psychosocial factors in HIV. (Contact: Hector Myers, myers@psych.ucla.edu)
- African American Men's Study. The African American Men's Study evaluated risk behaviors of 610 HIV positive African American or Black men ages 20-49 from three clinics. This case-control study matched cases to controls by age and neighborhood. The study period was from 1997-1998. (Contact: Dr. Amy Wohl, awohl@ph.lacounty.gov)
- Alcohol Use among HIV Positive Ethnic Minorities. In 2004-2005, eight focus groups were conducted to examine alcohol use among HIV-positive Latino and African American or Black men and women and service providers. These focus groups identified resiliency factors to decrease/eliminate alcohol abuse.

- (Contact: Frank Galvan, frgalvan@cdrewu.edu)
- Behavioral Surveillance – Project Native Voices. Project Native Voices was an offshoot of National HIV Behavioral Surveillance and was funded to address HIV risk behaviors and access to HIV prevention services for Native Americans in urban settings. The objectives were to 1) estimate prevalence of sexual and drug-use risk behaviors known to be associated with HIV infection; 2) estimate demographic, social and behavioral correlates of HIV infection; 3) estimate the prevalence of HIV testing behaviors and utilization of other HIV prevention services; and 4) characterize prevention service gaps and missed opportunities for prevention. Both qualitative and quantitative data were collected beginning in January 2006 and ending in December 2006. Qualitative data were collected on 7 MSM, 2 transgender individuals, and 7 women via focus groups. Using Respondent Driven Sampling (RDS), quantitative data were collected on 19 Native American MSM/TG and 66 Native American women. Due to the limited number of respondents, only descriptive analyses were conducted.
(Contact: Juli-Ann Carlos, jcarlos@ph.lacounty.gov)
 - Behavioral Surveillance – HET. The behavioral surveillance study of heterosexuals (HET) identified 789 heterosexual males and females in order to estimate their HIV risk behaviors and exposure to prevention services. Data for this population were collected during 2006 to 2007. (Contact: Trista Bingham, tbingham@ph.lacounty.gov)
 - Behavioral Surveillance – IDU. 544 men and women who were injection drug users (IDUs) participated in the Behavioral Surveillance Survey during 2005. The purpose of this study was to examine the HIV risk behaviors and exposure to prevention services of IDUs. (Contact: Trista Bingham, tbingham@ph.lacounty.gov)
 - Behavioral Surveillance – MSM. A venue-based probability sample of 1,591 MSM and MSM/W were a sample of individuals who participated in the Behavioral Surveillance Study. This cross-sectional study estimated HIV prevalence, risk behaviors, and exposure to prevention services of MSM and MSM/W participants.
(Contact: Trista Bingham, tbingham@ph.lacounty.gov)
 - Brothers y Hermanos. Focus groups and individual interviews were conducted with 110 Latino MSM and MSM/W participants in 2003. The objectives of this study were to describe HIV-related cultural, social, environmental, and psychological factors associated with being a Latino MSM or MSM/W. This was a multi-site study including New York City, Philadelphia, and Los Angeles.
(Contact: Trista Bingham, tbingham@ph.lacounty.gov)
 - Context of HIV Infection Project. Eighty recently HIV-positive males and matched female HIV-positive controls participated in this case-control study. The Context of HIV Infection Project was conducted in 2003-2004. The objective of the project was to understand factors associated with recent HIV infection and to identify missed HIV prevention opportunities. The total sample size was 320 individuals and both qualitative and quantitative data were collected.
(Contact: Trista Bingham, tbingham@ph.lacounty.gov)

- Directly Administered Antiretroviral Treatment Study (DAART). The Directly Administered Antiretroviral Treatment Study was a randomized intervention trial. Participants were 18 years or older and they either had to be treatment naïve or failing no more than one regimen. The study objectives were to evaluate three models of adherence support for patients on HAART from 2001-2004. A total of 250 patients from three Los Angeles County clinics participated in the study. (Contact: Dr. Amy Wohl, awohl@ph.lacounty.gov)
- HIV Testing Survey (HITS). In 2002, the HIV Testing Survey was conducted with 300 MSM, IDU, and high-risk heterosexuals. This was a venue-based, cross sectional study which assessed reasons for testing, barriers to testing, knowledge of state policies, and HIV testing patterns of study participants. (Contact: Nina Harawa, nharawa@ucla.edu)
- HIV Testing Survey (HITS). In 2003-2004, the HIV Testing Survey was conducted with 200 female sex workers and male to female transgender individuals. This was a venue-based, cross sectional study which assessed reasons for testing, barriers to testing, knowledge of state policies, and HIV testing patterns of the participants. (Contact: Nina Harawa, nharawa@ucla.edu)
- HIV/AIDS Reporting System. The HIV/AIDS Reporting System database has records of individuals diagnosed with AIDS dating back to 1981-present. Since 2002, cases of people living with HIV were recorded in the HIV/AIDS Reporting System, prior to this time only AIDS cases were recorded. An analysis of population-based data from the HIV/AIDS reporting system of 65,000 individuals from 1981 to present were analyzed to estimate HIV and AIDS in Los Angeles County. (Contact: Douglas Frye, dfrye@ph.lacounty.gov)
- Increasing HIV Testing through a Health Promotion Focus. This objective of this 2004-2005 study was to investigate HIV test acceptance rates of 394 Latino MSM and MSM/W ages 21-49. The study evaluated differences between offering only a HIV test versus offering the test “bundled” or in a panel with other tests. (Contact: Frank Galvan, frgalvan@cdrewu.edu)
- Jail Study. Approximately 1,200 male and female new jail entrants participated in the 2003-2004 Jail Study. The study sought to estimate HIV incidence and describe risk factors of the new jail entrants. (Contact: Trista Bingham, tbingham@ph.lacounty.gov)
- Latino Day Laborers’ HIV Risk in Targeted Geographical Areas. In 2005, the Latino Day Laborers’ HIV Risk in Targeted Geographical Areas study identified HIV risks associated with day labor activities of 450 Latino male day laborers. Both quantitative and qualitative data were collected. (Contact: Frank Galvan, frgalvan@cdrewu.edu)
- Los Angeles Bathhouse Study. The Los Angeles bathhouse study was conducted during 2001-2002. A convenience sample of 916 MSM and MSM/W participants ranging in age from 18 to 75 participated in this study. The primary study objective was to estimate HIV incidence and risk factors for patrons who frequent bathhouses in Los Angeles. (Contact: Trista Bingham, tbingham@ph.lacounty.gov)

- Los Angeles County Health Survey. A population-based random digit telephone survey was conducted. Los Angeles County residents 18 years of age or older were eligible to participate. The Los Angeles County Health Survey was administered in 1997, 1999, 2002 and 2005 to assess HIV risk behaviors and patterns of HIV testing. (Contact: Dr. Paul Simon, psimon@ph.lacounty.gov)
- Partner Study. In 2006 to 2007, an original study of women and their male partners was conducted. The study comprised of 103 “pairs” of heterosexual women and their male partners. The primary study objective was to examine concordance of reported risk behaviors between women and their male partners. (Contact: Trista Bingham, tbingham@ph.lacounty.gov)
- Project One (Identifying and Characterizing Newly Diagnosed Persons in SPAs 4 & 6). Project One study objectives were to describe the socio-demographic, behavioral, and viral characteristics of 400 recently infected and newly diagnosed MSM, IDU, and women in 2003-2004. (Contact: Trista Bingham, tbingham@ph.lacounty.gov)
- SRO Study (Low-income Hotel Study). A sample of 900 males and females who lived in low-income hotels on Skid Row was tested for HIV in order to estimate HIV incidence and HIV risk factors. This cross-sectional study was completed in 2003. (Contact: Trista Bingham, tbingham@ph.lacounty.gov)
- Supplement to HIV/AIDS Surveillance System (SHAS). An analysis was done on data from the Supplement to HIV/AIDS Surveillance System to obtain additional descriptive information on 4,117 adult males diagnosed with AIDS and females diagnosed with HIV and AIDS. (Contact: Dr. Amy Wohl, awohl@ph.lacounty.gov)

❖ **COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH, OFFICE OF AIDS PROGRAMS & POLICY (OAPP)**

OAPP was established in 1985 to respond to the growing HIV/AIDS epidemic in Los Angeles County. The office coordinates and directs the overall response to the epidemic in Los Angeles County in cooperation with community-based organizations, governmental bodies, advocates, and people living with HIV/AIDS. It sets the standards of care for countywide HIV/AIDS services. The mission of OAPP is to respond to the HIV/AIDS epidemic in Los Angeles County by preventing its spread, maximizing health and social outcomes, and coordinating effective and efficient targeted services for those at risk for, living with, or affected by HIV. In order to achieve this mission, OAPP conducts original epidemiologic studies, research projects, and program evaluation.

Examples of research studies conducted by the Office of AIDS Programs and Policy include:

- Advancing HIV Prevention (AHP) Evaluation. This evaluation examined the successes and challenges of two demonstration projects: the Routine HIV Testing and the Partner Counseling and Referral Services demonstration project. The Routine HIV Testing Demonstration Project offered routine, voluntary, confidential, rapid HIV testing in a variety of primary care settings in order to increase the number of clients who know of their HIV status. The Partner Counseling and Referral Services (PCRS) demonstration project examined whether outcomes for PCRS with use of HIV rapid testing improved. The information gathered from the program evaluations provided feedback that could be

used to implement administrative and programmatic improvements to better serve the needs of Los Angeles County residents. The results of the evaluation were also used by the CDC to assist in forming current guidelines for routine rapid testing and PCRS programs. (Contact: Saloniki Osorio, sosorio@ph.lacounty.gov)

- The HIV Rapid Testing Algorithm (RTA) Study. The HIV Rapid Testing Algorithm Study is a two-year project that will evaluate the feasibility, performance, and cost-effectiveness of implementing a rapid HIV testing algorithm in publicly funded HIV counseling and testing sites in Los Angeles County. OAPP is partnering with AIDS Healthcare Foundation, AltaMed Health Services, and Tarzana Treatment Centers for an 18-month study period. These three sites will implement a rapid HIV testing algorithm that will consist of the use of up to three different types of FDA approved CLIA-waived rapid HIV tests for HIV infection diagnosis and linkage to care all within the same visit.

At the intervention sites, clients testing for HIV are first tested with the OraQuick rapid test using either oral fluid or fingerstick whole blood specimens. If the Oraquick test is reactive, blood will be drawn for laboratory based testing in accordance with California Office of AIDS procedures for confirmation of a preliminary positive rapid test. The anticoagulated whole blood sample will then be used to perform a second rapid HIV tests. A third rapid test would be performed if the second test was non-reactive. Therefore, adding a second and potentially a third rapid HIV test at the intervention sites, would provide more information to both client and counselor, by improving the likelihood that someone with reactive results from *two* different tests is actually infected, and identifying likely false positive screening tests if the second and third tests are both non-reactive. Participants at the intervention sites will receive results of all rapid HIV tests performed the day they are tested and immediately referred to medical care if reactive results on two rapid HIV tests are received. The laboratory-based confirmatory test results will be available to the participants; however, no appointment will be required to disclose the confirmatory testing results since they are not expected to differ from the results of the HIV rapid testing algorithm. In the event that an individual has discordant results between the HIV rapid testing algorithm and the laboratory-based confirmatory testing, the counselor will contact the participant for further counseling and HIV testing. (Contact: Jacqueline Rurangirwa, jrurangirwa@ph.lacounty.gov)

- Expanded and Integrated Human Immunodeficiency Virus (HIV) Testing for Populations Disproportionately Affected by HIV, Primarily African Americans. The Office of AIDS Programs and Policy (OAPP) is increasing collaboration with the Sexually Transmitted Disease Program (STDP) and the Los Angeles County Sheriff's Department (LASD) to implement an expanded HIV/STD screening program within one of the largest jail systems in the world by routinely offering rapid HIV testing to inmates who may have an elevated risk for HIV through predictors established by a recent HIV testing research study. The Los Angeles County Sheriff's Department admits 750-1,000 inmates daily and approximately 185,000 inmates annually. The average inmate population is an estimated 18,750-19,500 each day, 89% of which are male. Among the male inmates, 34% are African American or Black. HIV testing providers operating within the jails identify 120-150 HIV positive inmates each month (approximately one-third of these have newly diagnosed infections). However, 46% of inmates who are identified as HIV positive are African American or Black indicating a disproportionate impact of the epidemic among this population, and offering an opportunity for HIV testing and prevention to be delivered to a high-risk population in this setting.

The proposed program will enhance the existing LASD's Medical Services Bureau services by introducing systematic rapid HIV and STD testing for all inmates who are at highest risk of acquiring HIV by using arrest reason, zip code of residence and age as predictors. A Medical/Health Screening Program will be introduced in seven jails in the LASD system and will offer an opportunity for increased testing activities and group educational activities. Additionally, individual counseling and testing will be available throughout the week. The health screenings will offer inmates rapid HIV testing, STD screening, referrals to hepatitis A, B and C testing, and Health Education/Risk Reduction services. The primary objective of the program is to identify at least 240 new HIV positive individuals, provide partner and referral counseling services for all confirmed new positive inmates, provide linkage to care while inmates are in the jail system, and provide linkage to care upon release through transitional care management services. (Contact: Sophia F. Rumanes, srumanes@ph.lacounty.gov)

- Health Stations Project. In an effort to improve client referrals and linkages to community-based organizations (CBOs) offering HIV/AIDS, STD, hepatitis, TB, and substance abuse services, 19 health stations have been placed throughout Los Angeles County. The stations are located in high risk venues (e.g. methadone clinic) and in areas with high numbers of homeless individuals. Health stations are touch screen operated health kiosks that provide basic health education on topics selected by the user. Brief health risk assessments for HIV, STDs, TB, hepatitis, and substance abuse are also available and referrals are automatically generated by the health station based on the participant's profile. All stations include a dedicated phone line so that users can reach staff at the referral agency to schedule an appointment. Project end date: March 2010. (Contact: David Pieribone, dpieribone@ph.lacounty.gov)
- Los Angeles Adult Viral Hepatitis Prevention Coordinator. The Los Angeles County Department of Public Health (LAC DPH) proposed to address the viral hepatitis problem using the HIV disease management model that integrates HIV prevention and care services, and engages community partners and community planning councils in HIV prevention and care planning, policy, and standards development for coordinating viral hepatitis services in LAC. The designated Adult Viral Hepatitis Prevention Coordinator (AVHPC) is responsible for working with key DPH programs to 1) enhance viral hepatitis surveillance system to include chronic cases, 2) increase viral hepatitis screening, prevention, and education activities, and 3) improve and track the viral hepatitis referrals to care and treatment within LAC. The five year grant was funded for implementation from November 1, 2007 through October 30, 2012. (Contact: Pierre Wasolua Nsilu, pnsilu@ph.lacounty.gov)
- Los Angeles Coordinated HIV Needs Assessment (LACHNA). The objectives of this project were to assess the HIV risk, service awareness, need, and utilization of individuals at risk for HIV, PLWHA who are currently in care, PLWHA who are returning to care after one year or more, and PLWHA who have never been in care. This project piloted the use of hand-held computing devices to collect data. Data collection began in July 2007. Analysis and dissemination will continue through the first quarter of 2008 and preliminary findings were presented earlier in this chapter. (Contacts: Mike Janson, mjanson@ph.lacounty.gov and Pamela Ogata, pogata@ph.lacounty.gov)

- Prevention with Positives (PwP). PwP is a demonstration project to evaluate the efficacy of a provider-led HIV prevention intervention with an in-care patient population. The intervention is modeled on the Partnership for Health (PfH) intervention, a CDC disseminated effective behavioral intervention. The evaluation assesses differences between intervention and control sites. Data collection occurred at baseline and 6-, 12-, and 18-months. Survey measures were demographic characteristics; HIV health status; service utilization; and patient and provider relations. Primary outcome measures assess HIV related risk behaviors (unprotected sex) and safer behaviors (using condoms). Interviews with medical providers were collected at baseline and subsequent follow-up sessions to assess issues related to utilization and implementation of the intervention protocol. (Contact: Gary García, gagarcia@ph.lacounty.gov)
- Prevention Gap Analysis. In 2004, OAPP and the PPC developed a needs assessment to determine unmet HIV prevention service needs of persons engaging in high-risk behaviors. The Community Needs Assessment was designed to be one source of data used to develop the 2004-2008 HIV Prevention Plan for Los Angeles County. A series of focus groups, long interviews, and short surveys were conducted with individuals recruited from high-risk venues including bars, clubs, parks, and cruising spots. A total of four focus groups were conducted with 21 participants in a mobile van. A total of 76 long interviews were conducted and 140 short surveys were collected from individuals at 12 high-risk venues located in SPAs 2, 4, and 8. (Contact: Mike Janson, mjanson@ph.lacounty.gov)
- Reducing Sexual Risk for HIV Acquisition and Transmission among Meth-Using MSM who are Not Currently in Substance Abuse Treatment: Project Tech Support. The objective of Project Tech support is to develop and pilot test novel information technology communication in behavioral interventions that focus on reducing risk for HIV acquisition and transmission by reducing the sexual risk behavior of meth-using MSM who are not currently in a substance abuse treatment setting. The intended outcome is the development of interventions for meth-using MSM that demonstrate potential efficacy in reducing risk for HIV acquisition and transmission. Project period: October 1, 2006 - September 30, 2008. (Contacts: Cathy Reback, rebackcj@aol.com and Jane Rohde, jrohde@ph.lacounty.gov)
- Situational Assessment of Meth Use Among MSM. Due to evidence documented in the literature linking crystal methamphetamine use with increasing HIV infection rates among men who have sex with men in Los Angeles County, the Office of AIDS Programs and Policy (OAPP) conducted a situational assessment to identify existing gaps in HIV prevention and substance-abuse education targeting this population. The overall goal of this process was to gather information regarding the current strategies and interventions existing in LAC and to gain a deeper understanding of the issues associated with crystal methamphetamine use among MSM. Qualitative data were gathered through in-depth interviews with 26 key informants identified as having expertise in the HIV/AIDS/substance abuse area and knowledge of the population at risk. This information was used to draft recommendations for a comprehensive intervention effort targeting this problem and to assist the local community to make informed decisions about the kinds of interventions necessary to address this problem. Project period: March 2005 - August 2005. (Contact: Jane Rohde, jrohde@ph.lacounty.gov)

- Young Men Taking Charge (YMTC). This Special Project of National Significance (SPNS) demonstration project assesses the effectiveness of an expanded outreach and Integrated Case Management (ICM) model in identifying HIV-positive African American and Latino men ages 13-24 and linking them to primary medical care. The ICM model integrates prevention, psychosocial, medical and treatment adherence case management into one comprehensive, youth-focused, case management program. Now in its fourth year, the project will continue through August 2009.
(Contacts: Wendy Garland, wgarland@ph.lacounty.gov and Juhua Wu, juwu@ph.lacounty.gov)

❖ **COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH, STD PROGRAM**

The STD Program's mission is to prevent and control sexually transmitted diseases in partnership with the communities of Los Angeles County. In order to accomplish this mission, the program is committed to conduct epidemiological surveillance of STDs in Los Angeles County, develop and implement programs to promote safer sexual behaviors with high risk populations, in collaboration with healthcare providers, community based organizations, and community members, and implement research projects to inform the design of programs and policies and evaluate their effectiveness in the community.

Relevant research studies conducted by the STD Program are as follows:

- Syphilis and HIV in Sexual Networks of Men who Have Sex with Men (MSM) in Los Angeles County, California. The study described key differences in men who have sex with men's (MSM) sexual networks and method by which these networks contribute to differential disease morbidity among MSM. The purpose of this study was to describe two types of venue-specific sexual networks that contribute to high syphilis and HIV morbidity in MSM and to discuss the implications of interventions seeking to disrupt these networks. The sexual networks under observation were: 1) an online network (total of 319 direct and indirect partners) of a syphilis patient and 2) a bar network (total of 123 indirect and direct partners) of a syphilis patient. 93% of the partners in the online network were directly exposed to syphilis or HIV compared to 50.9% for the bar network. Both networks can be isolated into small groups incapable of spreading disease by removing only three key members. Continued research on varied sexual networks will further the understanding of disease transmission, differential STD morbidity among MSM, and methods to break chains of infection.
(Contact: Peter Kerndt, pkerndt@ph.lacounty.gov)
- STD Co-infection Among Acute HIV Patients in Los Angeles County. Detecting acute HIV infection and treating STDs in the earliest stage of a HIV infection will help to prevent further HIV transmission. The objective of this study was to examine the prevalence of STDs among a cohort of acutely infected HIV patients in Los Angeles County. From February 2006 through October 2007, 34 persons with acute HIV were identified and tested for STDs. Overall, 56.3% of acute HIV patients were co-infected with at least one other STD. Prevention efforts should include testing to detect acute HIV among persons with STDs. Individuals with acute HIV and STD co-infection provide a target for interventions to reduce HIV transmission.
(Contact: Michael Chien, mchien@ph.lacounty.gov)

❖ THE RAND CORPORATION

For over 50 years, the RAND Corporation has provided decision-makers in the public and private sectors with objective analysis and effective solutions that address the challenges facing the nation and the world. RAND researchers and analysts are on the cutting edge of their fields and engaged with its clients to create knowledge, insight, information, options, and solutions that will be both effective and enduring. RAND's mission states:

The RAND Corporation is a nonprofit institution that helps improve policy and decision-making through research and analysis.

RAND has conducted far-reaching HIV prevention and related research locally and nationally. A small sample includes:

- Alcohol Outlets, Broken Windows, Gonorrhea and HIV. This NICHD funded study looks to determine if gonorrhea rates dropped in local neighborhoods where alcohol outlets were closed. Another goal of this study was to determine if there exists any association between changes in neighborhood deterioration and changes in gonorrhea rates. This study began on July 1, 2002 and ended on June 30, 2005. (Contact: Deborah A. Cohen, deborah_cohen@rand.org)
- Alcohol use and HIV Risk among Impoverished Women. September 25, 2005 – May 31, 2009. This study explores the social context of sexual behaviors and alcohol use/misuse and investigates how women's social network characteristics are associated with their patterns of alcohol use/misuse. Associations between women's social network characteristics and alcohol use/misuse with their propensity toward sexual risk behavior are also being studied. (Contact: Suzanne L. Wenzel, suzanne_wenzel@rand.org)
- A Training Intervention to Enhance Adherence to HAART. This NIMH funded study includes an adherence training intervention, which includes psycho-educational components for HIV-positive individuals to improve medication adherence of HIV-positive individuals. The study will be used to calibrate a structural model used to predict viral load and CD4 trajectories for patients before treatment onset. The study began on September 15, 2000 and ended on August 31, 2004. (Contact: David E. Kanouse, david_kanouse@rand.org)
- Children of HIV-Infected Adults. This NICHD funded study's goals include: to gain a better understanding of important issues in the lives of HIV-positive parents and their children, to examine factors associated with HIV-positive parents retaining, giving up, or losing custody of their children, and the effect custody arrangements have on the parent and child, etc. This study began on September 27, 2001 and ended five years later. (Contact: Mark A. Schuster, mark_schuster@rand.org)
- Drug Use, Social Context, and HIV Risk in Homeless Youth. During April 15, 2007 to March 31, 2011, 72 quantitative social network and 45 qualitative sexual event-level interviews will be conducted to better understand the social context of sexual behaviors and drug use. (Contact: Joan S. Tucker, joan_tucker@rand.org.)

- Evaluation of Treatment Advocacy (TA) in Involving Patterns. This evaluation will assess the effects of TA services on key decisions and outcomes related to HIV Care. Between September 28, 2006 – August 31, 2008 correlates of successful outcomes among African American and Latino clients in particular will be examined. (Contact: Laura M. Bogart, laura_bogart@rand.org)
- Long-Term Effects of a Worksite Parenting Program. The primary objective of this NIMH funded study is to determine whether the program reduces sexual risk behaviors over a period of several years. Specifically, the study assesses the persistence of program effects on parenting behaviors, parent-child relationships, and communication. The study also evaluates program effects on behaviors of youth who received a substantial amount of the intended parenting practices. This study began on September 28, 1999 and will end on July 31, 2008. (Contact: Mark A. Schuster, mark_schuster@rand.org)
- Mental Health and Substance Abuse Issues Among People with HIV: Lessons from HCSUS (2007). The HIV Cost and Services Utilization Study (HCSUS) was the first major research effort to collect information on a nationally representative sample of people in care for HIV infection. As HIV/AIDS spreads into different communities and as new therapies become available, policymakers require reliable information on the health care services persons with HIV disease are receiving and on the costs of those services. This information, which the HCSUS provides, is needed to guide policy decisions on the allocation of limited health care resources. The original study was active from September 1994 to October 2000, and related studies continue to add to our understanding of AIDS. (Contact: Megan K. Beckett, PhD, MHSA, megan_beckett@rand.org)
- Correlates of Sex Without Serostatus Disclosure Among a National Probability Sample of HIV Patients (2006). The researchers examined potential association of sex without HIV disclosure within a sample of 875 participants from the HIV Cost and Services Utilization Study. Interviews with each participant assessed sexual activities with up to six recent partners, and this study included both respondent and partnership characteristics. Compared with marriage and/or primary same-sex relationships, occasional partnerships and one-time encounters were associated with sex with disclosure, and shorter relationships were more likely to involve sex without disclosure. Knowledge of partner serostatus was also associated with sex without disclosure. Women were less likely to have sex without disclosure than men having sex with men. The authors found an association between the perceived duty to disclosure to all partners and sex without disclosure, while they found no association in multivariate analyses between outcome expectancies and sex without disclosure. (Contact: O. Kenrik Duru, MD, MSHS, kduru@mednet.ucla.edu)
- Interpersonal Context of HIV Risk in the Impoverished. This NICHD funded study aims to understand HIV risk and prevention behaviors among the homeless and impoverished women. Particularly, this study will conduct analyses of data collected from the *Drug Abuse, Violence, and HIV/AIDS in Impoverished Women Study*. The study began on April 4, 2003 and ended on September 30, 2005. (Contact: Joan S. Tucker, joan_tucker@rand.org).

- The Association of Partner Abuse with Risky Sexual Behaviors Among Women and Men with HIV/AIDS (2005). Prior studies have found that partner abuse is related to risky sexual behavior. However, few studies have explored gender, sexual orientation, or substance use differences in this association, especially among people with HIV. We examined data from the Risk and Prevention survey from the HIV Cost and Services Utilization Study (HCSUS) sample on 726 sexually-active individuals in three gender/orientation groups (286 women, 148 heterosexual men, and 292 gay/bisexual men). The study assessed whether individuals with HIV who experienced or perpetrated abuse within a close relationship were likely to engage in unprotected intercourse with that same partner. Both abuse perpetration and victimization were significantly associated with having any unprotected intercourse. In multivariate tests, gender/orientation and substance use during sex moderated the perpetration effects. Secondary HIV prevention interventions need to take into account potentially abusive contexts in which sexual activity may occur for both men and women. (Contact: Laura M. Bogart, PhD, laura_bogart@rand.org)
- Urban Congregations' Capacity for HIV Prevention. Starting June 6, 2005 to May 31, 2008, capacity for HIV prevention and care at Urban congregations are being assessed. Processes by which HIV/AIDS prevention and care activities are implemented in congregations and factors association with such activities will be identified. (Contact: Kathryn Pitkin Derose, kathryn_derose@rand.org)

❖ OTHER RESEARCH

- Adolescent Medicine Trials Network for HIV/AIDS. This NICHD funded program is in the process of developing a study involving the use of cell phones as reminders to address adherence issues. The program aims to recruit adolescents for clinical trials to contribute to the understanding of HIV in adolescents. The funding for the program began on April 16, 2001 and will end on February 28, 2011. (Contact: Marvin E. Belzer, mbelzer@chla.usc.edu).
- AIDS Clinical Trials Unit (ACTU). This NIAID study helps to answer important questions about the pathogenesis and clinical management of HIV. The study began on June 30, 1986 and ended on December 31, 2006. (Contact: Judith S. Currier, jscurrier@mednet.ucla.edu)
- Alcohol Associated Outcomes Among HIV-Positive/Aging Veterans. This NIAAA funded study looks to examine the influence of alcohol on adherence, CD4 cell counts, viral load, liver function, Hepatitis C viral load, and complete blood counts. The purpose of this study is to design, implement, and evaluate interventions that improve outcomes for people aging with HIV infection complicated by comorbid conditions. The study began on September 30, 2001 and ended on August 31, 2006. (Contact: Amy Justice, amy.justice2@va.gov)
- Alcohol Use among HIV-Positive Ethnic Minorities. This NIGMS funded study aims to obtain more comprehensive information about consumption by HIV-positive people using measure of actual alcohol abuse, targeting specifically, HIV-positive African-Americans and Latinos. The hypothesis is that HIV-positive African-Americans will be more likely to report alcohol abuse than Latinos. This study began on July 1, 2003 and ended on June 30, 2007. (Contact: Frank Galvan, frgalvan@cdrewu.edu).

- An Enhanced HIV Prevention Intervention for MTF. The objective of this study was to implement an evidence-based intervention that provided enhanced HIV prevention case management (PCM) and delivered a set of services consistent with the recommendations from the UARP-funded Los Angeles Transgender Health Study. The study evaluated the implementation of these services to determine the impact of HIV prevention case management as measured by the following: reducing sex work, facilitating legitimate employment, lowering HIV injection risks by helping TG women to obtain legal and monitored hormones, reducing substance abuse and reducing homelessness by helping to obtain stable, affordable housing. (Contact: Cathy Reback, rebackcj@aol.com)
- Child Abuse, HIV Risks and Reproductive Outcome. During March 1, 2004 to February 28, 2007, a child sexual abuse severity index (CSASI) of six dimensions of child sexual abuse experiences was constructed. This project examined the differential effects of the CSASI on HIV serostatus, HIV related sexual risk behaviors, reproductive outcomes, depressive symptoms, and adult revictimization. (Contact: Tamra B. Loeb, tloeb@mednet.ucla.edu)
- Cognitive Distance, Mobility Patterns, and Drug Use. This UARP funded study aims to enhance understanding of the key aspects of the social and spatial organization of the urban environment that affects designer drug use and high-risk behaviors. The study will collect data related to where, when, and how designer drugs are used and their relationship to increased HIV transmission risks. This one-year study began on January 1, 2004. (Contact: Vincent J. Del Casino, vdelcasi@csulb.edu)
- Drug Use and HIV Infected Female Adolescents' Care. This NIDA funded study looks to explore, using ethnographic methods, the inter-relationships between substance abuse, mental health, substance abuse networks, and engagements in care of HIV infected adolescent females. The purpose of this study is to determine ways to promote adherence and retention in treatment care, and prevention programs. This study began on September 30, 2001 and ended on July 31, 2005. (Contact: Johnathan M. Ellen, jellen@jhmi.edu)
- Health Related Interventions for People Living with HIV (PLH). This NIMH funded study focused on designing and testing interventions to reduce sexual risk behaviors and IDU risk behaviors. This particular intervention study targeted MSM, IDUs, and women. The study began in 1998 and ended in 2003. (Contact: Margaret A. Chesney, mchesney@psg.ucsf.edu)
- Health Related Interventions for People Living with HIV (PLH). This NIMH funded study was a multi-site randomized controlled prevention trial aimed at reducing HIV-related transmission acts among PLH. The study was conducted in 1998 to 2006 and sought to assist PLH to maintain positive coping styles to enhance health care behaviors. (Contacts: Mary J. Rotheram-Borus, rotheram@ucla.edu and Steven F. Morin, steve.morin@ucsf.edu and Anke A. Ehrhardt, aael@columbia.edu)

- HIV Intervention Development Study. This Agency for Healthcare Research and Quality funded study aimed to assist minority persons infected with HIV to meet their social needs through case management. The five-year study looked specifically at service adherence, medication adherence, and viral load suppression. (Contact: William Cunningham, wcunningham@mednet.ucla.edu)
- HIV/STD Risk Reduction for African American Couples. This NIMH funded study looks to examine couple-level interventions, particularly with serodiscordant couples, that changes the relationship factors that influence sexual decision-making and increase retention of these behaviors. This study began in April 2002 and will end in March 2009. (Contact: John B. Jemmott, jjemmott@asc.upenn.edu)
- HIV Prevention using Technology with Delinquent Youth. This five-year NIMH funded study focused on adapting the “Project Light” intervention for delinquent youth in Los Angeles. The study began in September 2000 and concluded in August 2005. A CD-ROM was used to deliver the intervention and this study may inform both researchers and community members about the feasibility and acceptability of HIV interventions delivered via a computer-based program. (Contact: Marguerita Lightfoot, mal@ucla.edu)
- Homeless Youth’s Reductions in HIV Risk Acts. This five-year NIDA funded study examines interpersonal and computerized strategies for maintaining the efficacy of the *Street Smart* intervention. The study began in September 2002 and ended in August 2007. (Contact: Marguerita Lightfoot, mal@ucla.edu)
- Increasing HIV Testing through a Health Promotion Intervention. This UARP funded study examined the extent to which presenting the HIV test in the context of offering other health and mental health-related tests is a more effective HIV testing protocol than one that only offers an HIV test. The study’s goal was to increase the rate of individuals who agree to take a HIV test and increase the rates of individuals identified as being HIV-positive. The study began in January 2004 and ended in December 2005. (Contact: Frank Galvan, frgalvan@cdrewu.edu)
- Los Angeles Pediatric AIDS Clinical Trials Unit. This NIAID study provided early treatment of infants and adolescents during primary HIV infection. This study also evaluated new potent combination therapies to enhance and prolong the lives of children/adolescents already infected with HIV. Another goal of the project was to reduce the incidence of perinatal transmission. Some of the outcomes of the study included: primary care for HIV-infected children and adolescents, development of HIV screening for pregnant women at community health centers, and enhanced outreach efforts in order to identify HIV-positive pregnant women and adolescents for entrance into clinical trials. The study began in September 1991 and ended in December 2007. (Contact: Yvonne J. Bryson; ybryson@mednet.ucla.edu).
- Meth Abuse: Natural History, Treatment Effect. This early NIDA study looked to assess HIV/AIDS risk behaviors among MSM and IDUs. One of its goals is to examine long-term treatment outcomes. (Contact: Mary-Lynn Brecht, lbrecht@ucla.edu)

- Monitoring Atypical HIV Strains in LA County. This study began in September 30, 2004 and will extend to September 29, 2009. The primary goal of this study is to utilize serum-based monitoring for the prevalence of atypical strains of HIV among recently diagnosed HIV individuals in LA County. The project will also evaluate the feasibility and efficiency of using dried blood spots (DBS) for routine surveillance of atypical strains of HIV where serum is not available.
(Contact: Ekow Kwa Sey, esey@dhs.co.la.ca.us)
- Mother's Living with HIV and their Adolescents. This NIMH funded study will strive to improve health behaviors for mothers living with HIV (MLH). The study seeks to increase MLHs health status, reduce mental health symptoms, encourage youth and MLHs' parent-child relationship, and reduce problem behaviors. The study began on September 2003 and will end on June 2008.
(Contact: Mary Rotheram-Borus, rotheram@ucla.edu)
- Organizational Factors in the Early Detection of HIV. This NIMH funded study aims to increase early detection of HIV. Organizations must increase the percentage of clients offered testing, the number of high-risk clients tested, the percentage tested who return for results, and the percentage of seropositives who are tested and linked into care. This study began in September 2001 and ended six years later.
(Contact: Oscar Grusky, grusky@ucla.edu)
- Partner-Oriented Drug Treatment and HIV Risk Reduction. This NIDA funded study determined if offering free drug treatment to one partner will improve treatment outcomes and reduce HIV risk behaviors among both partners. Also, the study examined whether offering free drug treatment to one partner will significantly alter the size, density, and stability of the personal drug using network of the partner. The study began in September 2001 and ended July 2007.
(Contact: Martin Yoneo Iguchi, iguchi@ucla.edu)
- Predictors: Medication Adherence in HIV-Positive Cocaine Addicts. This NIDA funded study examined how cocaine abuse/dependence affects medication adherence in HIV-positive individuals. One of the goals of this study was to assess whether cocaine abuse and a pattern of adherence failure was associated with the development of antiretroviral resistant HIV mutations. The study began in July 2001 and ended in June 2007.
(Contact: Charles H. Hinkin, chinkin@ucla.edu)
- Prevention for Homeless At-Risk for HBV/HCV/HIV. This NIDA funded study looks at the effect of a standard intervention combining brief education and incentives comparing that to another intervention that includes nursing care, and completion of HAV and HBV vaccines. Participants will be assessed using a battery of psychosocial, behavioral, health, and physical status, as well as HAV, HBV, HCV, and HIV serostatus measurements. This study began on August 1, 2003 and will end on June 30, 2008.
(Contact: Adeline M. Nyamathi, anyamath@sonnet.ucla.edu)
- Preventing HIV/AIDS in Teen Mothers and their Partners. This National Institute of Nursing funded study evaluated the impact of the CDC's *Be Proud! Be Responsible!* intervention targeting teen mothers and their partners. By addressing issues of gender and power, providing social-cognitive skill building experiences within the context of a

romantic relationship, sexual risk behaviors may be reduced in adolescent males and females. This study began in July 2000 and ended seven years later.
(Contact: Deborah Koniak-Griffin, dkoniak@sonnet.ucla.edu)

- Sexual Risk and HIV Disclosure Behaviors of HIV-Positives. This UARP funded study tested the hypothesis that HIV status disclosure is associated with increased condom use or risk reduction among HIV-positive MSM/W. Another goal of the study was to characterize the sexual risk, sexual behaviors, and HIV disclosure patterns among HIV-positive MSM/W. This study began in January 2001 and ended in December 2005.
(Contact: Matt Mutchler, mmutchler@apla.org)
- Social Ecology of HIV Prevention for Latino MSM. This UARP study evaluates the effectiveness of an HIV prevention program directed at Latino MSMs in Long Beach that aims to be socially and culturally appropriate. Specifically, the prevention program looks to evaluate the effectiveness of *retreats-reunion* in changing and sustaining participants' dating and relationship behaviors, improving self-esteem and self-efficacy, and in maintaining HIV prevention practices. (Contact: Ross Conner, rfconner@uci.edu)
- Southern California Primary Infection Program. This NIAID funded program looks to identify substantial cohorts with acute and early HIV infection. Another goal of this program is to reduce secondary HIV drug resistance and to design and evaluate strategies for prophylactic and therapeutic vaccines. Some of the studies conducted by this program include transmission of HIV drug resistance, CTL and CD4 proliferate responses, neutralizing antibodies, and apoptosis. Funding for this program began in August 1998 and will end in June 2008.
(Contact: Douglas D. Richman, drichman@ucsd.edu)
- Social Network-Based HIV Prevention for Homeless Youth. This five-year study began on March 16, 2007 and will assess the prevalence, social status, and social roles of pro-social peers in the social networks of homeless youth. One goal of the study is to model social network structures and the social influence process among homeless youth. Another goal is to develop an intervention manual and pilot test a peer-based HIV prevention intervention for homeless youth which mobilizes and augments the positive influence of pro-social peers. (Contact: Eric Rice, erice@mednet.ucla.edu)
- Social Settings and HIV Risk: Opportunities for Prevention. This NIMH funded study examined the dimensions of the social climate of bathhouses/sex clubs and the association with sexual risk behaviors. One goal of the study was to develop and validate a social climate scale to measure environmental dimensions of these venues.
(Contact: William J. Woods, william.woods@ucsf.edu)
- Social/Sexual Networks & HIV Risk: Men of Color. This project has many goals that include describing sexual partnership patterns and explaining the association between social discrimination, social networks, sexual partnerships, and HIV risk among African American, Latino and API MSM. Another project aim is to explore the nature of sexual partnership formation and examine key domains.
(Contact: Kyung-Hee Choi, kyung-hee.choi@ucsf.edu)

- Translating Street Smart for Use with Young Latino MSM. From January 1, 2004 to December 1, 2005, the process of translating evidence-based interventions for implementations in community organizations that serve Latinos was researched. (Contact: George Ayala, ayala@apla.org)
- UCLA Medication Development Unit for Stimulants. This NIDA funded study aims to measure associations between drug involvement (meth users, other drug users, non-drug users), IDU status, sexual risk behaviors (MSM, MSM/W, WSM), and HIV/STDs. The study hopes to predict the spread of HIV and STDs from sexual networks of high HIV prevalence individuals (drug using MSM) to those of low prevalence individuals (heterosexuals). This study began in September 2003 and will end in June 2008. (Contact: Steven Shoptaw, sshoptaw@mednet.ucla.edu)
- Understanding HIV Testing among Young Adults. This two-year UARP funded study investigated the HIV testing experience of young adults, their behavioral risk for HIV, and what the HIV test tells them. The study began in January 2004 and ended in December 2005. (Contact: Christine DeRosa, cjohnso@hsc.usc.edu)
- Virtual Sex: Real Risk Reduction for MSM. This National Institute of Allergy and Infectious Disease funded study looks to develop effective HIV prevention Interactive Video (IAV) for targeted audiences. It assesses whether IAV is effective in reducing HIV risk by comparing IAC along to a no counseling control. This study began in May 2003 and will end in five years. (Contact: Lynne Miller, lmiller@usc.edu)
- YMSM Drug Use, Sexual Risk and Health Promoting. This NIDA funded study's aims include: reducing sexual risk behaviors and reducing drug use. This study measured social support, drug use, and other predictors of sexual risk. The study began in September 2003 and ended in December 2007. (Contact: Michele Kipke, mkipke@chla.usc.edu)
- Youth Gangs: Drug Use, Sexual Behavior, Violence. During September 1, 2005 – June 30, 2007 an epidemiological profile of the practices and patterns of sexual behavior, drug use, and violence amongst gang-identified youths was developed. The research will describe the relationship between these behaviors and risks of HIV, STI's and other negative health outcomes, such as drug overdoses, cognitive impairment, unplanned parenthood, incarceration, injury, disability, and death. The research will further refine and ethno-epidemiological methodology to examine drug use, sexual behaviors, and violence among youth gang members in terms of HIV risk and other health risks. One of the project aims was to examine how well the existing theories on drug use, violence, and sexual risks explained these behaviors amongst gang-identified youth. (Contact: Bill Sanders, bsanders@chla.usc.edu)

■ Syringe Exchange / Harm Reduction

❖ CITY OF LOS ANGELES - SYRINGE EXCHANGE

To protect residents' health and safety, the City of Los Angeles sponsors syringe exchange programs (SEPs), allowing injection drug users to replace used needles, which are a major source of HIV infection, for clean needles. Like other large cities worldwide, Los Angeles recognizes the important role syringe exchange plays in preventing the spread of HIV and linking injection drug users with drug treatment programs, health care, and other assistance. Currently funded agencies that provide syringe exchange include:

- Asian American Drug Abuse Program (SPA 6)
- Bienestar Human Services (SPAs 3, 4, 7)
- Clean Needles Now (SPA 4)
- Common Ground (SPA 5)
- Homeless Health Care Los Angeles (SPA 4)
- Tarzana Treatment Centers (SPA 2)

❖ COUNTY OF LOS ANGELES - NEEDLE EXCHANGE

In late 2006, to complement the City's SEP, the Los Angeles County Health Department funded syringe exchange programs in locations outside of the City of Los Angeles. Funded agencies include:

- Clean Needles Now
- Asian American Drug Abuse Program
- Tarzana Treatment Centers
- Common Ground
- Bienestar Human Services

❖ STATE OFFICE OF AIDS – SATELLITE SYRINGE EXCHANGE (SSE) PROGRAM

In California, sharing of contaminated syringes and other injection equipment is linked to 19 percent of all reported AIDS cases and at least 60 percent of hepatitis C cases [3]. Increased access to sterile syringes among injection drug users (IDUs) reduces viral transmission among IDUs, their sex partners and children. A peer-based HIV prevention intervention was initiated by the California Department of Health Services (CDHS) Office of AIDS in 2004. The new intervention is the first to formalize the relationship between satellite syringe exchangers (SSEs) and the public health system. SSEs are recruited from the community, surveyed in order to allow project staff to learn about SSE risk behaviors and prevention efforts with IDUs, and trained to improve their role as peer educators within the IDU community [3]. As long as there has been needle exchange, SSEs have been filling gaps in harm reduction services to IDUs.

In Los Angeles County, Common Ground's (SPA 5) Needle Exchange Program (NEP) has implemented the intervention to recruit and train SSEs to spread health education and harm reduction messages to other IDUs.

Chapter References

1. HIV Epidemiology Program, Los Angeles County Department of Public Health. *HIV/AIDS Surveillance Summary*, July 2007:1-28.
2. MacKellar DA, Valleroy LA, Secura GM, Behel S, Bingham T, Celentano DD, Koblin BA, Lalota M, McFarland W, Shehan D, Thiede H, Torian LV, Janssen RS. Unrecognized HIV infection, risk behaviors, and perceptions of risk among young men who have sex with men: opportunities for advancing HIV prevention in the third decade of HIV/AIDS. *JAIDS* 2005 Apr 15;38(5):603-614.
3. Office of AIDS IDU-SSE High Risk Initiative, California State Department of Health Services. *Satellite Syringe Exchange and Public Health*.
<http://www.satelliteexchange.org/index3.htm>

Attachment 1: LACHNA Protocol

The LACHNA Protocol was approved for exemption by Health Department Institutional Review Board on June 5, 2007

A. TITLE

Los Angeles Coordinated HIV Needs Assessment (LACHNA)

B. SPONSOR OF THE STUDY

LACHNA will be supported by CDC (PA04012) and HRSA Title I (H89HA0016) funds. Both federal agencies provide funding for HIV community planning activities.

C. PREVIOUS FINDINGS

Los Angeles County has a population of 10,103,000 residents, making it the nation's most populous county, larger than 42 of 50 states. The median age of Los Angeles County residents is 32 years.

Los Angeles County represents 35% of California's Acquired Immunodeficiency Syndrome (AIDS) cases. As of December 2004, there were 20,315 individuals living with AIDS in Los Angeles County. The living AIDS case rate was 203 per 100,000 (HIV Epidemiology Program, Semi-Annual Surveillance, 2005). The impact of AIDS in the county varies greatly by SPA, with the highest rate of persons with AIDS (642 per 100,000 population) living in the metropolitan area (SPA 4), followed by 217 in South Bay (SPA 8), 196 in the South area (SPA 6), 163 in the West area (SPA 5), 125 in the San Fernando Valley (SPA 2), 94 in the East area (SPA 7), 77 in the San Gabriel Valley (SPA 3), and 63 in the Antelope Valley (SPA 1).

California implemented an HIV reporting surveillance system in 2002, however, as of February 2005, complete data on HIV still does not exist, and persons living with HIV in Los Angeles County must be estimated annually. Currently, it is estimated that 57,000 individuals are living with HIV or AIDS in Los Angeles County, one-quarter of whom are likely to be unaware of their infection.

Since 1981, 49,728¹ residents have developed AIDS and, of these, 28,989² people have died. Federal agencies such as the Center for Disease Control and Prevention (CDC) and HRSA have required that justification of need, priority setting, and resource allocation are all based on scientific evidence and geographically relevant data. The Los Angeles HIV Prevention Planning Committee (PPC), Commission on HIV/AIDS (COH) and the Office of AIDS Programs and Policy (OAPP) have conducted various projects to determine need. Historically OAPP and COH have conducted annual cross sectional surveys and more recently the HIV Care Assessment Project (H-CAP) to obtain data for the strategic planning of CARE services for individuals living with HIV or AIDS. And for prevention services, OAPP and the PPC have conducted focus groups, key informant interviews, community forums, and the Countywide Risk Assessment Survey (CRAS). In addition, both planning bodies also reviewed the HIV Epidemiology Profile compiled by Los Angeles County's HIV Epidemiology Program, other population based data (e.g. United Way, Census), and secondary data sources (e.g. YMSM study, bathhouse study, Transgender Study). These data are included in the 2004-2008 HIV Prevention Plan and the 2004 Comprehensive Care Plan.

■ H-CAP Overview

H-CAP measured the service needs and barriers of participants, demographic characteristics, prevalence of co-morbidities (such as substance use, homelessness, STDs, and mental illness). This project was originally designed as a longitudinal study where participants would be re-interviewed each year. The survey was designed as a telephone interview or web-based survey for HIV positive individuals ages 18 and older.

The sample size goal was set at 825 individuals. Due to some communication difficulties with providers, lack of Spanish speaking interviewers, and delayed start-up less than half of the goal was met (n=409). In addition, only 24% were re-interviewed from the previous year. Thus the following findings cannot be generalized to the estimated 55,875 PLWH/A but are still valuable to the priority and allocation setting process. The H-CAP data can also be used to identify emerging issues, changes in service needs, and to improve the HIV/AIDS Continuum of Care and the ability of persons living with HIV and AIDS to access and obtain needed services that enhance their health status and quality of life.

❖ **PROGRESSION FROM HIV TO AIDS**

As mortality decreases and PLWH do not advance to AIDS, there is a growing need to move persons from CARE Act-funded services to more sustainable funded services. The number of persons living with HIV and the number of persons living with AIDS is about equal, indicating the need to address services at all stages of infection. Services might be configured differently for different stages of infection, with greater emphasis on moving persons into care and maintaining care.

❖ **HIV MEDICATION AND ADHERENCE**

The HIV care system is doing well at distributing HIV medications. Eighty percent of the study participants reported taking antiretrovirals or protease inhibitors and the percentage of respondents who said that they had never been prescribed HIV medication decreased by 10% from the previous year. Those taking HIV medications vary by stage of infection, with over 85% of the PLWA reporting taking antiretroviral medication and 75% of the PLWH reporting taking antiretroviral medication.

Women, African Americans and individuals who were recently incarcerated or were unstably housed were less likely than other subpopulations to report taking HIV medications. Therefore, more outreach is needed to women, African Americans, incarcerated and re-entry populations, and unstably housed to increase their use of HIV medications.

The proportion of study participants who reported always taking their medication increased to 59% from 41% in 2004. However, more Treatment Education needs to be directed to African Americans and IDUs since they were more likely to report medication cessation than other ethnic and behavioral risk groups.

❖ **CO-MORBIDITIES**

The proportion of IDUs who said that they were unstably housed was almost twice as much as non injection drug users. Nearly 40% of the IDUs reported being homeless for some period in the last two years with over 20% currently homeless for at least 12 months. Eighty-two percent of MSM/IDUs reported receiving individual or group-level mental health counseling services and over 40% reported taking psychotropic medications.

❖ **MOST NEEDED SERVICES**

The top ten most frequently requested services were as follows: Medical outpatient services (91%), oral health (71%), bus passes (63%), food pantry (62%), nutrition therapy (56%), psychosocial case management (54%), medical specialty (52%), food vouchers (52%), prevention information (49%), and psychiatric services (49%). Men and women ranked the same service categories as the top four most needed services. However women were more likely to report needing home health care, family counseling, taxi vouchers, peer support, and medical specialists than men. Among the different ethnic or racial groups, Whites were more likely to need oral health, legal services, medical reimbursement and home delivered meals than other ethnic groups. African Americans reported the need for independent housing and medical specialists more frequently. Latinos requested prevention information and van transportation.

MSM/IDUs reported a much greater need for direct emergency financial assistance, housing information, substance abuse treatment, transitional housing, medication reimbursement, food vouchers and independent housing than other risk groups. In contrast, non-MSM IDUs reported a greater need for residential substance abuse, medical outpatient, peer support, spiritual counseling, home health care, family counseling, food pantry, psychosocial case management and prevention at a doctor's office. Heterosexual clients reported a greater need for nutrition therapy, taxi vouchers, and van transportation than other risk groups.

❖ **SERVICE UTILIZATION BARRIERS**

More than 30% of PLWH/A reported that they were unaware of the location of services, who to ask for help, or what treatment was available to them. Between 25% to 30% said they had physical barriers or that their "state-of-mind" were barriers to seeking care. Additionally, 20% to 30% said they did not understand instructions, were unaware of treatment needed, or felt they had poor communication with their providers. The greatest structural barrier reported by respondents was the amount of time that they had to wait before receiving services. Over 30% of respondents reported that the time they had to wait before receiving services was a barrier to receiving care. Over a quarter reported that the rules and regulations they had to meet, the red tape they confronted, their insurance coverage, or navigating the system were barriers to care. The greatest organizational barrier was the perceived lack of provider confidentiality. Approximately one-third of respondents were worried that their HIV/AIDS status would be disclosed by a provider and therefore did not want to utilize care services. Another issue survey participants reported was the perceived insensitivity of providers to clients' issues or concerns.

Based on these findings the Priorities and Allocations committee made recommendations for the continuum of care plan, shared the results with COH and the Service Provider Networks throughout Los Angeles County, and identified future topics to explore in the subsequent needs assessment.

■ **Countywide Risk Assessment Survey**

The importance of the Countywide Risk Assessment Survey (CRAS) data for the purpose of evaluation is that it provides demographic information and the nature and frequency of risk behaviors of individuals currently served by HIV prevention programs. CRAS is one component in Los Angeles County's overall needs assessment for the development of the 2004 HIV Prevention Plan.

CRAS was a cross-sectional survey conducted at agencies and in field settings. Surveys were one-on-one interviews where agency staff read the questions in either English or Spanish and

wrote the clients' answers on a hard copy form. The Countywide Risk Assessment Survey is designed to monitor the self-reported behaviors and perceptions of individuals who receive HIV prevention education, counseling, testing and treatment advocacy services at Los Angeles County-funded agencies. The survey is divided into four components: demographic information including client race/ethnicity, age, gender, educational level, sexual orientation, and place of birth; drug, alcohol, and needle use; sexual risk behaviors including inconsistent condom use, sex with multiple partners, sex with HIV positive partners, and exchanging sex for money or drugs; and utilization of HIV prevention and related services.

Out of the 51 agencies, 48 (94.0% agency response rate) collected a total of 2,276 surveys (92% survey response rate). Of these, 2,117 were completed and used in the final analysis. The 48 agencies provide HIV prevention programs targeting high-risk youth and adults. The populations targeted reflect current HIV prevention behavioral risk groups recommended by the PPC in the 2000 Prevention Plan.

❖ **SEXUAL RISK**

Approximately 1,899 CRAS respondents, or 37.6% of the total CRAS respondents, could not be classified as a member of one or more of the BRGs based on their reported behavior during the six months prior to having been surveyed.

Just over half of the respondents had a main sexual partner in the last six months (50.3%), and had been with that partner an average of 4 years ($M=3.94.05$, $SD=5.41$). Among those who have a main partner, 6.9% were in a serodiscordant relationship (either the respondent was HIV-negative and the main partner was HIV-positive, or vice versa). Forty-five percent of respondents had sex with a casual partner in the last six months, and had a median of 4 casual partners ($M=14.72$, $SD=52.69$). For those reporting a casual partner in the last six months, the range of partners was 1 to 877.

Table 1: CRAS Respondents and Sexual Risk Indicators

Sexual Risk Indicators	%
Inconsistently used condoms during vaginal or anal sex	74.1%
Used drugs or alcohol with their casual partners before, during or after sex	71.9%
Used drugs or alcohol with their main partners before, during or after sex	60.4%
Got paid for sex with money, drugs or something else at least once in their life	24.4%
Reported getting paid for sex in the last six months	25.5%
Did not know the serostatus of their main partner	10.0%
Did not know serostatus of at least one casual partner in the last six months	39.1%

Among CRAS respondents, 12.6% reported being HIV-positive, and 29.1% did not know their HIV status.

❖ CONDOM USE

A high proportion of women inconsistently use condoms with their male sexual partners. Inconsistent condom use was high among all racial and ethnic groups (range 69.2% - 85.1%). There was a statistically significant difference in condom use among BRGs ($p < 0.0001$). Table 3 summarizes the reported consistency of condom and other barrier use by behavioral risk group.

Table 2: CRAS Respondents and Barrier Use by Behavioral Risk Group/Target Population

BRG	% Inconsistent Condom Use
MSM	57.6%
MSM/W	75.4%
MSM/IDU	75.5%
Hetero Male IDU	91.9%
Female IDU	88.8%
WSR	80.1%
Transgenders	51.0%
Homeless	83.7%
Drug Users	80.7%
HIV+	48.8%

❖ DRUG USE

Approximately 87.0% of CRAS respondents reported using any substance including alcohol and tobacco in the past six months. Eighty-three percent of CRAS participants reported using alcohol, tobacco, or steroids or hormones only, while 55.8% reported using drugs (including marijuana) in the past six months. Smokable cocaine (16.1%), crystal methamphetamine (17.0%), and pure heroin (10.8%) were the most frequently reported drugs used.

Seventeen percent of CRAS respondents reported having used crystal meth in the six months prior to having been surveyed. Of that 17.0%, over half (53.2%) were MSM. Seventy-four percent of MSM who used crystal meth in the six months prior to being surveyed had used condoms inconsistently. Also, 10% of MSM who used crystal in the six months prior to being surveyed had also traded sex for something they needed in the same time frame.

Data collected from CRAS shows higher injection drug use compared to the AIDS surveillance data in Los Angeles County. Approximately 22.6% of CRAS respondents reported injecting drugs at least one time ever, and just over 13.9% reported injection drug use in the past six months. Approximately 44.3% of IDU were Latino, 19.5% African-American, 26.4% White, 3.5% Asian/Pacific Islander, and 6.3% Native American.

❖ TRANSGENDERS

Seventy-eight percent of transgenders reported being homeless. 79.4% reported having used steroid or hormones in the last six months. In the six months prior to having been surveyed, 70.4% of transgenders reported that they had traded sex for something they needed. Four percent of transgenders reported having had sex while high, compared to males 66.1% and females 30.2%. In addition, 52.0% of transgenders reported having used crystal meth. Over seven-and-a-half percent of transgenders reported having used condoms inconsistently. Thirteen percent of the transgender individuals surveyed reported having tested positive for HIV.

❖ **CHARACTERISTICS OF HIV-POSITIVE CLIENTS**

Among CRAS respondents who self-reported being HIV-positive, 47.9% were Latino, 33.7% were African-American, 13.4% were White, 1.5% were Asian American, 1.9% were Native American, 1.3% were Native Hawaiian or other Pacific Islander, and less than 1% were other or of mixed race/ethnicity. About 95% of those who said they were HIV-positive were 25 years old or older, and about 5.0% reported being youth (younger than 25 years old). Approximately 73.0% were male, 14.0% were female, and 13.0% were transgender (11.1% transgender male to female and 1.9% transsexual male to female). Approximately 14.8% of estimated HIV-positive clients were recent immigrants, and 25.7% were homeless at the time of the interview. These findings further highlight the continued need for cultural and linguistically appropriate prevention services for people living with HIV/AIDS.

❖ **RECENTLY DIAGNOSED**

Of the 637 CRAS respondents who reported being HIV positive, 48.0% (n=305) were diagnosed in the six months prior to having been surveyed. Twenty-four percent of those recently diagnosed had also used crystal meth within the six months prior to having been surveyed.

❖ **SEX FOR RESOURCES**

Over 5.5% of CRAS Respondents reported having exchanged sex for money or other resources in the six months prior to having been surveyed. Youth under the age of 25 comprised 6.4% of estimated clients who reported trading sex. Sixty-five percent of those who traded sex were male, 32.6% female and 2.5% were transgender. Seventy percent of those who had traded sex reported living in a house or apartment. Nearly sixteen percent reported living in a half-way house/treatment center/sober living or board and care facility. Over five percent reported living outside on the street, on the sidewalk, alley, on a park bench or under an overpass. With regard to education, 29.5% of those CRAS respondents who had traded sex had 1-2 years of college or technical/vocational school, followed by 21.0% who did not complete high school or get a GED, 19.4% who had a high school diploma and 17.6% who had a four-year college degree. Overall, 24.4% of clients reported that they have been paid for sex with money or other resources such as drugs or housing at least once in their lives. Nearly 17% of all youth reported exchanging sex for money or other resources they needed at least once in their life.

While 51.2% of those who had traded sex in the six months prior to being surveyed were HIV-positive, 36.6% reported inconsistent condom use.

❖ **SUMMARY OF KEY FINDINGS**

CRAS provides timely and geographically relevant data. When viewed in the context of other sources of data, including the HIV Epidemiology Profile, the Geographic Estimate of Need, and the Analysis of Gaps in HIV Prevention Services, CRAS makes a key contribution to understanding the characteristics of clients of HIV prevention services in Los Angeles County.

There could be various explanations for the discrepancies between the reported sexual behavior and orientation of CRAS respondents and the reported sexual behavior and orientation of AIDS cases. One possibility is that CRAS respondents truly are heterosexual and at relatively low risk of HIV infection, suggesting that targeting and outreach efforts have not been entirely successful. Another explanation is that self-reported sexual orientation does not necessarily reflect the sexual behavior of the client. Further analysis of the data shows that 3.9% (n=54) of self-identified heterosexual men reported having at least one male partner in the past six months.

■ Adult Film Industry

Adult film production is a legal, multibillion dollar industry in California and consists of the largest number of adult film workers in the nation³. Los Angeles County DHS was notified of HIV transmission by an adult film worker and subsequently initiated an outbreak investigation. This investigation included interviews and risk assessments of infected workers to elicit information about recent sex partners, review of the testing agency's medical records and laboratory results, molecular analysis of HIV isolates from the 4 infected workers. One finding from this study was that a male performer tested negative for HIV on February 12 and March 17, 2004. However he later tested positive for HIV on April 9, 2004⁴. During the period between the first and second negative test results, he reported experiencing flulike symptoms after performing unprotected vaginal and anal intercourse for an adult film. Despite these symptoms he continued to perform unprotected sex acts for adult films with 13 female partners. Each of these women initially tested negative for HIV but after a 30 day period, 3 subsequently tested positive for HIV (a 23% attack rate)⁴. Contact tracing identified no reasonable sources of infection other than the male index patient. Local and federal public health staff concluded that although current testing methods may shorten the window period to diagnosis of new HIV infection, they fail to prevent occupational acquisition of HIV in this setting⁴.

■ Methamphetamine

Among men who have sex with men (MSM) in Los Angeles County, methamphetamine use is associated with high rates of HIV prevalence and sexual risk behaviors. Local researchers Drs. Shoptaw and Reback recently published a literature review of methamphetamine use and HIV prevention interventions⁵. They reported that strong associations between methamphetamine use and HIV-related sexual transmission behaviors are noted across studies of MSM and correspond to increased incidence for HIV and syphilis compared to MSM who do not use the drug. Although the review found that behavioral treatments produce sustained reductions in methamphetamine use and concomitant sexual risk behaviors among methamphetamine-dependent MSM, this study did not examine other behavior risk groups or populations who frequently use crystal methamphetamines. Drs. Shoptaw and Reback also conducted a study of four separate samples of MSM who differed in the range of their intensity of methamphetamine use. The frequency of methamphetamine use varied from levels of recreational use to chronic use to those for MSM seeking drug abuse treatment, the association between methamphetamine use and HIV infection increased as the intensity of use increased. The lowest HIV prevalence rate (23%) was observed among MSM contacted through street outreach who mentioned recent methamphetamine use. Forty-two percent of the MSM who used at least once a month for six months reported being HIV positive followed by MSM seeking intensive outpatient treatment (61%). The highest rate (86%) was observed among MSM seeking residential treatment for methamphetamine dependence⁶.

D. PURPOSE

In an effort to enhance our understanding of both prevention and care services needs for individuals living with or at risk for HIV in Los Angeles County, the Office of AIDS Programs and Policy (OAPP), the Los Angeles County HIV Prevention Planning Committee (PPC) and the Commission on HIV (COH) have developed a needs assessment questionnaire. The Los Angeles Coordinated HIV Needs Assessment (LACHNA) is designed as a comprehensive survey instrument that provides a countywide profile of service needs and utilization of individuals at risk for HIV, as well as individuals living with HIV/AIDS who may or may not be accessing Ryan White Care Act treatment services.

These two parallel activities (CRAS and H-CAP) were integrated to 1) greatly reduce the role/time commitment of agency providers, 2) secure and utilize current technology (PDA and QDS software), 3) eliminated data entry, 4) share research experience and provide technical support, and 5) facilitate the IRB process.

E. OBJECTIVES

This needs assessment has the following major objectives:

1. To describe the populations receiving HIV services;
2. To assess populations not receiving services;
3. To identify unmet need
4. To identify where risky behavior is occurring;
5. To identify what services are needed;
6. To determine barriers of service utilization; and
7. To determine where services are needed.

F. STUDY DESIGN

Individuals will be randomly selected (systematic sampling=every “nth” client) to participate in this needs assessment during the three (3) month data collection period. Names and contact information will not be collected and there is no participant follow-up. This needs assessment will be implemented as a cross-sectional study. Individuals must complete the survey in a one-on-one interview. Interviewers will read the survey questions in English or Spanish and record the respondent’s answers on a hand-held electronic device (PDA).

G. LOCATIONS AND TARGET POPULATIONS

❖ SURVEY SITES

LACHNA will be conducted at a number of venues across Los Angeles County. A large pool of venues were identified which include high-risk venues (bars and clubs, parks, beaches, street corners, etc.), day labor sites, local hangouts, and HIV medical service provider sites. High-risk venues were identified from the HIV Behavioral Surveillance Survey, the HIV Community Needs Assessment, and through information obtained by the HIV Prevention Planning Committee. Day labor sites were identified through a priori knowledge (research studies, service providers, and members of the target population). HIV medical service provider sites include all sites which receive funding from the OAPP through the Ryan White Care Act. Care and prevention sites will first be stratified by SPA and then randomly selected. The number of sites is dependant on two factors 1) maximum number of projected surveys possible at the respective site and 2) the number of completed surveys needed in each service planning area (SPA).

❖ TARGET POPULATIONS

There are four primary target populations for this needs assessment:

1. Individuals at high risk for HIV
2. Individuals living with HIV who are currently receiving treatment (In Care)
3. Individuals living with HIV who are not currently receiving treatment (Out of Care)
4. Individuals living with HIV who have recently begun receiving treatment after not receiving treatment for 12 months or longer (Return to Care)

Geographical location will be the primary factor of interest in choosing participants to recruit for the survey, and HIV risk behavior will be a secondary factor. Recruitment and interviews will occur throughout all eight SPAs. The venues that have been identified are sites where individuals either at high risk for HIV or who are HIV-positive can be recruited. Individuals at high risk for HIV include men who have sex with men (MSM), men who have sex with men and women (MSM/W), men who have sex with men and inject drugs (MSM/IDU), injection drug users (IDU), women at sexual risk (WSR), transgenders at sexual risk or who inject drugs (TSR/TIDU), Native Americans/Alaskan Natives, and re-entry population (previously incarcerated).

H. ELIGIBILITY

Clients will be eligible to participate in LACHNA if they are:

1. Age 13 years or older (in accordance with California Health Code 121020)
2. Willing to provide verbal consent
3. Able to complete an interview in English or Spanish language

Clients will be ineligible to participate in LACHNA if they are:

1. Less than 13 years of age
2. Unwilling to provide verbal consent
3. Cannot speak or understand English or Spanish language
4. Currently incarcerated or detained (e.g. juvenile detention centers)

I. SAMPLE SIZE

Approximately 2,100 individuals are anticipated to participate in the needs assessment during the three-month study period. A two-step sampling methodology was employed. Tabulation method was used to determine the overall sample size. The tabulation method stipulates that a sample size of 5 individuals in the smallest subgroup is adequate when research hypotheses are not tested. In this assessment, TSR/TIDU living with HIV/AIDS who received Ryan White Care Act medical services in Year 15 was the smallest subpopulation. To ensure that a sample of five (5) HIV positive TSR/TIDU is obtained, a total of ten (10) HIV positive TSR/TIDU will be the smallest cell frequency. The next step in the sample size calculation was to determine the relative frequency of HIV positive TSR/TIDU to the overall population (total number of clients who received prevention services from a County-funded service provider and all clients receiving Ryan White Care Act-funded services). The sample size for each target group (TSR/TIDU, MSM and MSM/W, MSM/IDU, IDU, and WSR) was extrapolated for both prevention and care services to obtain the total sample size of 2,085. Table 3 shows the number of individuals expected to participate in the study.

Table 3: Sample by Behavioral Risk Group (BRG) and Target Group

Target Group	Prevention*	Care	Total
TSR/TIDU	121	10	131
MSM, MSM/W	1,054	361	1,416
MSM/IDU	60	32	92
IDU	90	26	116
WSR	181	149	330
Total	1,506	578	2,085

*Includes Unmet Need of HIV positive individuals

The next step involved determining how many individuals would be selected for participation from each service planning area (SPA). The distribution is based on a geographic estimate of need (GEN). For HIV prevention services the GEN model includes the following six indicators: living AIDS cases, recent AIDS cases, poverty, sexually transmitted disease incidence, substance abuse, and HIV counseling and testing results. The GEN model for care services only has three equally weighted indicators: poverty, AIDS incidence, and AIDS prevalence. The GEN model was applied to both the prevention and care sample size (1,506 and 578 respectively) to determine how many surveys will be conducted in each SPA. Table 4 shows the number of individuals expected to participate from each service planning area.

Table 4: Sample by Service Planning Area (SPA)

SPA	Prevention	Care	Total
SPA 1	31	7	38
SPA 2	223	75	298
SPA 3	170	42	212
SPA 4	386	212	599
SPA 5	74	31	104
SPA 6	241	61	302
SPA 7	157	39	196
SPA 8	225	111	336
Total	1,506	578	2,085

J. PARTICIPANT SELECTION CRITERIA

All needs assessment participants will be selected through systematic random sampling where every “nth” client will be selected at each session/site.

K. DATA COLLECTION

All interviewers are required to attend a mandatory training where they will review survey methodology, sampling, mandatory reporting requirements, and confidentiality. Surveys will be administered during oral interviews by trained interviewers using handheld computing devices (PDAs). Surveys are available in English and Spanish. Because not all survey topics may be relevant to all participants, numerous skip patterns are embedded within the survey. Only relevant questions (based on participant’s previous answers) will be asked. Survey topics include demographic characteristics, service utilization, sexual risk behavior, history of drug use, history of methamphetamine use, zip code of residence, zip code of employment, service utilization barriers, housing status, HIV status, insurance status, and condom use.

Interviews will be conducted one-on-one with participants. Names and contact information will not be asked and surveys will be completed anonymously. Every “nth” individual will be randomly approached and asked if they are willing to participate. Everyone has the option to decline as participation is completely voluntary. If the individual agrees to participate, the interviewer and the participant will step aside to a private area where the survey can be administered orally and the participant’s confidentiality is not compromised. Participants may decline to answer any question, or terminate the interview at any time.

Surveys take approximately 30-60 minutes to complete and participants will be compensated for their time. The length of the survey is dependant on numerous factors including HIV serostatus, HIV treatment status, substance abuse history, and number of sexual partners. Therefore, a participant who is HIV-negative with only one partner may complete the survey in 30 minutes,

while a participant who is HIV-positive, is currently receiving treatment but has returned to care, and who has multiple partners may complete the interview in 60 minutes. To address this disparity, a two-tiered compensation method will be employed. Those who finish the survey in 45 minutes or less will be compensated with an item valued at \$20 while those who take longer than 45 minutes to complete the survey will be given an item valued at \$30. Types of compensation will include Target Stores gift cards, grocery store vouchers, and AMC movie ticket packages. Clients will be informed that their compensation will be determined by a formulary.

Interviewers will meet at a pre-arranged spot. Sessions will occur at various times during the day and night and the session time will be based on the site or type of venue. Each session will last approximately four to six hours in length. Once everyone is accounted for, the field coordinator will divide the data collectors into teams of two. Each data collector will receive a PDA and vouchers for reimbursement. All interviewers will have cell phones to contact each other if needed. Depending on the length of time determined for that particular venue, there will be periodic check-ins where teams will meet with the larger group. At the end of the collection period, everyone will meet at a pre-assigned time and location and the survey instruments and any remaining vouchers will be collected. The field coordinator is responsible for ensuring the safety of all data collectors, confidentiality of the clients, integrity to the protocol, maintenance of electronic devices and incentives, and ultimately responsible for transmitting the data from each PDA to a secured network server.

L. DATA MONITORING

One of the advantages of electronic data collection is the ability to include built-in data validation tools which dramatically improve the accuracy of data as they are being collected. Data validation tools will be built into the electronic version of the survey to address inconsistencies and potential data collector errors that may arise. In addition, data collection in the field will be routinely monitored by the field supervisor. The field supervisor will remind data collectors of protocols prior to collecting data at each venue. Further a random 10% sample of data will be analyzed weekly to ensure that protocols are being followed correctly.

M. DATA MANAGEMENT, SECURITY, STORAGE, AND TRANSMISSION

Surveys will be administered using PDA by trained interviewers. Each survey will be stored in an encrypted batch file on the PDA until it is either transferred or moved. Each batch file contains all the surveys collected during primary, secondary, and pilot methods will be employed to transmit or move data from each of the PDAs to a secure server located at OAPP.

The primary method of data transfer will occur at the completion of data collection at each venue. The process will involve synchronizing (transferring) the encrypted survey batch files on each PDA with a laptop managed by the field supervisor and then sending the files through a secure wireless line (virtual private network) to OAPP's secure FTP site located within the office. The secondary method of data transfer will also occur at the completion of data collection at each venue and will involve transferring the encrypted survey batch files to a secure digital memory card, then transferring the data to the field supervisor laptop using a card reader. This secure encrypted data will remain on the laptop until the field supervisor returns to the office. In addition to the primary and secondary data transfer methods, a pilot transfer method will be tested. One of the PDAs used for data collection will be a smartphone (combination PDA and cellular telephone). Data collected using this device will be encrypted and transferred directly to OAPP's secure FTP site as surveys are completed. Data transferred to OAPP's secure FTP site will be managed in a password protected SAS database. All project staff accessing data will do so through password-protected computers.

N. DATA ANALYSES

Geographical data will be collected at the census tract level for three Spatial analyses that will be conducted to assess the geographical distribution of HIV risk across Los Angeles County.

Geographic data will be displayed in aggregate, and small-area geographic results will not be included if there are less than 5 cases. Additional analyses will assess distances from individuals at risk for HIV, or living with HIV/AIDS to appropriate HIV services, as well as the service utilization patterns of these individuals compared to where they live, work, and socialize.

In addition to the GIS analysis, fundamental descriptive statistics will be calculated and reported in statistical summaries. Chi square, t-tests, univariate regression, and multi-regression analysis will also be conducted. Structural equation modeling may also be completed however this analysis is dependant on the final sample size and frequency of each measure of interest. Sexual risk, history of drug use, history of homelessness, utilization of services, sexual behavior among adult entertainers, HIV knowledge, motivators for condom use, motivators for HIV testing, service needs, and factors associated with no care or return to care will be analyzed first.

O. PROVISIONS FOR MANAGING ADVERSE REACTIONS

No physical risks are involved. Inconvenience and psychological discomfort for the participant at the study sites are the primary risks. There may be some anxiety associated with answering survey questions regarding the participants sexual risk behaviors and/or HIV status. If any psychological stress should develop, the participant may stop the interview at anytime. Any unanticipated adverse events relating to the study will be immediately reported to the Principal Investigators who will immediately file a report with the Los Angeles Department of Health Services Institutional Review Board. The board will review the case and report it to the Office for Human Research Protections (OHRP) at the United States Department of Health & Human Services if necessary.

P. PROTECTION OF HUMAN RESEARCH SUBJECTS

All project staff are HIPAA and IRB certified. OAPP does not have an internal IRB but defers to the Los Angeles County Department of Public Health (DPH) IRB for review and approval. The project evaluator is also the OAPP IRB liaison and will ensure that all local and DPH regulations for the protection of human research subjects (45 CFR 46) are followed.

Q. WAIVER OF RESEARCH CONTENT

The IRB is requested to waive consent for this study because there is minimal risk involved with participation and the client's signature on the consent form would be the only identifier linking the client's identity to survey data. In addition, this needs assessment is completely paperless, and thus the consent form would be the only paper form used for this project. The following four requirements for waiver of research consent, set out in 45 CFR 46.116(d), are met by this study (see descriptions below):

1. The research involves no more than minimal risk to the participants.
2. The waiver or alteration will not adversely affect the rights and welfare of the participants.
3. The research could not practicably be carried out without the waiver or alteration.
4. Whenever appropriate, the participants will be provided with additional pertinent information after participation.

R. MINIMAL RISK REQUIREMENT

This study is collecting data on HIV risk behaviors, HIV service need and utilization. Thus, this study meets the minimal risk criterion that the probability and magnitude of harm or discomfort anticipated in the study are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

S. RIGHTS AND WELFARE OF PARTICIPANTS

The rights and welfare of participants are not adversely affected because of this study. The welfare of some participants may be enhanced because they may learn about HIV prevention and/or HIV treatment services which they may be entitled to. In addition, talking about and/or learning about HIV risk behaviors may reduce some risk behaviors in the future.

T. PROVISION OF ADDITIONAL PATIENT INFORMATION

Not Applicable

U. INCLUSION OF PERSONS AGED 13 TO 18

All individuals ages 13 years of age or older are eligible to participate in this needs assessment per California Health Code 121020. In the state of California, individuals age 13 years of age or older are able to receive HIV prevention services without parental consent. However, it is anticipated that less than 7% of all study participants will be between the ages of 13-18 years.

V. WAIVER OF CHILD'S ASSENT AND PARENTAL PERMISSION TO PARTICIPATE IN RESEARCH FOR PERSONS AGED 13 TO 18

As such all of the reasons put forth in the Section entitled "**Waiver of Research Consent**" above, also apply to this population, and we request that a Waiver of child's assent to participate in research be granted for this study on these grounds.

W. WAIVER OF DOCUMENTATION OF PRIVACY RULE AUTHORIZATION (HIPAA)

Based on 45 CFR 164.512.b1(i), the IRB is requested to waive authorization under the privacy rule for this study because the following three requirements are met (described below):

1. The use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on the presence of the following elements:
 - A. an adequate plan to protect identifiers from improper use and disclosure;
 - B. an adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research; and
 - C. adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity
2. The research could not practicably be conducted without the waiver; and
3. The research could not practicably be conducted without access to and use of the protected health information.

❖ MINIMAL RISK REQUIREMENT

The study protocol includes an adequate plan to protect identifiers from improper use and disclosure and adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity. This study is collecting data on HIV risk behaviors, service need, and utilization. The only personal identifier collected is client zip code. Data will only be analyzed in aggregate form. If there are less than five individuals in a specific zip code, the zip code will not be presented on maps.

No physical risks are involved. Inconvenience, psychological discomfort, and potential loss of confidentiality are the primary risks. Social and legal risks from participation in this study are expected to be low. There may be some anxiety associated with discussing personal information. If any psychological stress should develop during the interview, staff will terminate the interview and the interviewer will assist the participant until the crisis has passed. Additionally, each staff will provide a booklet with referrals to local HIV services following the completion of the interview.

❖ **PRACTICALITY**

This study could not be practically conducted without a waiver of authorization because individual authorization forms cannot be routinely collected on a PDA in a field setting. Also this form would be the only names-based link between the client and the survey.

❖ **ACCESS AND USE OF PROTECTED HEALTH INFORMATION**

This study could not be practically conducted without the access and use of protected health information (client zip code) because evaluating the patterns of HIV service need and service utilization by geography will allow Los Angeles County to better target future HIV prevention and treatment efforts, thus using funding more efficiently.

X. COMPENSATION TO SUBJECTS FOR THEIR PARTICIPATION

Clients will be compensated with an item valued at either \$20.00 or \$30.00 for their time. The exact denomination given will be calculated by the PDA based on the time it takes to complete the survey. Individuals who complete the survey in 45 minutes or less will be compensated with an item valued at \$20, while participants who complete the survey in 45 minutes or more will be compensated with an item valued at \$30.

Y. ANY COMPENSATION FOR INJURED RESEARCH SUBJECTS

Injured research subjects will be compensated per subcontracting agency policy.

Z. EXTRA COSTS TO SUBJECTS FOR THEIR PARTICIPATION IN THE STUDY

Not applicable.

AA. EXTRA COSTS TO THIRD PARTY PAYERS BECAUSE OF SUBJECT'S PARTICIPATION

Not applicable.

References

1. HIV Epidemiology Program, Los Angeles County Department of Health Services. HIV/AIDS Semi-Annual Surveillance Summary. January 2005: 1-29.
2. HIV Epidemiology Program, Los Angeles County Department of Health Services. An Epidemiology Profile of HIV and AIDS, Los Angeles County 2004.
3. Centers for Disease Control and Prevention. HIV Transmission in the Adult Film Industry Los Angeles, California, 2004. MMWR 2205 Sep 23; 54(37):923-6.
4. Taylor MM, Rotblatt H., Brooks JT, Montoya J., Aynalem G., Smith L, et al. Epidemiological Investigation of a cluster of workplace HIV infections in the adult film industry: Los Angeles, California, 2004. Clin Infect Dis 2007 Jan 15; 44(2):301-5.
5. Shoptow S. and Reback CJ. Methamphetamine Use and Infectious Disease Related Behaviors in Men who have Sex with Men: Implications for Interventions. Addiction 2007 April; 102 Suppl 1:130-5.
6. Shoptow S. and Reback CJ. Associations between Methamphetamine Use and HIV among Men who have Sex with Men: A Model for Guiding Public Policy. J. Urban Health 2006 Nov; 83(6):1151-7.

Attachment 2: Focus Group & Key Informant Questions – Facilitator Guide

The Focus Group and Key Informant Questions and Facilitator Guide (including the question guide and protocol) were approved for exemption by the Health Department Institutional Review Board on July 19, 2007.

■ Question Guide for Facilitators:

Proceed through each section, allowing individuals to share their thoughts and ideas on the subject. Introduce outlined discussion point if the conversation stalls or is not adequately explored.

I. INTRODUCTION & TARGET POPULATION/SERVICES

- Describe your population (e.g., target population, race/ethnicity, age, etc.)
- What types of services are provided to your specific program/target population?

II. RECRUITMENT & RETENTION

- What specific recruiting strategies have you used that have been successful in reaching this target population?
- What specific retention strategies have you implemented that have been successful in retaining your target population?
- What are some specific challenges that you have had in reaching your target population? What have you done to try to overcome these challenges?
- What are some specific challenges that you have had in retaining your target population? What have you done to try to overcome these challenges?
- Can you think of any innovative strategies that you have not tried that might work for reaching and retaining your target population?
- What have been some unique issues you have noticed with your target population (i.e., are there any sub-populations within your target population that are more challenging in reaching and/or retaining than the other members)? How have you addressed these issues?

III. PREVENTION SERVICES & NEEDS

- What prevention services are needed by your target population that are not currently being funded?
- Should HIV testing be routinely offered to all residents in your SPA regardless of age, risk, etc.? Yes or no, please explain.
- What non-monetary resources are needed to achieve desired program outcomes (e.g., behavioral change, change in beliefs and/or attitudes)?

IV. SUCCESSES & CHALLENGES IN BEHAVIOR CHANGE, BELIEFS, ATTITUDES

- What factors are associated with the success of your intervention (e.g., incentives, the facilitator, the intervention)?
- What behavior, beliefs, or attitudes are the intervention trying to change?
- What are some unexpected behavior changes, beliefs, attitudes that resulted from your program?

■ Focus Group and Key Informant Interview Protocol

❖ WHAT IS A FOCUS GROUP?

A focus group is a small-group discussion guided by a trained leader. It is used to learn more about opinions on a designated topic, and then to guide future action. A focus group is a group of individuals, usually six to eight, brought together for a more or less open-ended discussion about an issue. Specifically, the focus group session concentrates on:

- Gather opinions, beliefs, and attitudes about issues of interest.
- Encouraging discussion about a particular topic.
- Building excitement from spontaneous combination of participants' comments.
- Providing an opportunity to learn more about a topic or issue.

❖ MAIN GOALS OF THIS FOCUS GROUP

1. What interventions worked and why.
2. What interventions didn't work and why.
3. Innovative future interventions.

❖ FREQUENTLY ASKED QUESTIONS

Questions	Answers
Are the participants going to be compensated for their time?	There will be no compensation
What is the benefit to participating?	We get information regarding successful interventions and identify challenges with other interventions for the planning of future prevention services.
Did I have to participate because it is an OAPP funded program?	No, your participation is voluntary and your feedback will not effect your current or future funding.
Do I have to answer every question?	No, it is not required that you answer every question, however your feedback is very important to us. This is one component of the overall needs assessment that is funded by the CDC. We are trying to learn about successful interventions so we can plan and allocate for future funding opportunities.
Will we be provided a copy of the report on our focus groups?	We will not be providing the participants with the transcripts, but they can get a copy of the presentation or the preliminary reports if they would like. The findings will also be presented at the Standards & Best Practices subcommittee meeting, the Prevention Planning Workgroup meeting, Data Summit meeting and at future PPC meetings.

❖ CONDUCTING THE FOCUS GROUP

Here is a scripted way to begin the focus group starting with the introduction, ground rules, and target population/services:

Good afternoon. My name is _____ and I work for _____. The main goals of this focus group are to find out what interventions worked and why, what interventions didn't work and why, and innovative future interventions.

As part of our needs assessment, we've asked you here to learn about successful interventions so we can plan and allocate for future funding opportunities. Our discussion should last for about 2 hours.

I will be helping to guide the discussion and make sure everybody has a chance to speak. This is _____. S/he will be making notes during the discussion so that we do not forget any of the points discussed. Although s/he will be recording the points raised, s/he will not write down any names, so whatever you say will be anonymous and confidential.

Please remember, you are the experts and we are here to learn from you. Please don't tell us what you think we might want to hear. Tell us your views, whatever they are. Again, this is entirely anonymous and neither the moderator nor the note-taker is your OAPP program manager and this will not impact your funding in any way.

Before we go further, we should introduce ourselves. Please tell us your first name, describe the population you provide services for (e.g., what type of HERR services do you provide to your target population, race/ethnicity, age, etc.) and what types of services are provided to your specific program/target group.

Now that we have introduced ourselves, let me explain the ground-rules.

1. Please talk one at a time and avoid side conversations so that your comments can be clearly recorded on the tape.
2. Everyone doesn't have to answer every single question, but I'd like to hear from each of you today as the discussion progresses.
3. This will be an open discussion, so feel free to comment on each other's remarks.
4. There are no "wrong answers", just different opinions. Say what is true for you and/or your program, even if you are the only one that feels that way.
5. Please respect each others' opinions.

❖ **MODERATOR DO'S AND DON'TS**

Do's	Don'ts
Make everyone feel welcome	Talk too much
Speak in a loud, clear voice	Let one person dominate the discussion
Include everyone in the discussion	Fail to stay neutral on the issue
Leave enough time for people to answer questions	Ask more than one question at a time
Probe for clarity	Ask "yes" or "no" questions (instead ask open-ended questions)
Vary your style of asking questions to get a variety of answers	Forget to thank the group for participating

❖ **DEALING WITH ISSUES**

A focus group moderator should be able to deal tactfully with outspoken group members, keep the discussion on track, and make sure every participant is heard. The following are some of the most common issues that you may come across when being the moderator of a focus group and suggestions as to what to say in order to deal with it.

Challenging Characteristics	What to do...
<p>Overly Talkative</p> <p>An "eager beaver" or a showoff is always the first to respond to a question and has lots to say. If allowed, will monopolize the conversation</p>	<ul style="list-style-type: none"> ■ Acknowledge the person's comments and interject with, "That's an interesting point...now let's hear what other people have to say." ■ "I'd like to hear more about that, who else would like to share?"
<p>Argumentative</p> <p>Combative person always disagrees with something</p>	<ul style="list-style-type: none"> ■ Keep calm and turn it over to the group, "Would anyone like to comment about what was just said?" ■ After enough debate, state the importance of moving on and if necessary agree to disagree. ■ As a last resort, talk to the person privately during the break. Try to find out if there is an immediate problem that can be worked out..
<p>Rambler</p> <p>Lacks focus on the subject. Basically not on the same page and likes to talk regardless of the lack of relevancy to the current topic of discussion</p>	<ul style="list-style-type: none"> ■ When an opportunity arises, politely interject with, "I'm sure that is interesting, how does it connect with (agenda topic)?" ■ Attempt to make some connection of what was said with the group's discussion and ask if there is anyone else who would like to comment. ■ Re-emphasize issue or topic at hand.
<p>Distracter</p> <p>Distracts by having a side conversation while someone else is talking</p>	<ul style="list-style-type: none"> ■ Stop the group discussion and simply remark that it is difficult to hear when more than one person is talking. ■ Ask the distracter if he/she would like to comment on the last comment made by someone else.
<p>Misstatement Stater</p> <p>Makes an obvious incorrect statement</p>	<ul style="list-style-type: none"> ■ Turn it over to the group, "Would anyone like to comment about what was just said?" ■ If no one chooses to respond, then state that while some people have said or believed <i>so and so</i>, (correct statement).
<p>Inquisitor</p> <p>May put you on the spot by asking your opinion. May want you to take sides</p>	<ul style="list-style-type: none"> ■ Again, turn it over to the group. "I'm more interested in what others might have to say, who had a comment?" ■ If appropriate, give your opinion in a diplomatic way without taking sides.

❖ PROBE FOR ANSWERS

Good probing questions:

- Why do you think this is the case?
- Can you say more about that?
- Can you give me an example?
- Does anyone else have some thoughts on that?
- What's another way you might.....?
- What would it look like if.....?
- What do you think would happen if.....?
- How was.....different from.....?
- What sort of an impact do you think.....?
- What criteria did you use to....?
- When have you done/experienced something like this before?
- How did you decide to.....?

Attachment 3: PPC Task Force Recommendations

The PPC Task Force Recommendations were approved by the PPC on December 7, 2006.

During 2004-2006, three main priority issues arose: (1) a need to examine HIV prevention in Commercial Sex Venues; (2) the epidemic within the African American MSM population; and (3) the Crystal Methamphetamine epidemic among men who have sex with men. OAPP, the HIV Prevention Planning Committee, contractors, community groups, and community leaders, responded by conducting a number of activities and forming focus groups, task forces, and community town halls to discuss these issues, make recommendations, and prompt a community response.

The PPC formed three task forces to address these emerging community needs. During 2006, the PPC endorsed and presented to OAPP three separate sets of recommendations. Each set of recommendations were formatted similarly and provide an introduction, a summary of issues identified, the purpose of each Task Force, a review of available data, a list of successful strategies and interventions, recommendations, and feedback received from community members. Below are the results of each task force. New information is also presented below based on the breakout sessions held by PPC members on October 23, 2006.

A. Venue Based Task Force Recommendations

❖ INTRODUCTION

The following summarizes discussions held between February 24, 2005 and May 28, 2005 regarding HIV prevention within “high-risk” venues. A Venue-based Task Force convened by the Prevention Planning Committee (PPC) was charged with:

- Examining available data regarding HIV prevention in these settings (defined below);
- Identifying successful strategies or interventions for HIV prevention in specific venues;
- Gathering feedback from community members; and
- Formulating recommendations to be considered by the PPC.

❖ ISSUE

Venues consisting of physical locations (e.g., public spaces) or businesses (e.g., commercial sex venues) where individuals engage in sexual or drug use behaviors, or where individuals meet partners with whom they later engage in sexual or drug use behaviors putting them at risk for HIV infection or transmission, have been identified in Los Angeles County (PPC Community Needs Assessment, 2004). The PPC was asked to consider whether there were sufficient resources allocated for HIV prevention in these settings.

❖ PURPOSE OF THE VENUE-BASED TASK FORCE

The purpose of the Venue-Based Task Force was to review available data on HIV prevention in these venues, gather information from key informants regarding venues where HIV prevention programs are being delivered and venues where there are documented needs for HIV prevention, identify strategies and interventions that have been used successfully in other health jurisdictions to reduce reported risk behaviors in specific venues, gather feedback from community members, and formulate recommendations to be considered by the PPC. The Venue-based Task Force held

its last meeting on May 28, 2005 and agreed to forward draft recommendations to the Standards and Best Practices Subcommittee of the PPC.

❖ **REVIEW OF AVAILABLE DATA**

• **PPC Community Needs Assessment**

In 2004, the PPC undertook a comprehensive Community Needs Assessment, involving sampling of HIV risk behaviors reported by members of behavioral risk groups (BRGs) at venues identified by the health department including street corners, designated neighborhood blocks, bathhouses and spas, parking lots, cruising areas, parks, and gyms (PPC Community Needs Assessment, 2004).

• **Sexually Transmitted Disease Control Program**

In 2003 and 2004 STD Control Program surveillance data indicate that bars/clubs, the Internet, and bathhouses and spas were the three most frequently cited venues where men recently diagnosed with syphilis met sexual partners (STD Control data January 2005).

• **Venue-Based Task Force Key Informants**

Members of the Venue-based Task Force identified day laborer sites, motels, alleys, parking lots, adult-oriented bookstores, and adult-oriented theatres as potential venues where high-risk sexual activities may be transacted (various meetings of the task force in 2005, see minutes).

• **Successful Strategies and Interventions**

The Center for HIV Identification, Prevention and Treatment Services (CHIPTS) provided the task force with information on two Centers for Disease Control and Prevention-recommended interventions that have been found to be effective in bars and clubs. These were the Popular Opinion Leader and the Community PROMISE interventions at www.effectiveinterventions.org and <http://www.cdc.gov/hiv/projects/rep/promise.htm>.

CHIPTS also identified strategies undertaken by the San Francisco Department of Public Health and the Baltimore Department of Public Health Syphilis Elimination Project to respond to recent outbreaks of syphilis associated with Internet use or solicitation of sex in public spaces (various meetings of the task force in 2005, see minutes).

• **Feedback from Community Members**

Members of the Venue-Based Task Force were concerned about the potential for a gap in service in the provision of HIV testing at specific commercial sex venues (April 28, 2005 Venue-based Task Force meeting). Members emphasized that testing should continue to be made available at these venues.

Members of the Venue-based Task Force observed that high-risk sexual behaviors at some of the identified venues may be intertwined with substance use (April 28, 2005 Venue-based Task Force meeting). Members indicated that outreach and prevention staff working at these venues needed training in recognizing signs of substance use and being able to address other issues of concern (e.g., mental health, sexual addiction).

❖ RECOMMENDATIONS

The members of the Venue-Based Task Force recommend that the Los Angeles County HIV Prevention Planning Committee in conjunction with the Health Department:

1. Release the results of the Community Needs Assessment to identify those venues in which BRGs members report engaging in unprotected anal intercourse, injection drug use and other behaviors that place them at high-risk for contracting or transmitting HIV.
2. Review the distribution of the delivery sites for HIV prevention programs, as reported in prevention contractors' progress reports in summer and fall quarter of 2005.
3. Compare the compiled list of HIV prevention program delivery sites with the list of Community Needs Assessment venues and sites where high-risk behavior occurs.
4. Conduct a gaps analysis to determine if there are sufficient HIV prevention resources being directed to deliver HIV prevention to the venues where prioritized BRG members report engaging in high-risk behaviors for HIV transmission.
5. Explore the capacity of funded prevention providers' venue-based staff to provide referrals to substance abuse prevention or treatment or to appropriately manage interactions with venue patrons who are under the influence of intoxicating substance(s).

If it is determined that a gap exists between the distribution of HIV prevention program delivery sites and the venues where BRG members report engaging in risk, the members of the Venue-Based Task Force further recommend that:

1. The PPC and the Health Department encourage the delivery of BRG-specific prevention programs in the venues identified where HIV risks are most likely to occur;
2. The PPC and the Health Department further support the adaptation and tailoring of interventions for such venues as those jointly identified in the Community Needs Assessment, key informant observations, and the STD surveillance data;
3. The Health Department continues to prioritize the delivery of rapid HIV counseling and testing in those venues where BRG members most frequently report engaging in high-risk behaviors;
4. The PPC and the Health Department consider appropriate strategies to address the need for providers' venue-based program staff to receive training in making substance abuse referrals or handling interpersonal interactions with venue patrons who are under the influence of a substance; and
5. The PPC and the Health Department ensure the provision of training to prevention staff working in these venues that encompasses substance use, sexual addiction, mental health and comfort in discussing highly sensitive sexual topics.

❖ **FURTHER PPC WORKGROUP RECOMMENDATIONS**

On October 23, 2006, a work group was created to review the Venue Based Task Force Recommendations and provide further topics to consider when implementing these recommendations. The PPC workgroup requested that further data be obtained to:

1. Identify those venues in which BRG members report engaging in unprotected anal intercourse, injection drug use and other behaviors that place them at high-risk for contracting or transmitting HIV by Service Planning Area (SPA).
2. Provide summary table by study of BRG/target populations, client demographics, HIV/AIDS incidence and prevalence, venues, and risk behaviors (e.g. condom use, unprotected anal intercourse, injection drug uses) and include GIS maps.
3. Identify gaps between the distribution of HIV prevention program delivery sites and the venues where BRG members report engaging in risk.

B. African American Men who have Sex with Men Task Force Recommendations

❖ **INTRODUCTION**

The following summarizes discussions on December 9, 2005, January 12, 2006, February 9, 2006, March 23, 2006 and April 27, 2006 regarding HIV prevention recommendations for the African American Men who have Sex with Men (MSM) community. The African American MSM Task Force convened by the HIV Prevention Planning Committee (PPC) was charged with:

- Examining available data regarding HIV prevention for the African-American MSM population;
- Identifying successful strategies and/or interventions for HIV prevention for the African-American MSM population;
- Gathering feedback from community members; and
- Formulating recommendations to be considered by the PPC.

❖ **ISSUES**

- Seriousness of HIV infection among African American MSM (*CDC, May 2001; The Body, 2001*).
- CDC findings reported in June, 2005 reported African American MSM had the highest prevalence of HIV (46%) and undiagnosed HIV infection (67%) (*Greenberg, 2005, MMWR, 2005*).
- In the LA Men's Survey conducted by the HIV Epidemiology Program in 2004, African American MSM had the highest prevalence of HIV (36%) and previously undiagnosed HIV infection (75%) compared to other racial/ethnic groups.
- 91% of African American MSM (ages 23-29) who tested HIV+ were unaware of their infection (*MacKellar et al., 2005*).
- Identified risk factors for African Americans include substance use, sexually transmitted diseases, denial, socioeconomic challenges, stigma, late diagnosis and inadequate infrastructure (*CDC, February 2005*).
- To increase the number of prevention programs that specifically target African American MSM in Los Angeles County.

❖ PURPOSE OF THE AFRICAN-AMERICAN MSM TASK FORCE

The purpose of the African American MSM Task Force was to review available data on HIV prevention for this population, gather information from stakeholders regarding organizations/locations where HIV prevention programs are being delivered, document needs for HIV prevention, identify strategies and interventions that have been used successfully in other health jurisdictions, gather feedback from community members, and formulate recommendations to be considered by the PPC.

❖ REVIEW OF AVAILABLE DATA

- Greenberg, 2005, MMWR, 2005
- MacKellar et al., 2005
- CDC, February 2005

• Successful Strategies and Interventions

Currently, the only intervention that is recognized and recommended by the CDC which targets AA MSM is the Many Men, Many Voices (3MV). 3MV is a 7-session group-level intervention program to prevent HIV and sexually transmitted diseases among Black men who have sex with men (MSM) who may or may not identify themselves as gay. The goal of the intervention is to implement 7 sessions “aimed to foster positive self-identity, educate clients about their risk for HIV and sexually transmitted diseases and teach assertiveness skills.” Based on this finding that only one current CDC recommended intervention is available, it is critical to focus local efforts on building, cultivating and developing and adapting effective intervention’s that target AA MSM in Los Angeles County.

• Feedback from Community Members

Community members of the AA MSM Taskforce in conjunction with members of the HIV Planning Prevention Committee of Los Angeles are in unanimous agreement that the fore stated recommendations are of utmost importance in effectively addressing the concerns of AA MSM and HIV/AIDS in Los Angeles County.

❖ RECOMMENDATIONS

The members of the African American MSM Task Force recommend that the Los Angeles County HIV Prevention Planning Committee in conjunction with the Health Department, consider the following:

1. The PPC should establish/adopt a “set aside” category for African American Men Who Have Sex with Men (AA MSM) and ensure that HIV Counseling and Testing (HCT) and Health Education/Risk Reduction (HE/RR) services are provided.
 - (a) Forward this recommendation to the Evaluation Subcommittee of the PPC. It is recommended that the PPC Evaluation Subcommittee develop a rationale for what proportion of the overall allocation will be set aside for AA MSM programs. The allocation should consider an adjustment to recognize the fact that a large percentage of AA MSM do not know their HIV status.

2. Capacity Building should be supported in the following manner:
 - a. Recommend additional training or a process to continually improve and evaluate successes or weaknesses in providing HIV prevention services for organizations intended to impact AA MSM.
 - b. Increase the number and the capacity of African American MSM to provide effective HIV prevention services to other AA MSM in the community.
 - c. Recommend strengthening indigenous African American community based organizations by addressing capacity and infrastructure challenges (i.e., fiscal) within those agencies.
 - d. Identify effective programs and interventions that have strong outcomes provided for or developed by indigenous organizations or other agencies.
 - e. Support efforts that will ensure that additional research and evaluation support be made available to agencies that provide services to AA MSM and to increase their capacity to link and collaborate with research institutions.

3. Fund three (3) Demonstration Projects that target African American MSM in Los Angeles County:
 - a. Fund one (1) Demonstration Project for HIV Counseling and Testing (HCT) for AA MSM that would include but not be limited to storefronts in Service Planning Areas (SPA) 4, 6, and 8.
 - b. Fund one (1) Demonstration Project for Health Education/Risk Reduction (HE/RR) for AA MSM.
 - c. Fund one (1) Social Marketing campaign that addresses stigma and internalized homophobia as it relates to taking care of your health around HIV.

If it is determined that a gap exists between the distribution of HIV prevention program delivery sites and the African American MSM population engaging in risk, the members of the African American MSM Task Force further recommend that:

1. A Mental Health and Substance Use component be developed and included in the allocation of resources.

❖ **FURTHER PPC WORKGROUP RECOMMENDATIONS**

The African American MSM Task Force offered the following recommendations to further assist in developing an HIV prevention response for African American MSM:

- Evaluation Subcommittee will provide recommendations for resource allocation based on available scientific data.
- Develop innovative interventions culturally tailored for African Americans.
- Integrate co-morbidities in program curriculum and interventions.
- Evaluate interventions (homegrown and DEBI) for African American MSM.
- Support efforts that will ensure that additional research and evaluation will be made available to agencies that provide services to African American MSM and to increase their capacity to link and collaborate with research institutions.

C. Crystal Methamphetamine Task Force

The use of Crystal Methamphetamine (crystal meth) has reached epidemic proportions locally, particularly among groups at highest risk for HIV infection including men who have sex with men. In 2005, OAPP, the Public Health Department, the HIV Prevention Planning Committee, and community groups conducted a number of assessments, community forums, and task forces to address this issue.

Crystal Meth use has become an increasingly visible trend among men who have sex with men (MSM) in Los Angeles County, facilitating individuals to engage in high risk sexual and/or drug use behaviors, leading to increased risk for HIV infection or transmission. The PPC was asked to consider whether there were sufficient resources allocated for HIV prevention to address meth use.

In November 2005, the PPC formed the Crystal Meth Task Force. The Crystal Meth Task Force was charged with examining available data regarding HIV prevention strategies for MSM using crystal meth, identifying successful strategies and/or interventions for HIV prevention for crystal meth users, gathering feedback from community members regarding the prevalence of meth use and programs that address meth use, and formulating recommendations to be considered by the PPC. At the PPC's Annual 2-day Meeting (January 19-20, 2006), crystal meth was listed as one of the major prevention issues in Los Angeles County.

❖ INTRODUCTION

The following summarizes discussions held between November 8, 2005 and March 16, 2006 regarding strategies to integrate crystal meth prevention strategies into HIV prevention programs. The Los Angeles County HIV Prevention Planning Committee (PPC) charged the Crystal Meth Task Force with the following activities:

- Review existing data on prevalence rates of crystal meth use among all populations in LA County
- Identify effective strategies and interventions for HIV prevention efforts among crystal meth users
- Gather feedback from community members regarding crystal meth issues
- Formulate recommendations to be considered by the PPC

❖ ISSUE

Many studies have documented the link between crystal methamphetamine and increasing HIV infection rates among men who have sex with men (MSM). The PPC was asked to evaluate the public health problem and assess resources allocated for HIV prevention for this population in Los Angeles County.

❖ PURPOSE OF THE CRYSTAL METH TASK FORCE

The Crystal Meth Task Force was formed in response to a deeply troubling correlation between crystal meth use and HIV infection among MSM. The purpose of the Crystal Meth Task Force was to review available local and national data on HIV prevention efforts with this population; identify effective strategies and interventions to reduce reported risk behaviors for HIV transmission; gather feedback from community members regarding necessary action steps to address the impact of crystal meth; and formulate recommendations to be considered by the PPC. The Crystal Meth Task Force does not want to duplicate work from existing workgroups

addressing the methamphetamine issue in Los Angeles County and therefore convened its final meeting on March 16, 2006 and agreed to forward draft recommendations to the Standards and Best Practices Subcommittee and the Evaluation Subcommittee of the PPC for consideration.

❖ **REVIEW OF AVAILABLE DATA**

- *Los Angeles Men's Survey 2004 (HIV Epidemiology)*

The National HIV Behavioral Surveillance System is an ongoing national system to estimate risk behaviors, HIV testing behaviors and exposure to HIV prevention. It is conducted among 25 sites throughout the U.S. and within three primary populations (MSM, IDU, HRH). The annual surveys are repeated in three year cycles and data gathered were from 12/20/03-12/30/04 and examined crystal methamphetamine use, other drug use, HIV prevalence and risk behaviors among MSM.

- *Crystal Methamphetamine Use Among MSM in Los Angeles County: A Situational Assessment*

OAPP conducted a situational assessment in mid-2005 by interviewing 26 key informants to identify gaps in HIV prevention and substance abuse efforts in LA County and gather information for the local community to make informed decisions about the kinds of interventions needed. The report generated recommendations based on the information gathered from experts in the field and was used by the task force to prioritize their own recommendations.

- *HIV Counseling and Testing Data, 2001-2003 (Preliminary Results)*

Data from counseling and testing sites on prevalence of crystal methamphetamine use in the behavioral risk groups and the link with HIV illustrating that while meth use is a substance use issue among all populations, HIV prevention efforts need to target all MSM (including MSM/IDU, MSM/W and MSM).

- *Methamphetamine Use Among Men Who Have Sex with Men: A Review of Effective Interventions*

A review of effective interventions from the literature reporting that although there are successful treatment strategies for MSM meth users (Cognitive Behavioral Therapy and Contingency Management), there is little documented evidence surrounding effective prevention efforts for this population.

- *Methamphetamine Use in Los Angeles County: Report from the Los Angeles County Alcohol & Drug Program Administration Program*

Report on treatment admissions for meth and other drugs highlighting that meth has become the primary drug of abuse for person admitted to treatment in Los Angeles County funded substance abuse programs.

- *The Social Construction of a Gay Drug: Methamphetamine Use Among Gay and Bisexual Males in Los Angeles, Reback CJ (1997)*

Qualitative research study that examines sexual and drug related behaviors among gay and bisexual men who use methamphetamine. Through interviews and focus groups, the report explores the internal dynamics associated with crystal use including the meaning of different identities (gay, crystal, HIV) that users associated with, and the association and meaning of

crystal use and the sex experience. The external dynamics associated with crystal use are discussed along with the HIV risks that accompany crystal use. Recommendations and conclusions based on the information gathered are provided.

❖ **SUCCESSFUL STRATEGIES AND INTERVENTIONS**

- *Cognitive Behavioral Therapy*

One of the more popular interventions for use with drug-using populations is CBT, which views human behavior as primarily learned. Components of CBT are used in virtually every drug treatment program in the United States, and CBT is one of the most effective treatment interventions for meth addiction. Additionally, CBT has been demonstrated to be effective as an HIV prevention intervention in reducing risk behavior.

- *Contingency Management*

Contingency Management (CM) involves the use of contingencies to reward an individual for evidence of abstinence of an unwanted behavior. This intervention has been extremely effective in substance use treatment. Further, CM has been shown to be effective with relatively small rewards.

- *Cognitive Behavioral Therapy & Contingency Management*

Researchers in Los Angeles have assessed behavioral interventions focused on drug abuse treatment using CBT, as well as CM, as an effective approach to reduce methamphetamine use among gay men as well as other risk behaviors associated with HIV. Participants in the culturally-tailored CBT condition achieved the most reductions in UAI in the first few weeks of the intervention, but by follow-up there was no difference between sexual behavior outcomes between the treatments and all participants had reduced the number of sexual partners in half.

- *Motivational Interviewing*

Motivational interviewing involves the use of cognitive behavioral methods and allows for the heightening of cognitive dissonance. This intervention requires individuals to set goals for behavior change and highlights the discrepancies between goals and current behaviors. Motivational interviewing has been demonstrated to be effective in reducing HIV risk behaviors and substance use and can be used in more complicated settings such as public sex environments (PSEs) and CSVs, and has also shown success with MSM in drug treatment settings. Recently, motivational interviewing has been combined with CBT to provide a more flexible approach to changing behavior in drug treatment settings. Research has shown that interventions that use this combined approach are successful in reducing drug use.

- *Popular Opinion/Peer Leader Models*

Models based on the Diffusion of Innovations theory represent some of the most successful interventions in reducing HIV risk behavior including reducing UAI and reducing number of sexual partners. These interventions focus on training peers or role models to deliver prevention messages and encourage behavior change by empowering individuals to be actively involved in the process. Although there is not a study in the literature which assesses the effectiveness of popular opinion/peer leader models with meth-using MSM, they have been included in this review because many researchers believe that their success with other MSM groups have strong implications.

- *Harm Reduction*

Harm reduction is a set of practical strategies that reduce negative consequences of drug use and improve the quality of the person's life. The harm reduction approach incorporates a spectrum of strategies including safer use, managed use, and abstinence that can be used in concert with HIV Prevention methodologies.

- *Substance Use Treatment*

Substance use treatment including out-patient, day treatment, and residential treatment are avenues for addressing HIV Prevention for clients with multiple physical, social, and mental health needs in addition to their addiction. In this setting, clients would be able to receive HIV testing, counseling, and risk reduction techniques.

❖ **FEEDBACK FROM COMMUNITY MEMBERS**

Community members representing a grass roots advocacy group, Act Now against Meth, request that the LA County PPC assist and support with the following recommendations:

1. Create and expand state and federal training programs to educate health care professionals to identify, educate and treat methamphetamine addiction;
2. Coordinate and integrate methamphetamine prevention, educational and treatment strategies among local, state and federal health programs including HIV/AIDS, sexually transmitted disease, substance abuse, and mental health programs;
3. Determine effective and innovative research-based interventions such as the development of a targeted social marketing campaign to reach at-risk populations;
4. Promote the implementation of prevention messages around methamphetamine use at large -scale social events, such as circuit parties and community events; and
5. Declare a public health state of emergency in the County of Los Angeles regarding the methamphetamine crisis.

❖ **RECOMMENDATIONS**

The members of the Crystal Meth Task Force recommend that the Los Angeles County HIV Prevention Planning Committee, in conjunction with the Department of Health Services, consider:

1. Recommending and supporting trainings for PPC members and OAPP/CDC - directly funded agencies on crystal meth and the impact on HIV transmission among MSM. The training should include, but not be limited to: primary prevention strategies, outreach techniques to actively-using crystal meth populations (including a discussions regarding healthy sexual behaviors), long and short term effects of crystal meth use, harm reduction techniques, and healthy sexual relationships after meth usage;
2. Requesting additional funding to support the implementation of strategies targeting both HIV positive and HIV negative individuals using crystal meth;
3. Increasing collaboration with the Commission on HIV (COH) to initiate a dialogue on how Care and Prevention can identify appropriate services and availability of treatments

for crystal meth and other methamphetamine users. Provide report back at monthly PPC meetings about ongoing dialogue between PPC and COH;

4. Gathering and analyzing crystal meth related data that focuses on behavioral risk groups and multi-ethnic groups from other California health jurisdictions, such as San Diego, Orange, Riverside, San Bernardino Counties, San Francisco, and Sacramento in order to identify successful and innovative efforts in similar jurisdictions;
5. Incorporating crystal meth/substance use messages into LA County HIV Prevention funded programs;
6. Supporting opportunities for open, honest, realistic dialogue surrounding sex & drug behavior among all populations and the risks for HIV and STD infection;
7. Supporting and encouraging dialogue between the public and law enforcement authorities regarding crystal meth use and foster an understanding of the impact of the epidemic on law enforcement and those affected by crystal meth by exchanging information and educating the public on awareness surrounding legal consequences (such as possession, sale, usage) of crystal meth;
8. Recommending that the PPC consider and respond to feedback from community members regarding the crystal meth problem in Los Angeles County (please see feedback below); and
9. Collaborating with other local taskforces and workgroups convened to address the meth problem in Los Angeles County.

❖ **FURTHER PPC WORKGROUP RECOMMENDATIONS**

The PPC work group offered the following information to assist with considering an HIV prevention response with Crystal Methamphetamine Users:

- Trainings for staff working in HIV prevention should be completed within six months of being hired.
- Currently available crystal meth treatment and prevention services for meth users should be assessed.
- HIV prevention curricula should include messages surrounding crystal methamphetamine use and its connection to HIV and STD infections.
- Other public and private programs should be included in the dialogue.
- The PPC should collaborate with other local taskforces and workgroups convened to address the meth problem in Los Angeles County.