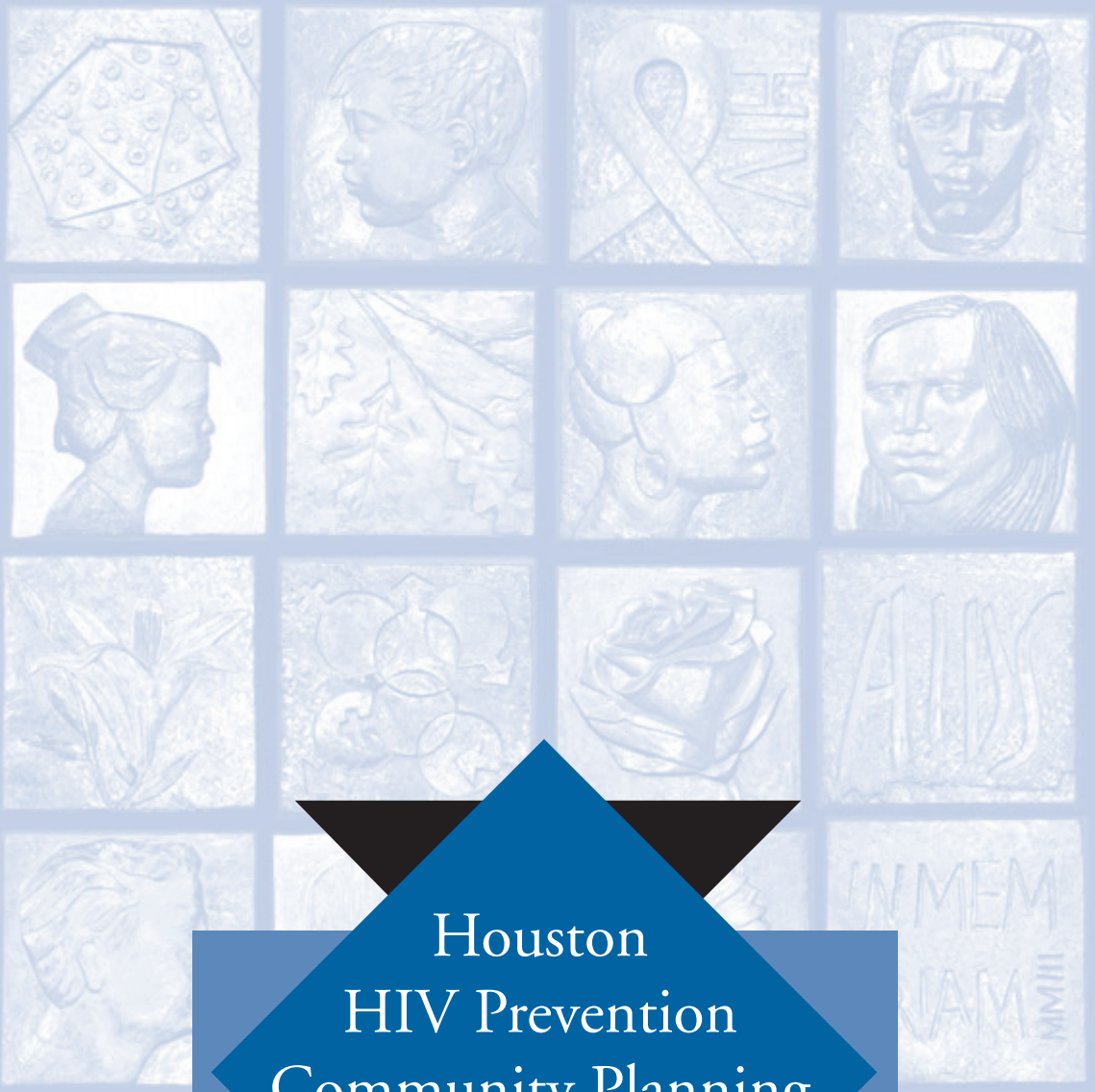
Houston HIV Prevention Community Planning Group 2004-2006 Comprehensive Plan



Houston HIV Prevention Community Planning Group

Dedication

2004-2006 Prevention Comprehensive Plan

In recognition for over 20 years of commitment to excellence in public health at the Houston Department of Health and Human Services, and her instrumental role in the establishment, maintenance and growth of the Houston HIV Prevention Community Planning Group (HHPCPG), we dedicate the goals, objectives and spirit of the 2004-2006 HIV Prevention Comprehensive Plan to:

Glenda Gardner
Bureau Chief
Bureau of HIV/STD Prevention
October 6, 1990 – March 28, 2003

Acknowledgements

This plan is a collaborative effort of many individuals. We would like to gratefully acknowledge all current and past HHPCPG members and HDHHS staff that worked long, hard hours to create the ideas and actions that are presented in this plan. Their commitment, passion, expertise, and participation in the HIV prevention planning process will serve as the catalyst for HIV prevention for the next few years. We would also like to thank Vyann Howell, CDC Project Officer for Houston support. The following list of individuals reflects those who, in one way or another, have contributed to the work of HHPCPG.

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Introduction

Ricardo Mendiola
HIV Prevention Program Manager
Bureau of HIV/STD Prevention

The process of constructing a Comprehensive Plan for HIV/AIDS Prevention encourages consideration of the bigger picture in Houston. Since the inception of HIV Prevention Community Planning in 1993, the Houston HIV Prevention Community Planning Group (HHPCPG) and the Houston Department of Health and Human Services (HDHHS) have been working together to develop an effective and comprehensive approach to HIV prevention in Houston.

The plan builds up the hard work, dedication and efforts of former and current planning group members and staff from the Bureau of HIV/STD Prevention. It is the product of year-round collaborations and partnerships between the local health department and the local community-planning group.

The plan identifies priority populations and a set of interventions to effectively provide HIV/AIDS Prevention. HDHHS will use the 2004-2006 Comprehensive Plan as the foundation for resource and program allocation decisions in regards to HIV prevention in Houston.

Prevention of HIV/AIDS and STDs is our goal, and the plan addresses prevention by focusing on increased counseling and testing, using evidence-based interventions and prevention with positives.

Please use this document in planning to reduce the transmission of HIV/AIDS and STDs in your community. Feel free to contact us with any questions or clarifications you may have regarding the Houston HIV Prevention Comprehensive Plan at 713.794.9092.

The Houston HIV Comprehensive Plan

The 2004-2006 HIV Prevention Comprehensive Plan marks several milestones and benchmarks for the Houston HIV Prevention Community Planning Group (HHPCPG). One milestone is that soon after its implementation, the HHPCPG, the Houston Department of Health and Human Services (HDHHS), community stakeholders, at risk individuals and ordinary citizens will mark the 10th year of community planning in Houston.

Another important milestone is that December 2004 will mark the 5th year of specialized efforts targeting the African-American community following the declaration of a State of Emergency in 1999. Additionally, this edition is the fifth HIV prevention comprehensive plan developed and released to address the needs of Houstonians.

Just like other HIV Prevention Comprehensive Plans, individuals from at risk and marginalized communities, community based organizations (CBOs), school systems, governmental agencies, research, faith communities, business and persons with HIV/AIDS came together with a common purpose: to eliminate HIV from Houston.

The blending of our similarities and differences, likes and dislikes, strengths and weaknesses, loves and hates and skills and deficiencies is the perfect mixture that during the planning phase facilitated honest and open dialog where our realized our common purpose and developed the 2004-2006 HIV Prevention Comprehensive Plan.

Our goal remains simple, to prevent HIV. Contained within this plan is the rationale used to identify high risk groups, identification of their immediate, short and long term HIV prevention needs, a discussion of strategies to meet those needs, and a plan to implement the strategies we feel are most important.

We strongly believe that if this plan is implemented, we will continue to reach those who are at risk, link HIV infected persons into the Houston continuum of care and continue making strides to eliminating HIV from our city.

Membership on the Houston HIV Prevention Community Planning Group

BACKGROUND / OBJECTIVES

The key objectives for the membership committee has always been retention of members coupled with maintaining PARITY in membership. While there has never been a lack of applicants, there is a constant effort to assure the membership is representative of the HIV community.

KEY FINDINGS

The lack of participation from adolescents as well as Caucasian MSM is a concern, and an effort is under way to increase participation from these two populations. Recruitment efforts need to continually concentrate in these populations. Some discrepancies exist between the policy and procedures and the by-laws, these need to be addressed.

KEY QUESTIONS

A concern with adolescents is transportation and time away from school. Should transportation be paid for, and how? Is there anyway to get the school system to allow credit for attendance at the HHPCPG? Should the meeting times be changed from 3pm in the afternoon to later in the day or on a week end to allow adolescents (along with others) to be able to attend?

NEXT STEPS / RECOMMENDATIONS

It is important, to assure continuity, the by-laws and the policy and procedure manual match each other; efforts are under way to make these two important documents congruent. Further recommendations are to continue to offer a 5-minute training at each HHPCPG meeting facilitating the learning curve for new members and as a refresher for all members.

Membership Requirements

Anyone from the community interested in HIV prevention can apply for membership on the Houston HIV Prevention Community Planning Group (HHPCPG). All applicants are made aware of the amount of time and work involved in the planning process and with that knowledge comes a great deal of responsibility. Since the Houston HHPCPG is responsible for making major decisions concerning local HIV prevention efforts, the membership of the HHPCPG takes its roles very seriously. The work that the HHPCPG must do is often a difficult and time-consuming job.

How to Become a Member

A person who is interested in applying for membership on the Houston HHPCPG is invited to call the Houston Department of Health and Human Services (HDHHS), Bureau of HIV/STD Prevention for information and an application form. In an effort to solicit as many qualified applicants as possible the HHPCPG and HDHHS send out nomination packets to community-based organizations, professionals, churches, and individuals who have expressed an interest in the past as positions come open. The HHPCPG's Membership Committee reviews all applications, and potential members are invited to interviews.

An interview process, conducted by the Co-Chairs of the Membership Committee, the Co-Chairs of the Community Relations Committee, and overseen by the HHPCPG Evaluator, has been developed to include a set of standard questions covering significant areas of concern related to community planning and HIV prevention. After completing the interview process, the committee reviews and discusses the applicants' responses. The membership application documents in use by the committee are in the Appendix.

After all applications are scored, the Membership Committee makes recommendations for applicants for membership, (a minimum score of 80 is required for recommendation). The committee forwards the recommendations to the HDHHS Director, and the Director then sends letters to the nominees to invite them to join the HHPCPG. Letters of appreciation are sent to those who were not selected for membership, and they are encouraged to join one or more of the HHPCPG committees as non-voting external committee members. This step is a critical process in the membership selection and assures committees of additional representation while allowing a continuing pool of potential members who are already familiar and active in community planning.

The new members of the HHPCPG are required to attend an orientation meeting and a training process; orientation and training are held at least twice a year as needed. The orientation and training assure that new HHPCPG members are familiarized with the planning process and socialize the new members into the HHPCPG.

The guiding principles for choosing new members to serve on the HHPCPG are parity, inclusion, and representation, or "PIR." Parity means that all members of the HHPCPG have equal opportunity to provide input. Inclusion is the principle that assures all communities affected by the HIV epidemic are represented and involved in the community planning process.

Representation assures that those who have been selected to represent a specific community truly reflect the values, norms, and behaviors of that community. Major efforts have been initiated to assure that the membership of the HHPCPG reflects the epidemic within the Houston EMA.

During the application and appointment process, new members are asked to make a commitment to the process and its results, to actively participate in decisions and problem-solving, to undertake special tasks as requested by the HHPCPG, and to market the HIV prevention planning process.

Length of Commitment

During 2002, the Houston HHPCPG looked extensively at representation as reflected by the epidemic and made significant strides to assure proper representation while also realizing the need to keep qualified members who may not directly reflect the epidemic. However, they do offer expertise in areas of HIV/STD prevention. Members currently serve three-year terms. Upon the expiration of the term, a member is eligible to extend his/her membership on the HHPCPG for another three-year term. Members are limited to two three-year terms.

Time Required

Regular Houston HHPCPG meetings are held monthly and usually last approximately two hours. Additional meetings are sometimes called when the workload exceeds the regular meeting time. These rare extra meetings are generally held in the afternoon. Members are asked not to accrue more than eight absences during their tenures with the HHPCPG. If they do so, they forfeit their membership. In addition, members are required to serve on at least one committee; these committees meet monthly for approximately 1 1/2 hours.

Membership Profiles

The Houston HHPCPG bylaws are in the Appendix. The following list briefly describes the general categories of membership on the Houston HHPCPG as noted in Article III of the bylaws.

1. **Substance Abuse prevention and/or treatment.** The representative must have expertise in substance abuse issues especially crack cocaine. The representative must also be able to identify and articulate problem areas and issues that are related to the substance abusing community especially as they relate to behaviors that put substance abusers at risk for HIV infection. Individuals with personal experience in this category will be given additional consideration.

2. **Gay / lesbian / bisexual / transgender people.** The representative must have direct ties to the gay, lesbian, bisexual and/or transgender communities. Traditionally, the individuals selected to represent these categories have been members of these groups and have personal and professional knowledge that will enable him/her to identify and articulate problem areas and issues related to sexual health.

3. **Communities of Color.** This individual must be a person of color and should also have some community involvement or professional experience with the population as a whole. This experience should include knowledge of community attitudes and behaviors toward HIV/AIDS and sexual health issues.

4. **Youth.** The individual must be a member of the category and/or should have expertise with youth at risk for HIV infection. Additionally, this individual should know about the kinds of behaviors in which youth engage that put them at an increased risk for HIV. A good working knowledge of HIV/AIDS is also very helpful.

5. **HIV prevention workers.** The individual must have expertise in HIV prevention including community outreach, case management, and/or work with HIV-infected individuals.

6. **Spiritual issues and/or Faith-Based Communities.** The individual must have experience in relation to spiritual issues. Experience does not necessarily have to be connected or limited to any formal, organized religious organization; however, the individual must be able to communicate with local clergy from all walks of life in order to create a stronger links between local churches, synagogues, temples and mosques with HIV prevention programs. Again, additional consideration will be given to those individuals who have had personal experience with this community.

7. **People with Disabilities.** This individual must have community involvement or professional experience with persons with disabilities, especially relating to the deaf and hearing impaired community. Experience should include knowledge that will enable the individual to assess the behaviors of those who put themselves at risk for HIV infection. Additional consideration is given to individuals who are members of this community.

8. **Male and female HIV-infected persons.** This individual must have expertise and experience in relation to HIV/AIDS infected persons and should be able to identify and present problem areas in relation to this population. Experience should include basic knowledge of HIV/AIDS, HIV prevention, counseling and testing and outreach. Additionally, this individual must be a member of the HIV infected population.

9. **Persons with expertise in Mental Health.** This individual must have community/professional expertise in the mental health field. It is also important that the individual who accepts this position has knowledge of HIV/AIDS-related health issues, especially when associated with persons who have mental health problems.

10. **Persons with expertise in HIV primary care.** This individual must have community / professional expertise in the HIV primary care field. It is also important that the individual who accepts this position has knowledge of HIV/AIDS prevention issues, especially when associated with HIV primary care services.

11. **Persons with expertise in Social Services.** This individual must have community and/or professional expertise in the social services. It is also important that the individual who accepts this position has knowledge of HIV/AIDS-related health issues, especially when associated with the delivery of social services.

12. **Incarcerated and/or Recently Released persons.** This individual must have professional expertise in relation to the criminal justice system and be able to identify and articulate problem areas within the population residing in and associated with the criminal justice system. Experience and knowledge of the types of risky behaviors engaged in by this population when it comes to sexual health issues is essential. The HHPCPG has indicated a preference for an individual who is a formerly incarcerated person, and additional consideration will be given to individuals with personal experience in this category.

13. **Persons with expertise in Homelessness.** This individual must have community/professional expertise with the homeless. It is also important that the individual who accepts this position has knowledge of HIV/AIDS-related health issues, especially when associated with persons who are homeless.

14. **Persons with expertise in Tuberculosis treatment and prevention.** This individual must have community/professional expertise with tuberculosis as a public health issue. It is also important that the individual who accepts this position has knowledge of HIV/AIDS-related health issues, especially when associated with persons who have tuberculosis.

15. **Persons with expertise in Sexually Transmitted Diseases.** This individual must have community/professional expertise in the field of sexually transmitted diseases. It is also important that the individual who accepts this position has knowledge of HIV/AIDS-related health issues, especially when associated with persons who have or are at risk for sexually transmitted diseases.

16. **Sex Workers.** This individual must have expertise in relation to sex worker issues, including knowledge of the kinds of behaviors engaged in by sex workers that put this population at risk for HIV infection. Any experience in HIV prevention, street outreach and HIV/AIDS education is a plus. Additional consideration will be given to individuals with personal experience in this category.

17. **Persons with expertise in the Juvenile Justice System.** This individual must have expertise in the juvenile justice system as well as a good deal of knowledge concerning the attitudes about sex and the risky sexual behaviors of adolescent and juvenile offenders.

18. **Persons with expertise in Epidemiology.** This person must have expertise in dealing with and understanding the complexities of gathering epidemiology data, interpreting such data and being able to comprehensively relay that data to people without this knowledge.

19. **Persons with expertise in Behavioral Science.** Understanding that all prevention efforts are based on behavior change, the need for representation from the behavioral science field is a critical piece in the community planning process. The HHPCPG has been fortunate to have the services of a UTSPH Behavioral Scientist to assist in this area.

Orientation for New Members

All new members must attend a full orientation to the HIV prevention community planning process. Information covered during this orientation includes an introduction and explanation of the following:

- The Centers for Disease Control and Prevention (CDC) materials and requirements according to the Community Planning Document
- Planning process history, purposes, and deadlines
- The roles and responsibilities of HHPCPG members
- The roles and responsibilities of HDHHS
- The principles of parity, inclusion, and representation
- The principles of confidentiality
- Various instances of conflict of interest and the proper procedures for dealing with conflicts of interest
- The HHPCPG bylaws and Policies and Procedures
- Technical assistance
- The letter of concurrence / non-concurrence
- Strategies for applying for the HIV prevention grant
- Needs assessment, priority setting, and the HIV prevention comprehensive plan.

Current Members

As of December 31, 2002, there were 26 members serving on the Houston HHPCPG. These members represent the various communities that are infected and affected by HIV and AIDS, and they bring to the HHPCPG the extensive expertise they have in various HIV/AIDS-related fields. The Table below presents information on the current HHPCPG membership.

The Co-Chairs of the Community Planning Group

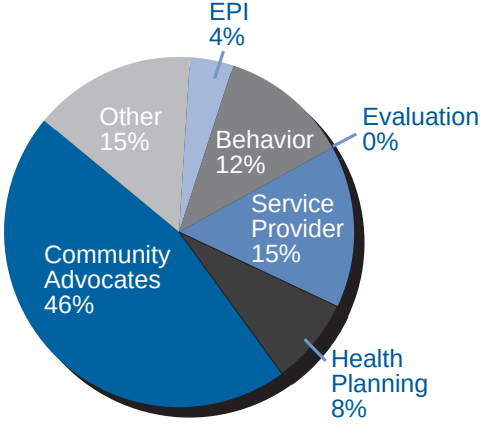
The current institutional co-chair of the Houston HHPCPG is Rick Gamble. Mr. Gamble works for the City of Houston health department as a Senior Community Liaison and has been active with the HHPCPG since August 1999. The community co-chair of the Houston HHPCPG is Steven Walker. Mr. Walker works for SLW Consulting and was previously associated with HIV prevention with a local AIDS service provider and prior to that was the manager of the HIV Prevention program for HDHHS, Bureau of HIV/STD Prevention. As an African American male he brings additional representation and issues to the planning process.

The Future of Membership on the Community Planning Group

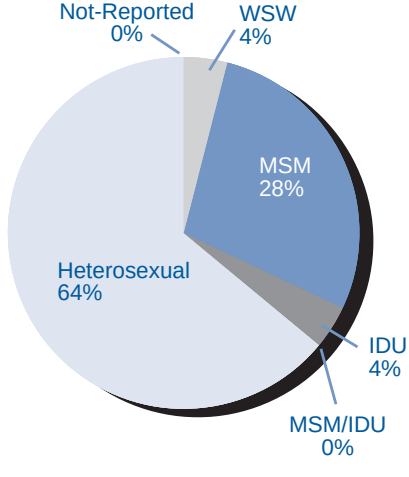
The Houston HHPCPG is authorized to have a total of 35 members. Currently, as noted above, there are 26 members. The HHPCPG actively and continually solicits applications for membership in order to fill all vacancies in a timely manner. The membership selection process has as its goal the recruitment of persons who can play an active role in the planning process. It also strives to meet the federal guidelines for membership by recruiting representation from the communities that are most severely infected and affected by HIV. The representation of the infected and affected communities will help the HHPCPG to be more aware of and receptive to the HIV prevention needs of all the communities in the Houston area.

During the past year, membership recruitment became a high priority for the Houston HHPCPG. Current HHPCPG members and HDHHS staff spent a considerable amount of time in the at-risk communities in an effort to increase community awareness of the HIV prevention planning process. Community participation at HHPCPG meetings is always encouraged. Additionally, city staff and members of the HHPCPG will continue to hold educational seminars that inform the various infected and affected communities, as well as various community-based organizations, about the HIV prevention planning process. Additionally, HHPCPG members and city staff will continue to participate and coordinate HIV prevention and services activities with other planning bodies, including the Ryan White Title I Planning Council, the State of Texas Assembly Group East, and the East Texas HIV Prevention Community Planning Group. The HHPCPG members are also coordinating their efforts with those of HDHHS staff in the STD Prevention program program. There is an increasing awareness of the connection between high rates of STDs and high rates of HIV infection. Through these efforts, the HHPCPG fosters an even greater participation by the infected and affected communities as well as develop effective, culturally sensitive, and linguistically appropriate HIV prevention interventions and strategies.

Membership Expertise



Membership Mode of Exposure



Behavioral Rapid Needs Assessment (BRNA) for Targeted Priority Subpopulations in Houston, Texas

OBJECTIVES / SUMMARY

Eleven priority populations in Houston were surveyed between October and December 2002 about current sex and drug-use practices, other risk behaviors and current met and unmet needs with respect to HIV prevention. The findings vary for each targeted population, but provide assistance to the HHPCPG in setting funding priorities for HIV prevention in 2004-2006.

KEY FINDINGS

We have observed a substantial incidence of unsafe sexual and drug-use practices among populations at high-risk for HIV. These observations help to explain an increase in STD in some of the target populations and can assist the local health department in setting priorities for HIV-prevention funding in 2004-2006.

KEY QUESTIONS

How can HDHHS and the HHPCPG design Community-Level Interventions to rapidly reduce the prevalence of unsafe sexual and drug-use behaviors, particularly in populations at high risk for HIV transmission?

RECOMMENDATIONS / NEXT STEPS

Develop metricies for ongoing tracking of unsafe behaviors and their consequences in terms of new STD and HIV outbreaks. Develop more street and community-level interventions targeting substantial numbers of individuals in high-risk categories. Continue collecting needs assessment information from other at-risk populations not included in the current study.

Contractors

Dr. Jan Risser, UT School of Public Health
The Lesbian Health Initiative/ UH Graduate School of Social Work
Dr. Maria Eugenia Fernandez-Esquer, UT School of Public Health
Dr. Michael Ross, UT School of Public Health/Saving Lives Through Alternative Options
SUMA Partners

Methodology

Eleven Target Priorities were set by HHPCPG

- African-American Women
- African-American MSM
- African Immigrants (Men and Women)
- Asian/Pacific-Islanders
- HIV-Positive Individuals
- Latina Women (US Born)
- Latino Immigrants (Men)
- Latina Immigrants (Women)
- Latino MSM
- Transgender Individuals
- Women Who Have Sex with Women (WSW)

  – Surveys were conducted between October 2002 and December 2002
  – Survey contractors were selected and managed by HDHHS
  – 25-Question baseline survey was designed by HDHHS, contractors, HHPCPG-representatives
  – Target length of survey – 15 to 20 minutes
  – Target number per population – 50

Strengths and Limitations of the Current Study

Strengths

- Rapid assessment of behavioral risks and indicators of potential risk
- Brief survey facilitates high degree of participation by targeted populations
- Study was directed at current knowledge gaps and specific subpopulations.

Limitations

- Non-representative sampling of target populations based on convenient access through gatekeepers
- Brevity of survey limits depth and level of detail for information collected
- All information is self-reported and the accuracy cannot be confirmed independently.

Summary of HIV-Risk Behavior Data for Eleven Targeted Subpopulations in Houston

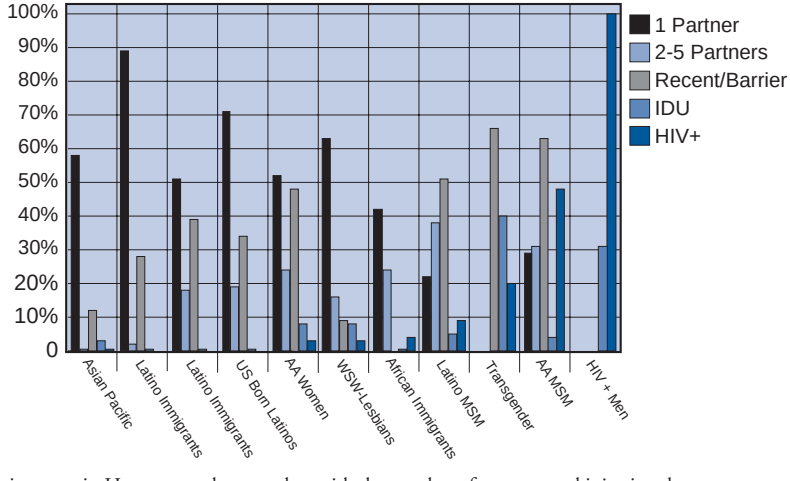
	0 Part. %	1 Part. %	2-5 Part. %	DrgSex P %	Drg SexN %	Recent Barrier %	Alch Use %	Drug Use %	IDU %	HIV Test %	HIV+ %	STD+ %	Mean Age
Asian Pacific Islander	41	59	0	0	3	13	12	5	3	3	0	2	4
Latina Immigrants (Women)	6	90	2	7	0	29			0	79		0	29
Latino Immigrants (Men)	9	51	18	19	33	40			0	47		4.50	31
US Born Latinas	8	72	20	14	75	35			0	73		6.80	29
AA Woman	21	54	25	27	27	48	51		7	80	2.6	12	
WSW-Lesbian	18	65	17	30	37	10	82	30	8	73	3.0	3	3
African Immigrant	30	43	25	15	30		35	4	0	63	3.9	9	33
Latino MSM	14	24	38	29	30	53	69	33	5	59	10	12	2
Transgender MTF				80		67	97	73	40	93	20.9	42	
AA MSM	23	30	32	30	42	65	48	29	8	88	48	6	3
HIV+ Men				70			94	90	33		100	56	

Summary Of Houston Findings

1 API, Latina Immigrants and WSW tend to have fewer sexual partners.
2. AA-MSM, Latino MSM, AA-Women and African Immigrants tend to have more sexual partners.
3. Transgender and HIV+ could not be normalized in this study, but are likely to exhibit high numbers of sexual partners.
4. WSW and API exhibit the lowest rate of self-reported barrier usage – both groups tend to have one partner.
5. Transgender and HIV+ men exhibit the highest rates of alcohol/drug use, IDU and Sexually Transmitted Infections (STD).
6. AA-MSM have among the highest HIV+ rates, but low-to-moderate STD rates; this may reflect decreasing rates of unprotected sex and may predict decreasing HIV infection rates. Follow up is crucial.
7. Latino MSM have moderate-to-high STD rates and moderate-to-high HIV infection rates; this may indicate higher rates of unprotected sex, lower rates of HIV testing and may predict increasing HIV infection rates. Follow up is crucial.
8. The data in this study represents baseline values only. Any conclusions drawn are necessarily tentative and the baseline data should be tracked on an annual basis.

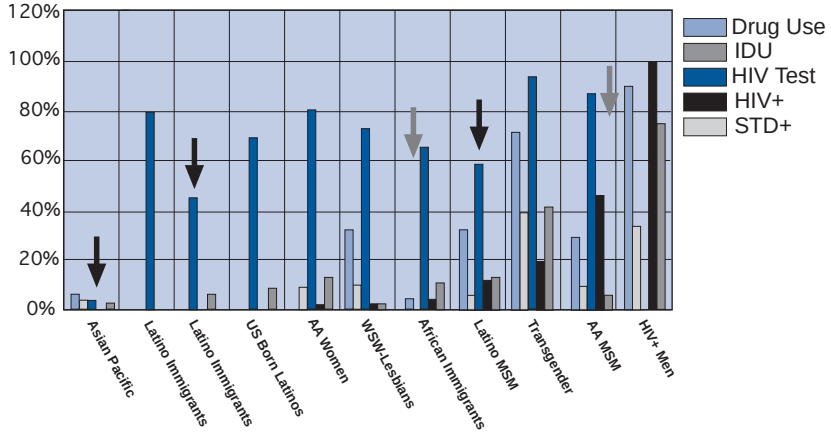
Data and Findings

Sex-Related HIV Behavioral Risk in Targeted Subpopulations



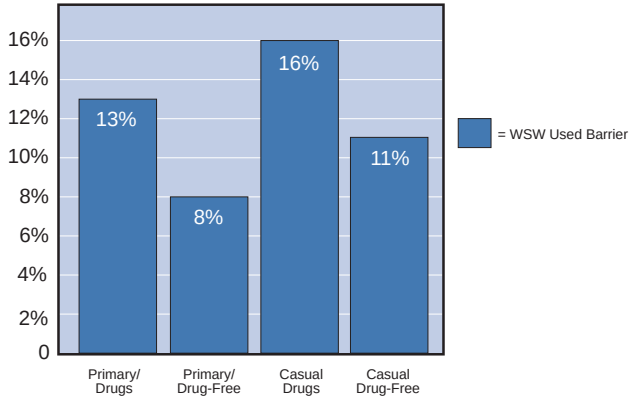
- HIV infection rates in Houston tend to correlate with the number of partners and injection drug use.
- WSW exhibited low barrier protection rates in relation to the prevalence of HIV infection in the community.

Drug-Related HIV Behavioral Risks in Targeted Subpopulations



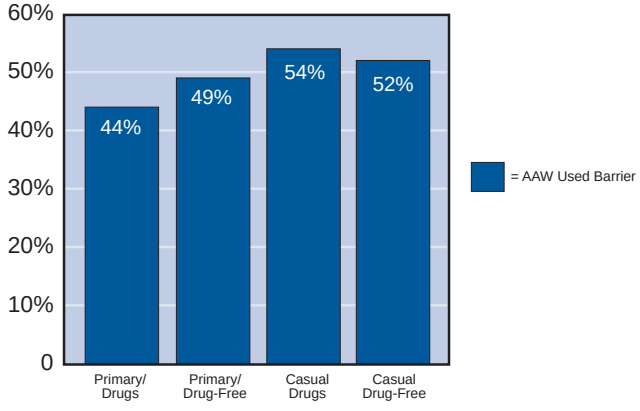
- HIV infection rates in Houston tend to correlate with overall drug usage (+/- IDU) and the prevalence of STD.
- HIV awareness based on testing rates is moderate-to-high (45-90%) with the exception of API, in which awareness is low (< 5%).

Effect of Drug Use on Barrier Protection Use in Houston WSW



- The observed relationship between drug use and HIV infection rates is not necessarily due to impairment of barrier use and partner negotiation skills, at least for WSW.
- These findings should be tracked in the future for all targeted subpopulations.

Effect of Drug Use on Barrier Protection Use in Houston African-American Women (AAW)



- The observed relationship between drug use and HIV infection rates is not necessarily due to impairment of barrier use and partner negotiation skills for AAW.
- These findings should be tracked in the future for all targeted subpopulations.

Conclusions and Recommendations

I. African-American Women 152 Total

- Unprotected sex in high risk situations is a significant risk factor in AA Women
  - 57% of respondents practicing vaginal sex did not use consistent protection
  - 80% of respondents practicing anal sex did not use consistent protection
  - Moderately high STD rates (12%) may predict increasing risk of HIV infection as a group
  - Age adjusted risk was greatest for those in lowest socioeconomic strata
- Prevention efforts should emphasize importance of barrier protection in high-risk activities and should be directed primarily at those women who are most vulnerable economically.

II. African-American MSM 66 Total

- AA-MSM exhibited the highest prevalence of HIV infection (48%) among all subpopulations studied (other than HIV+)
- 12% of respondents had not been tested for HIV and up to 68% do not use barrier protection consistently during anal sex. Further analysis of data with respect to insertion vs. reception behaviors is recommended.
- STD rates were lower than expected (6%) and suggest that prevention efforts may be working in this population
- All of the IDU respondents (8%) in this group were greater than 35 years of age
- Prevention efforts should focus on further reduction of risk through testing and barrier protection. Both African-American and MSM CLIs should reach this subpopulation.

III. African Immigrants 77 Total

- Respondent population exhibited relatively high rates of both HIV infection (3.9%) and STD (9%)
- 21% of respondents engage in casual sex while on holiday
- May carry "African Subtypes" of HIV that could be used to identify transmission patterns
- Prevention efforts should emphasize importance of barrier protection in high-risk activities, and emphasize HIV prevention education in collaboration with Houston offices of Dept. of Immigration and Consulates.

IV. Asian/Pacific Islanders 44 Total

- Most respondents were first-generation immigrant Vietnamese recruited through refugee agencies. Surveys were translated to Vietnamese.
- Respondents tended to be older (average age 42), monogamous, and exhibited little HIV awareness (3% HIV testing rate) or concern (13% barrier protection during most recent encounter)
- 10% of males reported paying for sex during the past 3 months
- The HIV infection rate was 0% and the STD rate was 2%
- Follow up surveys should target younger generations using primarily English surveys. Relatively high rate of prostitute visits may predict increasing STD and HIV rates for this population.

V. HIV-Positive Men 54 Total

- All HIV-positives targeted, but accessible sample was exclusively male (69% AA, 6% Lat, 22% Anglo)
- 90% of respondents used drugs and 33% reported as IDU
- 57% do not use barrier protection consistently with primary partners and up to 92% do not use barriers consistently with casual partners during anal sex. Further analysis of data with respect to insertion vs. reception behaviors is recommended.
- 56% report a recent STD (not otherwise specified)
- Prevention efforts emphasizing the critical importance of barrier protection in this population are needed. Interventions should stress prevention with positives carrying other HIV subtypes, increased susceptibility to STD and high risk of transmission to partners

VI. US Born Latina Women 50 Total

- US born Latinas have a relatively high rate of multiple partners (20%), a relatively high rate of drug/alcohol use with casual partners (75%) and a 6.8% rate of STD
- 65% of US born Latinas did not use barrier protection during their most recent sexual encounter
- US born Latinas have substantial awareness of HIV risk characterized by 73% HIV test history
- Prevention efforts should include bilingual awareness of the need for barrier protection and reinforcing skills for negotiating safer sex. Recruiting of more Latina HIV Peer Educators is also recommended.

VII. Latino Immigrants (Men and Women) 97 Total

- Latina (Women) and Latino (Men) immigrants exhibited contrasting attitudes and behaviors in this survey
- Latina immigrants tend to be monogamous (90%), highly aware of HIV risk (79% HIV tested), and exhibit a low incidence of STD (0%)
- Latino immigrants tend to have more partners (18% multiple partners), a higher frequency of drug use, less HIV testing (47%) and higher STD incidence (4.5%)
- Prevention interventions should target bilingual populations and support barrier protection through free condom distribution, HIV testing and bilingual help lines. Recruiting of more Latino immigrants (men and women) as peer educators is also recommended.

VIII. Latino MSM 69 Total

- L-MSM exhibit moderate to high STD rates (12%) and 33% of these are self-treated
- Only 59% of L-MSM have been tested for HIV and only 33% report consistent use of barrier protection during anal sex. Further analysis of data with respect to insertion vs. reception behaviors is recommended.
- The current HIV infection rate among sampled L-MSM is 12%.
- The high rates of STD, low barrier usage and high frequency of multiple partners (38%) puts this population at significant risk of increasing HIV transmission rates
- Prevention interventions should target bilingual populations and support barrier protection through free condom distribution, HIV testing and bilingual help lines.

IX. Transgender Individuals (Male to Female Transgender) 67 Total

- 51% of respondents self-report as sex workers, 73% use drugs and 40% reported as IDU
- 67% of Transgenders report using barrier protection during most recent sexual encounter, but STD rates are very high (42%). This contrasts with 6% self-reported STD among AA-MSM.
- Transgender study participants reported high HIV infection rates (20.9%).
- Prevention efforts should address high potential rates of HIV transmission in this group through sex work and IDU. Education of health workers about needs of transgender population would encourage better reporting, treatment and prevention of STD and HIV-related health problems.

Transgender Populations: Special Considerations

An effective AIDS prevention initiative targeting Transgender populations must transcend traditional notions of gender identity and take sexuality into account. It should include the following strategies: First, although transgender sex workers are aware of the importance of condoms during anal sex, few actually use them. Not only are condoms expensive, but the clients are often unwilling to use them. As such, not only must there be greater availability of condoms, but also mechanisms to teach transgenders how to negotiate condom use with clients. Condom negotiation and empowerment techniques have long since been a part of risk reduction initiatives for women. However since transgenders are most often looked upon as “men”, this aspect of prevention is typically not utilized.

X. Women who have sex with women (WSW) 270 Total

- WSW participants reported low incidence of multiple partners (17%) compared with MSM (35%), but also low incidence of barrier protection (10%)
- 18% of WSW in this study report having sex with a male during the previous 12 months. The survey did not allow determination of barrier use with males vs. females.
- The current HIV infection rate among sampled WSW is 3%. The STD rate is also 3%. Awareness of HIV risk is high, (HIV test rate of 73%)
- WSW reported significant use of drugs and alcohol with both primary and casual partners, but drug use did not appear to affect barrier usage.
- Prevention interventions should target significant risk of HIV transmission from sex with men and women and should seek to increase current barrier protection rates. Observed HIV and STD rates are higher than expected and should be tracked in future.

Overall Conclusions

1. There is a wealth of information in the current studies
2. There is an additional opportunity to re-analyze the raw data across original project boundaries. For example,
   - HIV + individuals were surveyed in every project
   - IDU and sex workers were surveyed in most projects.
   - While the information on these groups and their risk behaviors is likely to be limited in any one project, the total dataset is likely to provide substantial and invaluable new insights.
3. All Contractors will be asked to participate in a follow-up meeting to share raw data and evaluate potential benefits of re-analyzing comprehensive data

Next Steps

1. Compare findings to Epidemiological Profile
2. Refine priority populations set forth by HHPCPG
3. More in-depth needs assessment for specific populations

Prioritizing Target Populations

BACKGROUND / OBJECTIVES
Select priority populations for Houston based on evaluation process consisting of both objective epidemiological data and subjective weighting criteria.

KEY FINDINGS
HIV-positive individuals, African-American adults (men and women) as well as Caucasian men who have sex with men (MSM) represent the top tier of priority populations for Houston in 2003. The second tier of priority populations includes African-American adolescents; Latino men, women and adolescents; and Latino MSM.

KEY QUESTIONS
Obtaining reliable data on needs and current HIV-risk behaviors from inner city adolescents has proven to be a considerable challenge in 2003. Rapid emergence and spread of syphilis among HIV+ men in Houston should be tracked closely.

NEXT STEPS / RECOMMENDATIONS
1) Focus more concerted efforts on sites where HIV+ men meet for anonymous sex. 2) Focus efforts on obtaining HIV-related needs assessments in adolescents, particularly African American and Latino adolescents.

The Priority Setting Process

The Epidemiology Committee was composed of eleven members representing diverse communities, each bringing different knowledge and skills to the process. The following text and tables illustrate the seven steps that were used by the committee in its prioritization process.

Step 1: Identify Target Populations

Table 1 lists the twenty-seven target populations that were evaluated during the priority setting process. Racial/ethnic characteristics were not considered for two populations, Transgender and HIV+, because of the small sizes of these populations in relation to the general at-risk population.

Table 1. Target Populations

1) Transgender	
2) Adolescents Ages 13-19	
	a) African-American
	b) Hispanic
	c) Caucasian
	d) Asian/Pacific Islander
	e) Native American
3) Adolescents Ages 20-24	
	a) African-American
	b) Hispanic
	c) Caucasian
	d) Asian/Pacific Islander
	e) Native American
4) Men who Have Sex with Men (MSM)	
	a) African-American
	b) Hispanic
	c) Caucasian
	d) Asian/Pacific Islander
	e) Native American
5) Men	
	a) African-American
	b) Hispanic
	c) Caucasian
	d) Asian/Pacific Islander
	e) Native American
6) Women	
	a) African-American
	b) Hispanic
	c) Caucasian
	d) Asian/Pacific Islander
	e) Native American
7) HIV +	

Step 2: Determine Relevant Factors

The final list of ten factors included some that were strictly hard data and some that were more subjective, but all were deemed by consensus as important to the priority setting process. Table 2 below provides a brief definition of each factor as well as the sources of underlying data.

Table 2. Factors, Definitions, and Data Sources

Factor	Definition	Data Source(s)
1) AIDS Incidence	The number/rate of new AIDS diagnoses reported in a defined population.	HDHHS—HIV/AIDS Reporting System
2) AIDS Prevalence	The number/rate of people living with AIDS in a defined population.	HDHHS—HIV/AIDS Reporting System
3) HIV Data	The number/rate of people living with HIV/Not AIDS in a defined population reported and diagnosed since January 1, 1999 (when HIV became reportable by name in Texas).	HDHHS—HIV/AIDS Reporting System
4) Gonorrhea	The number/rate of diagnoses of gonorrhea reported in a defined population during a specified period of time.	HDHHS—STD Surveillance System (STD*MIS)
5) Primary and Secondary Syphilis	The number/rate of diagnoses of primary and secondary syphilis reported in a defined population during a specified period of time.	HDHHS—STD Surveillance System (STD*MIS)
6) Chlamydia	The number/rate of diagnoses of chlamydia reported in a defined population during a specified period of time.	HDHHS—STD Surveillance System (STD*MIS)
7) Barriers to Reaching the Population	The extent to which barriers that inhibit the implementation of HIV prevention programs to a defined population have been identified.	Needs Assessment
8) Size of At-risk Population	Size of a defined population within the general population.	2000 US Census Existing literature
9) Emerging Issues	Relatively new or emerging factors in the transmission of HIV, or in factors associated with the transmission of HIV, in a defined population.	Needs Assessment CDC Behavioral Risk Factor Report HDHHS Surveillance Systems
10) Resource Inventory	The extent to which HIV prevention resources are currently available to a defined population.	HDHHS Resource Inventory

Step 3: Assign Factor Weights

Both subjective (e.g., barriers, emerging issues) as well as objective factors were carefully considered and given relative weightings by the Epidemiology Committee. In general, the less subjective, more reliable data were given higher weights. Table 3 below discusses each factor, its assigned weight, and the weighting justification.

Table 3. Factors, Weights, and Justification

Factor	Weight	Justification
1) AIDS Incidence	4	The data describing this and the other two HIV/AIDS factors are subsets of the Houston HIV/AIDS Reporting System (HARS). This dataset is the most complete and accurate assessment of persons diagnosed with AIDS in Houston. The data represent the real time epidemic and are useful in monitoring trends, changes in proportions by population, failure of prevention programs, and failure of care programs. The recent data more closely reflect the current modes of transmission. Due to reporting lag and the nature of disease progression, the data do not accurately reflect recent infections; however, trends are observable in the data. It is important to remember that trends change over time, not over night. The date range for these data is January 1999 to December 2002.
2) AIDS Prevalence	4	This dataset is very accurate and complete. AIDS prevalence data are useful in monitoring trends, gauging the success/failure of treatment, and are of paramount importance in describing the pool of known "infectious" individuals. This is critical in targeting secondary prevention efforts. Due to reporting lag and the nature of disease progression, AIDS prevalence data do not represent the most recent infections. These data describe all persons diagnosed with AIDS who are not known to have died as of December 31, 2002.
3) HIV Data	4	This dataset is new, exciting, and incomplete. Due to the manner in which the State of Texas mandated the rules governing HIV infection reporting, which began January 1, 1999, no distinction can be made between old and new infections. As with AIDS incidence and prevalence, these data do not represent the most recent infections, because a positive HIV test today could indicate a 10-year-old infection. HIV reporting will become an important dataset in documenting and describing HIV in Houston, but not for several years. Over time, the dataset will yield a more accurate picture of incident and prevalent HIV cases, but not for 3 to 5 more years. These data describe all HIV cases reported from January 1999 to December 2002 who are not known to have died.
4) Gonorrhea	4	Because rates of other Sexually Transmitted Infections are a surrogate measure strongly indicative of unprotected sex, weights were assigned to gonorrhea, primary and secondary syphilis, and chlamydia data. The weights for the STD data were derived from the sex- and racial/ethnic-specific rates of disease for the last three years as presented in the HDHHS epidemiologic profile and from further analysis of the data from STD surveillance records.
5) Primary and Secondary Syphilis	4	
6) Chlamydia	4	
7) Barriers to Reaching the Population	2	This factor was subjective and thus received a lower weight. The intent is to identify whether current prevention interventions and programs have reached a defined population.
8) Size of At-risk Population	3	A larger population engaging in risky behaviors is more likely to have a greater impact on the continued spread of HIV resulting in greater numbers of infections. However, some smaller populations can be just as effective in spreading HIV when other variables (e.g., frequency/multiple partners) are taken into account.
9) Emerging Issues	2	This factor demonstrates a leading edge of the epidemic, but is unscientific and difficult to capture.
10) Resource Inventory	1	The Resource Inventory is a new tool that was completed for the first time this year, which is the reason that it received a low rating. It attempts to identify gaps in funding of prevention efforts specific to defined populations.

Step 4: Assign Rating Scales

The sub-committee chose a relative numerical rating scale ranging from 1 to 5, with 5 representing values associated with the highest risk for HIV transmission. Some of the more subjective factors had less quantifiable scales (e.g., "Yes/No" or "Declined/Stable/Increased"). Table 4 identifies the rating scales for the ten factors considered as part of the process.

Table 4. Factors and Rating Scales

Factor	Weight	Rating Information	Rating Scale
1) AIDS Incidence	4	How many people in the target population were diagnosed with AIDS in the last 3 years?	1: 0—199 2: 200—399 3: 400—599 4: 600—799 5: >=800
2) AIDS Prevalence	4	How many people in the target population were living with AIDS as of December 2002?	1: 0—299 2: 300—699 3: 700—1,099 4: 1,100—1,499 5: >=1,500
3) HIV Data	4	How many people in the target population were reported living with HIV/Not AIDS as of December 2002?	1: 0—99 2: 100—199 3: 200—399 4: 400—599 5: >=600
4) Gonorrhea	4	What is the proportional ranking of the gonorrhea rate within the target population?	1: Lowest Rank 2: Next Lowest 3: Middle Rank 4: Next Highest 5: Highest Rank
5) Primary and Secondary Syphilis	4	What is the proportional ranking of the primary and secondary syphilis rate within the target population?	1: Lowest Rank 2: Next Lowest 3: Middle Rank 4: Next Highest 5: Highest Rank
6) Chlamydia	4	What is the proportional ranking of the chlamydia rate within the target population?	1: Lowest Rank 2: Next Lowest 3: Middle Rank 4: Next Highest 5: Highest Rank
7) Barriers to Reaching Population	2	Are there significant barriers to reaching the target population with HIV prevention interventions?	1: There are few or virtually no barriers. 3: There are moderate barriers. 5: There are substantial barriers.
8) Size of At-risk Population	3	The size of the target population within the general population.	1: 0 2: 1—99,999 3: 100,000—199,999 4: 200,000—299,999 5: >=300,000
9) Emerging Issues	2	Has there been a significant change in any factor associated with the transmission of HIV/STDs among the target population?	1: Declined 3: Stable 5: Increased
10) Resource Inventory	1	What is the current amount of prevention funding available for the target population?	1: >=$1,000,001 2: $700,001—$1,000,000 3: $400,001—$700,000 4: $100,001—$400,000 5: <=$100,000

Table 5. The Decision Matrix

Rating	X Weight =	Score

Decision Matrix for Targeted Populations: 2003
Houston HIV Prevention Community Planning Group

Factor	AIDS Incid.		AIDS Prev.		HIV Data		Gonorrhea		P & S Syphilis		Chlamydia		Barriers to Reach Pop.		Size At-Risk Pop.		Emerging Issues		Resource Inventory
Approved Weight	**4**		**4**		**4**		**4**		**4**		**4**		**2**		**3**		**2**		**1**
1) TRANSGENDER	1	4	1	4	1	4	1	4	1	4	1	4	5	10	1	3	3	6	5
2) ADOLESCENTS AGES 13-19																			
African-American	1	4	1	4	3	12	5	20	5	20	5	20	5	10	2	6	3	6	2
Hispanic	1	4	1	4	1	4	4	16	4	16	4	16	5	10	2	6	3	6	3
Caucasian	1	4	1	4	1	4	3	12	3	12	3	12	5	10	2	6	3	6	5
Asian/Pacific Islander	1	4	1	4	1	4	2	8	1	4	2	8	5	10	2	6	3	6	5
Native American	1	4	1	4	1	4	1	4	1	4	1	4	5	10	2	6	3	6	5
3) ADOLESCENTS AGES 20-24																			
African-American	1	4	1	4	3	12	5	20	5	20	5	20	3	6	2	6	3	6	2
Hispanic	1	4	1	4	2	8	4	16	4	16	4	16	5	10	2	6	3	6	3
Caucasian	1	4	1	4	2	8	3	12	3	12	3	12	3	6	2	6	3	6	5
Asian/Pacific Islander	1	4	1	4	1	4	2	8	1	4	2	8	3	6	2	6	3	6	5
Native American	1	4	1	4	1	4	1	4	1	4	1	4	3	6	2	6	3	6	5
4) MEN WHO HAVE SEX WITH MEN (MSM)																			
African-American	3	12	4	16	4	16	5	20	4	16	5	20	3	6	2	6	5	10	5
Hispanic	2	8	3	12	3	12	4	16	3	12	4	16	3	6	2	6	5	10	5
Caucasian	3	12	5	20	5	20	3	12	5	20	3	12	3	6	2	6	5	10	5
Asian/Pacific Islander	1	4	1	4	1	4	2	8	2	8	2	8	1	2	2	6	5	10	5
Native American	1	4	1	4	1	4	1	4	1	4	1	4	1	2	2	6	5	10	5
5) MEN																			
African-American	3	12	3	12	4	16	5	20	5	20	5	20	5	10	3	9	3	6	2
Hispanic	1	4	1	4	1	4	4	16	3	12	4	16	3	6	4	12	3	6	2
Caucasian	1	4	1	4	1	4	3	12	4	16	3	12	1	2	4	12	3	6	3
Asian/Pacific Islander	1	4	1	4	1	4	2	8	2	8	2	8	3	6	2	6	3	6	5
Native American	1	4	1	4	1	4	1	4	1	4	1	4	3	6	2	6	3	6	5
6) WOMEN																			
African-American	3	12	3	12	5	20	5	20	5	20	4	16	3	6	4	12	3	6	1
Hispanic	1	4	1	4	1	4	4	16	4	16	5	20	3	6	4	12	3	6	1
Caucasian	1	4	1	4	2	8	3	12	3	12	3	12	1	2	4	12	3	6	4
Asian/Pacific Islander	1	4	1	4	1	4	2	8	1	4	2	8	3	6	2	6	3	6	5
Native American	1	4	1	4	1	4	1	4	1	4	1	4	3	6	2	6	3	6	5
7) HIV +	5	20	5	20	5	20	5	20	5	20	5	20	3	6	2	6	3	6	3

Step 5: Rate and Score Target Populations

To determine the final score for each risk factor, the assigned rating value was multiplied by the predetermined weight of the factor. For example, the population Transgender received a rating of 1 for the factor AIDS Incidence, which has a weight of 4. The score for the population Transgender regarding the factor AIDS Incidence was calculated by multiplying 1 by 4, which equals a score of 4. The total score for each population was then calculated by adding the score for each factor together. For example, the total score for the population Transgender was calculated by adding the scores of the following factors: AIDS Incidence (4), AIDS Prevalence (4), HIV Data (4), Gonorrhea (4), P & S Syphilis (4), Chlamydia (4), Barriers to Reach the Target Population (10), Size of the At-risk Population (3), Emerging Issues (6), and Resource Inventory (5) for a total score of 48. The decision matrix in Table 5 was used to accomplish this task. Table 6 lists each population and its calculated total score.

Step 6: Rank Target Populations

Priority populations were determined by comparing overall scores for each population to the mean score for all populations. A mean score of 80.4 was calculated by adding the total scores for all populations (2,170) and dividing by the number of populations (27). The mean score was used as the demarcation to determine which populations to exclude from the final prioritization process. All populations with a total score below the mean score were automatically excluded from prioritization. The remaining 12 populations were ranked according to their total score. Table 7 illustrates this process.

Table 6. Target Populations and Total Scores

Populations		Total Score
1) Transgender		48
2) Adolescents Ages 13-19		
	a) African-American	104
	b) Hispanic	85
	c) Caucasian	75
	d) Asian/Pacific Islander	59
	e) Native American	51
3) Adolescents Ages 20-24		
	a) African-American	100
	b) Hispanic	89
	c) Caucasian	75
	d) Asian/Pacific Islander	55
	e) Native American	47
4) Men who Have Sex with Men (MSM)		
	a) African-American	127
	b) Hispanic	103
	c) Caucasian	123
	d) Asian/Pacific Islander	59
	e) Native American	47
5) Men		
	a) African-American	127
	b) Hispanic	82
	c) Caucasian	75
	d) Asian/Pacific Islander	59
	e) Native American	47
6) Women		
	a) African-American	125
	b) Hispanic	89
	c) Caucasian	76
	d) Asian/Pacific Islander	55
	e) Native American	47
7) HIV +		141

Table 7. Target Populations, Total Scores and Rank

Populations	Total Score	Rank
1) Transgender	48	
2) Adolescents Ages 13-19		
a) African-American	104	5
b) Hispanic	85	9
c) Caucasian	75	
d) Asian/Pacific Islander	59	
e) Native American	51	
3) Adolescents Ages 20-24		
a) African-American	100	7
b) Hispanic	89	8
c) Caucasian	75	
d) Asian/Pacific Islander	55	
e) Native American	47	
4) Men who Have Sex with Men (MSM)		
a) African-American	127	2
b) Hispanic	103	6
c) Caucasian	123	4
d) Asian/Pacific Islander	59	
e) Native American	47	
5) Men		
a) African-American	127	2
b) Hispanic	82	10
c) Caucasian	75	
d) Asian/Pacific Islander	59	
e) Native American	47	
6) Women		
a) African-American	125	3
b) Hispanic	89	8
c) Caucasian	76	
d) Asian/Pacific Islander	55	
e) Native American	47	
7) HIV +	141	1

NOTE: Bolded populations were excluded from ranking because their total score was below the mean score (80.37).

Step 7: Prioritize Target Populations

During the final step, the committee prioritized the remaining 12 populations in a manner similar to the previous step. A total mean of 107.9 was calculated for the 12 priority populations and each individual score was compared to this mean. All populations with a total score above the mean were included in the primary tier of prioritization. The remaining 7 populations were included in the secondary tier of prioritization. The final prioritized populations recommended for funding are shown in Table 8.

Table 8. Target Populations Recommended for Funding by Tier

Populations	Total Score	Rank
HIV +*	141*	1*
African-American Men*	127*	2*
African-American Men who Have Sex with Men (MSM)*	127*	2*
African-American Women*	125*	3*
Caucasian Men who Have Sex with Men (MSM)*	123*	4*
African-American Adolescents Ages 13-19	104	5
Hispanic Men who have sex with men (MSM)	103	6
African-American Adolescents Ages 20-24	100	7
Hispanic Women	89	8
Hispanic Adolescents Ages 20-24	89	8
Hispanic Adolescents Ages 13-19	85	9
Hispanic Men	82	10

*Primary Funding Tier

2001 HIV Prevention Needs Assessment: Persons Living with HIV/AIDS

Executive Summary

Until recently, targeted primary prevention for people living with HIV and AIDS received minimal serious discussion. For most of the epidemic, the lethality of AIDS overshadowed consideration of sexual behavior among HIV-positive persons. Moreover, there was great concern that attempts to address sexual risk behaviors among HIV-positive persons would only result in further stigmatization of already marginalized groups. With advances in testing and treatment for HIV disease, however, a more traditional epidemiological approach to the control of HIV/AIDS is being widely considered; that is, in addition to focusing on the behaviors of uninfected persons to reduce risk of acquisition, attention is now being given to the behavior of infected individuals to reduce risk of transmission. The Centers for Disease Control and Prevention (CDC) has called for targeted primary prevention for HIV-positive persons, including sexual risk reduction interventions, as an integral part of their Serostatus Approach to Fighting the HIV Epidemic (SAFE) as well as their HIV Prevention Strategic Plan Through 2005.

The body of this report includes a brief review of the published literature regarding sexual risk behaviors among persons with HIV, factors influencing those risk behaviors, and implications for prevention interventions. This review is followed by a two-part description of a 2001 study with Houston's HIV-positive population, designed to broaden understanding of relevant knowledge, attitudes, and behaviors among individuals who are capable of transmitting the virus.

With respect to the literature, several conclusions may be drawn. Studies suggest that some factors influencing sexual risk behaviors among HIV-positive persons are similar to those factors affecting HIV-negative or unknown status persons, such as intentions and self-efficacy for condom use, communication and negotiation skills, and recreational drug use. Other factors appear to be unique to HIV-positive persons, such as fear and anxiety related to disclosure of serostatus, feelings of responsibility to protect potential partners, and concerns about protecting oneself from superinfection or other sexually transmitted diseases. Still other factors appear to be related to contextual and relational factors that may differentially impact specific subgroups of HIV-positive persons. To be effective, risk reduction interventions must address these multiple and complex influences on the sexual behavior of HIV-positive persons and must do so without incurring further stigmatization of HIV-positive persons. Moreover, these interventions can serve only as a single component of a comprehensive disease control strategy that includes increased HIV testing and improved continuity and quality of care and treatment for HIV-positive persons.

The local survey of 217 HIV-positive persons in Houston also offers notable findings about the behaviors and attitudes of this group. First, there is considerable sexual activity among this population, with 52% reporting two or more sex partners during the previous year. Of the 38% describing themselves as in a marriage or committed relationship, 34% reported two or more sex partners in the past year. Although 89% report using a condom at least some of the time, 11% report never using one. As in other studies, a significant proportion (15%-25%) of the study population feared a sexual partner's reaction to the suggestion of condom use, and was unsure of their ability to correctly use a condom or negotiate condom use. While men appear more likely than women to use a condom, their confidence in their ability to use one consistently is linked to the belief that condom use is "good." A significant majority of both men and women endorse the idea of disclosure; however, about 20% do not routinely disclose their HIV status to partners, and more than one-third consistently fail to learn the HIV status of their partner. More than one-fourth (28%) endorse the idea that having only one sex partner protects against HIV disease. Those in "committed" relationships may be more at risk for reinfection and transmission, either because of failure to disclose status or perhaps mutual agreement with a partner. While most respondents do not view HIV/AIDS as worse than any other terminal illness, it is not clear how much this opinion reflects their view at the time of infection, whether it may have been influenced by advances in treatment, or whether it influences decisions about risk-taking behavior.

Focus groups with 21 survey respondents in many ways demonstrate the changes that have occurred for those living with HIV since the advent of Highly Active Antiretroviral Therapy (HAART). Concerns about how to face challenges of living rather than the certainty of dying appear uppermost in their minds. With respect to prevention, the data generally complement findings of the survey and offer additional information, as well. All participants emphasize the importance of healthy emotional functioning as a precondition for safe behavior, noting that self care and healthy sexual behavior are unlikely without self-respect and the absence of emotional distress or illness. Just as strongly, participants emphasize the importance of having family support during their illness, and that seeking it can be very difficult. For some, disclosure to families is stopped by fears of rejection because of the illness or homosexuality. African-Americans in the groups agree that significant portions of their communities lack basic knowledge about HIV transmission and treatment, and that homophobia contributes to a reluctance to address the issues of both HIV and sexuality. While males in particular convey the

sense that disclosure of their HIV status to sexual partners is desirable, they acknowledge that disclosure in fact is far from consistent. In general, suggestions from males about how to encourage safer behavior tend to focus on broad social change, e.g., decreasing homophobia, while women's tend to emphasize the role of the individual in self-care.

Combining the results of both the literature review and the local study allows a number of specific recommendations for local prevention efforts. Many of these suggest the need to modify current approaches, and are summarized below. All were mentioned in the needs assessment conducted for the Houston Department of Health and Human Services in 1999 (City Psychological Services, 1999). More detail on the recommendations may be found beginning on page 24 of this report.

It is strongly recommended that local prevention efforts begin to focus on effectively coordinating prevention and primary care services for PLWHA. It is especially important to take advantage of the influence that medical and mental health care providers appear to have with their patients and clients, utilizing these professionals as sources of education and motivation for risk reduction. Additionally, interventions directed toward PLWHA should emphasize building the specific skills needed for effective negotiation with sexual partners and disclosure of HIV status. These interventions should also be targeted to specific groups and include multiple intervention points in order to be effective. Finally, it is imperative that testing be more widespread and accessible, to increase the number of individuals who know their serostatus.

Beliefs and Practices Among PLWHA in Houston

Survey Methodology

The purpose of the study was to identify HIV prevention beliefs and behaviors of people living with HIV disease. In order to collect information from this population, the AIDS Planned Behavior Scale (APBS) (Zagumny, Dolzycki, Bedkowska-Heine, Hammonds, and Salyer, 2000) was adapted for the HIV-positive population, and a Spanish language version developed. The 59-item instrument measured attitudes toward HIV and condom use, self-efficacy related to sexual behavior, influences on sexual behavior, and past and intended HIV risk behaviors. A cover letter explaining the project, the surveys, and a stamped returned envelope were prepared. An area AIDS service organization agreed to send the surveys to clients in their database, and prepared mailing labels. The instrument was mailed to a total of 2,098 clients. Of these, 1,321 were delivered to persons with HIV disease (777 were undeliverable), and 217 individuals completed and returned the survey instrument for a return response rate of 16.4%. Respondents received a $5 coupon that was mailed to an address of their choice, addressed to "Resident" to maintain anonymity. They were also invited to participate in subsequent focus groups and receive an additional $20 coupon. A total of 135 or 62.5% expressed interest and of these, 30 were contacted and 21 attended a focus group session.

Summary of Results

Demographics of Participants

Sixty-two percent of the participants were males, 37% were females, and 1% transgender. African Americans comprised 63% of the total population, followed by Euro Americans (20%), Hispanics (13%), Native Americans/Asian Pacific Islanders (1.4%), and "other" (2.3%).

Sexual Orientation

Fifty-two percent of respondents were heterosexual, 34% were homosexual, and 14% were bisexual. By gender, 89% of females were heterosexual, 4% homosexual, and 8% bisexual; 29% of males were heterosexual, 53% were homosexual, and 18% were bisexual. Of the two transgender participants, one was bisexual and one was homosexual.

Marital Status

An equal number of participants were unmarried (38%) as were either in committed relationships (21%), or married (17%); 11% were divorced, 8% were separated, 5% were widowed. A greater percentage of males than females were single while more females had either been married or divorced.

Ages

The ages of participants ranged from 19 to 65 years with the majority (44%) between 41 and 50 years, followed by 35% between the ages of 31- 40 years

Number of Sex Partners

Participants were asked the number of sex partners they had had in the past year. The numbers ranged from 0 to 52 with a mean of 3.3 and a mode of 2. Three times as many females as males (21% versus 7%) had had no sex partner in the past year, and 52% had had 2 or more sex partners in the past year.

When the number of sex partners was compared with relationship status, of the 38% in a marriage or committed relationship, 20% had 2 sex partners in the past year, 14% had 3 or more sex partners in the past years, and of these 6 were female and 5 male.

There were no significant differences between males and females.

Likelihood of Condom Use

When asked specific questions regarding the likelihood of condom use in the next three months, there was no statistical difference between males and females with 82% of the total population indicating they would likely use protection, with males slightly more likely to insist on condoms than females.

Knowledge Domains

Two of the questions sought to define knowledge of transmission factors. The responses indicated that individuals with HIV disease need education regarding disease transmission in order to protect themselves as well as their sex partners from infection.

Attitude Toward AIDS

Four questions sought to determine an attitude toward HIV/AIDS, and the majority indicated a concern for infecting others and/or re-infecting themselves. When asked to compare AIDS to another terminal diseases, the responses were within 10 percentage points of each other with the general sense being that in the context of diseases, HIV/AIDS wasn't significantly better or worse than any other terminal illness.

	Disagree	Agree
I would rather have any other terminal illness than AIDS.	53.4%	46.6%
I feel the chances are good that I can give HIV to another person.	30.7%	69.3%
I am afraid of being re-infected with an HIV virus or with another sexually transmitted infection.	22.4%	77.6%
AIDS is probably the worst disease a person can get.	44.6%	55.4%

Perceived Responsibilities

The responses about perceived responsibilities regarding disclosure of HIV status indicated that while the majority of participants report acting in a responsible manner, nearly 1/5th do not always disclose HIV status to sexual partners and over 1/3rd do not always know their sexual partner's status.

Perceived Responsibilities	Disagree	Agree
I always disclose my HIV status to my sexual partner.	19.0%	81.0%
I feel it is very important to protect my partner from HIV.	3.8%	96.2%
I feel it is very important that my partner protect himself/herself from HIV.	7.0%	93.0%
I always know the HIV status of my sexual partner.	36.2%	63.8%
I think it is worth the effort to have condoms readily available.	4.2%	95.8%
If a condom is not available, it would be worth the effort to stop sexual activity to obtain a condom.	10.6%	89.4%

A statistical comparison was done between the last question in this grid, "If a condom is not available, it would be worth the effort to stop sexual activity to obtain a condom" and the question regarding projected use of condoms in the next three months. There was an overall statistically significant comparison, at a 95% CI, between those who would stop activity and those who think using condoms with their sex partner would be "good". When the question was grouped by gender, only the males showed a statistically significant correlation at 99% CI. These questions were also compared with sexual orientation and again there were no significant differences between groups.

When the same question about projected condom use was compared with the foolish/wise question choice, again there was a statistically significant correlation at 99% CI, and when compared by gender, again only the males showed this strong correlation. On neither the "harmful/helpful" question, nor the "unpleasant/pleasant" choice were there powerful correlations.

Attitudes Regarding Condom Use

Attitudes were collected through a 9-domain question grid, and while the majority (75%-90%) gave a "responsible" answer to questions regarding condom use, on any given question at least 10% were in disagreement. The areas of greatest variance were regarding the partner's beliefs, e.g. it would be an insult; s/he would think I have a sexually transmitted disease, s/he would think I thought they had a sexually transmitted disease.

Attitudes Regarding Condom Use	Disagree	Agree
Using a condom seems like an insult to my partner.	77.5%	22.5%
It is embarrassing (to me) to buy condoms.	83.3%	16.7%
I do not enjoy (or think I might not enjoy) sex when using a condom.	79.0%	21.0%
I would feel embarrassed to put a condom on myself or my partner.	83.8%	16.2%
If I were to suggest using a condom to a partner I would feel afraid that he/she would reject me.	81.6%	18.4%
If I were unsure of my partner's feelings about using condoms, I would not suggest using one.	85.0%	15.0%
I would be afraid s/he would think I've had a homosexual experience.	89.6%	10.4%
I would be afraid s/he would think I have a sexually transmitted disease.	76.2%	23.8%
I would be afraid s/he would think that I thought they had a sexually transmitted disease.	74.9%	25.1%

Skills Regarding Condom Use

The majority of respondents indicated having experience or skill with condom use, however this scale also demonstrates that 16% were unsure of their abilities to negotiate condom use without insulting their partner. 14% were unsure of their ability to remember to use a condom when high.

I feel confident in my ability to:	Disagree	Agree
- put a condom on myself or my partner quickly.	11.7%	88.3%
- use a condom correctly.	5.6%	94.4%
- properly remove and dispose of a condom.	6.1%	93.9%
- discuss condom usage with any partner I might have	10.9%	89.1%
- suggest using a condom without my partner feeling "diseased"	16.4%	83.6%
- persuade a partner to use a condom during intercourse	7.6%	92.4%
- remember to use a condom even after I have been drinking	10.5%	89.5%
- remember to use a condom even if I were high	13.7%	86.3%
- stop to put a condom on myself or my partner even in the heat of passion	11.3%	88.7%

Likelihood of Condom Use

Over 80% indicated a likelihood of condom use during the next three months, with 14%-17% refusing protective behaviors.

Likelihood of Condom Use	Unlikely	Likely
How likely are you to use a condom with your partner(s) over the next 3 months?	17.4%	82.6%
How likely are you to use condoms with your partner(s) the next time you have sex?	13.4%	86.6%

Beliefs about condom use mirror projected usage in that 92% believe it would be a good behavior. There was a statistically significant (99% CI) similarity between those who would likely use condoms in the next three months and those believing condom use is “good”.

Projected Use of Condoms – Three Months

	Low	Moderate	High	
Bad	3.2%	4.8%	91.9%	Good
Foolish	10.0%	3.9%	86.1%	Wise
Harmful	24.1%	9.8%	66.1%	Helpful
Unpleasant	25.3%	21.7%	53.0%	Pleasant

Perceived Sources of Influence Over Condom Use

This chart illustrates the influence of the health care provider in the use of condoms with 79% indicating a sphere of influence that is 20%-25% greater than that of friends, family, or sexual partners.

The following people believe I should use condoms:

	Never	Seldom	Often	Always	Don't know
My sexual partner(s)	11.0%	12.0%	21.5%	51.2%	4.3%
Most of my close friends	3.3%	7.6%	22.9%	54.3%	11.9%
My doctor or health care provider	2.4%	1.9%	10.0%	79.4%	6.2%
My mother or father	5.9%	1.0%	8.9%	55.0%	29.2%

Desire to Please Others

Health care providers were the primary group of respondents most desired to please (88%), versus sexual partners (65%), close friends (55%), or parents (72%), echoing again the power of those providing medical care to exert influence for protection and prevention.

Generally speaking, I want to do what the following people want me to do:

	Never	Seldom	Often	Always
My sexual partner(s)	10.0%	25.2%	31.9%	32.9%
Most of my close friends	11.1%	33.8%	33.3%	21.7%
My doctor or health care provider	2.4%	9.6%	37.3%	50.7%
My mother or father	9.0%	19.5%	29.0%	42.5%

Beliefs and Practices Among PLWHA in Houston Focus Groups

Methodology

Three focus groups of approximately 90 minutes each were held with a total of 21 respondents, including 13 African-American gay males, 3 gay white males, 1 straight white male, 2 straight African-American females, 1 gay African-American female, and 1 bisexual African-American female. Participants' ages ranged from 24 to 49 years, with a mean age of 39 years. Participants were chosen from among the 135 survey respondents who indicated interest in focus group participation. While an effort was made to choose a sample representative of the larger pool of survey respondents, scheduling conflicts and no-shows made this impossible. Overall the focus groups participants were somewhat older than those answering the survey, and African-Americans were disproportionately represented, as they comprised 81% of focus group participants, and 63% of survey participants. Males were also overrepresented, comprising 81% of focus group members and 62% of survey participants. Focus group questions were intended to elicit information about how individuals with HIV disease understand the idea of "safe" behavior, and to identify both obstacles to safe behavior as well as sources of support for beginning or continuing such behavior. It should be noted that both the nature of the sample and the relatively small numbers dictate that findings be used cautiously. However, the results are generally consistent with findings of both the survey and the published literature.

Summary of Results

Meaning of Safety

With respect to safety, there was considerable agreement among the groups. Each group was quick to note sexual abstinence as the safest way to behave. Straight men were most likely to mention abstinence as currently characteristic of their lives. Being in a committed relationship with one partner, knowing one's partner, and having fewer partners were also mentioned as enhancing safety, as was the importance of protecting oneself either through low-risk activities such as mutual masturbation or consistent condom use. The women were explicit about the need to be prepared with what one called "the toys" needed for sexual protection, and appeared to accept the primary responsibility for protecting themselves from either HIV reinfection or infection with another sexually transmitted disease. The women were also clear in defining safety in terms of caring—for themselves and others—and emphasized the importance of developing a thorough awareness of one's own body and which situations were likely to pose challenges to safe sex behaviors.

Obstacles to Safety

When discussing obstacles to safer behaviors, participants were unanimous that substance use and abuse, and even being in situations where drugs are available, were especially problematic. Drugs were seen as clouding judgment, and in instances of drug dependence, creating a situation in which the need for the drug always outweighed considerations of safety. Women mentioned that medications such as Vicodin prescribed by physicians unfamiliar with the patient's drug history were as dangerous as illicit drugs.

Along with the need or desire for drugs, need for money was mentioned by some male participants as a possible obstacle to safe behavior. One noted that when trading sex for money, one would do what is requested "when the rent's due." While for some, trading sex for money appeared to be a response to a purely economic problem, for others, it was tied to a need to buy drugs. As one woman noted, "You'd be surprised what anyone will do for drugs." Some participants expressed a combination of incredulity and amusement that some johns appear either naïve or indifferent about the dangers of unprotected sex with a stranger.

Participants identified a widespread misunderstanding about HIV and its treatment as a serious barrier to safer behavior. They noted what one called a general "misperception of what it is to be HIV-positive," including the fact that no cure exists despite improvements in treatment, that those with the illness continue to face social ostracism, and that the illness takes a heavy emotional toll on those afflicted and affected. Male participants were especially disdainful of advertisements for medical treatments, pointing out that the promotions ignore unpleasant side effects such as fatigue and diarrhea, as well as the difficulty of the regimens. While participants denied that treatment improvements had fostered carelessness in their own behavior, they tied overly optimistic public information about new treatments to others' barebacking and less fear about the consequences of contracting HIV.

Women tended to connect others' misunderstanding of HIV disease with a lack of motivation to take care of themselves. Several noted that "silence" or ignorance about HIV among their family members made it difficult to stay focused on the reality of being ill and the need for continual medical treatment and other self-care behaviors. They also observed that their emotional reactions to being diagnosed with HIV contribute to indifference about their health. Another psychological factor mentioned by women is being in pain, related to losses that come with an HIV diagnosis and/or with substance abuse.

Age itself was seen by some males as a barrier to safer behavior. Younger gay men, in particular, were seen as lacking the experience of watching numerous peers die, keeping the illness from becoming a "reality" to them. A few were described as wanting to "fit in" with HIV-positive friends by actively exposing themselves to the virus, a practice characterized as "crazy thinking."

Some males mentioned that getting "too comfortable in the relationship" made continued safe practices difficult, and women noted that an uncooperative partner could also pose a barrier to safe behavior, particularly a partner who claimed the intent to use a condom but did not.

The question about disclosing one's HIV status elicited much discussion among both female and male participants. Women described less difficulty and fewer negative consequences in disclosing to partners, but pointed out instances of rejection from family; one noted that her mother continued to warn other family members not to drink after the infected daughter. Male participants were more inclined to describe the process of disclosure as very difficult; one described it as the "hardest thing I ever had to do." Their reasons included fear of rejection, fear of being judged as having "something wrong," and fear that telling one person is tantamount to telling many others because confidentiality will not be respected. The men's descriptions of rejection experiences illustrated the basis of their fears. While generally conceding the desirability of disclosure, the men were clear that they did not always disclose, particularly when they were with a casual partner, when the partner did not enquire about their status or suggest a condom, or if the partner responded negatively to a probe such as, "I hear that so-and-so's positive. What do you think about those people?" Disclosure was also less likely when engaging in a lower risk activity such as mutual masturbation. No consensus emerged about how an emotional tie to a sexual partner might affect disclosure. Some noted a tendency to disclose quickly to someone with whom a serious relationship seemed possible, to avoid the later pain of possible rejection. Others said that really liking the potential partner made disclosure more difficult and therefore perhaps less likely.

Among African-American gay men, disclosure issues were seen partly in terms of the general difficulty of being a gay man in the African-American community. Participants were unanimous in agreeing that being a gay black man was a "strike against you," and that the homophobia they had experienced from family members and the church contributed to feelings of shame and low self-worth, which they saw as related to several problems. These include a reluctance to disclose either their homosexuality or HIV status, emotional difficulties that made drug use and unsafe sexual behaviors more likely, and general indifference to keeping themselves safe. Black participants were emphatic in describing the homophobia they perceive in the black community, asserting that it is much more pronounced than among whites. They noted that it tended to restrict their visibility – "You won't see us at Gay Pride" – and to encourage the phenomenon of "being on the down low." This was described as the practice of professional, married or heterosexually active black men having unprotected sex with male prostitutes or anonymous partners in venues such as bookstores or gyms, then "taking it [a sexually transmitted disease] home." To some extent, the reluctance to address issues such as "being on the down low" within the community was seen as part of a community-wide lack of open discussion about sexuality. African-American women voiced similar observations about the denial in their ethnic community of homosexual behavior, where they observe a perceived need for men to uphold a "macho-macho" image.

Explicitly or implicitly, all the groups agreed that responsible disclosure of being HIV-positive depends on "morals." This was defined in terms of feeling some responsibility for others, and as a component of having or wanting to have a positive self-image. Some male participants pointed out that those who maintain an "angry" response to having been infected are less likely to care whom they infect, and are not likely to disclose.

Supporting Safe Behavior

Participants offered several categories of support for encouraging safe behavior and possibly decreasing HIV transmission. One category related to general health promotion. Female participants were clear about the need for more drug treatment programs, especially for persons emerging from prison, and suggested that the programs needed to provide more education about the relation between HIV and drug use, the prevalence of HIV among drug users, and the prevalence of hepatitis C and other sexually transmitted diseases. There was consensus about the need for wider testing, and suggestions about how to make it more attractive. Women noted that testing should be free, heavily advertised, and widely available in such accessible places as shopping malls and churches, noting that some are afraid to go to clinics because of concerns about confidentiality. Both women and men recommended offering incentives for testing; these might include concert tickets provided at the time results are delivered, or $5 for gas. Males also noted that education about HIV should be delivered before the results are given, to increase the likelihood of the information being retained. Testing in prisons was also recommended. More generally, some men made the point that making health care in general more accessible might encourage people to take better care of themselves, and that better experiences with the health care system might increase willingness to get tested in that system. They noted that providers of mental and medical health care have great credibility, and should be discussing safer sex practices, especially with those recently diagnosed, and should make risk assessment a regular part of health care visits.

Mental health care was also mentioned as important, not only for the delivery of explicit information about safer behaviors and the barriers to them, but also as a source of ongoing support for safe behavior and self care among individuals with HIV. Both men and women agreed about the importance of support groups and other activities such as volunteerism to combat the isolation that may follow a diagnosis or loss of work. Men also mentioned that the venue for mental health care should not be explicitly identified with mental health treatment ("a nut house") or with HIV because of the stigma associated with both.

Participants strongly agreed about the desirability of involving churches in efforts to promote awareness of HIV in the black community. Churches were also seen as a potential source of psychological and social support for those who are positive and their families, and as appropriate sites for testing. African-American gay males observed that churches could be a valuable source of sexuality education and support for being gay, citing support groups and openness at one local predominately black church. They also noted that churches might be the best place to educate older members of the community about the realities of sexual activity and illness among younger people in the community.

Strong advocacy for the importance of the church was part of the participants' view that "education" and "awareness" about HIV need to be much more widespread in order to counter lack of knowledge among the public. One cited the practice in his small hometown of burning those who die of AIDS-related illness. They noted that HIV-positive "role models" should "speak up" about the unattractive "real consequences" of the illness and its treatment, and emphasize that "it can happen to anyone." Greater involvement of the HIV-positive as educators was also seen as useful, in part to counter the isolating behavior of some in this population, and also to counter the stereotypes about who can contract the virus. In general, participants agreed that many simply do not understand the disease or the needs of those who have it.

African-American gay men saw a definite need for more acceptance in their families and communities for homosexuality, particularly for teens attempting to come to terms with their orientation. They saw this as promoting self-respect and reducing shame. They also mentioned the need for more outreach into their communities by other African-Americans.

Recommendations

Both the literature review and the local study suggest that broad generalizations about the population of PLWHA are not warranted. However, both sources strongly indicate that local prevention efforts aimed at persons living with HIV/AIDS (PLWHA) should emphasize: 1) integration of prevention into primary care, 2) greater emphasis on skills acquisition, 3) more focused targeting of prevention efforts to specific subpopulations, and 4) increased testing of persons who do not know their HIV status. These and other recommendations are described more fully below.

- Provide comprehensive and ongoing education about treatment and transmission as part of patients' primary medical and mental health care. Medical and mental health care providers appear to be respected sources of information, and there is evidence that patients may act in ways that they believe will gain the approval of medical care providers. Given the psychosocial distress that is likely to accompany being HIV-positive, emotional support as well as skills-building over time are needed to promote accurate understanding of reinfection risk, adoption of safer behaviors, and an increased sense of responsibility for protecting self and others from additional exposure to sexually transmitted infections.

  Implementation of this recommendation implies a need to expand the training that medical and mental health care providers receive regarding communication about sexual issues and methods of risk reduction. Realistically, these professionals cannot be the sole source of patients' information and support; however, their credibility with patients suggests a crucial role in assessment of problematic behaviors and emotional distress, as well as referral to other appropriate providers. More coordination and collaboration between prevention service providers and care services should be arranged as a first step toward a comprehensive continuum of care that serves both the HIV-infected population and those with whom they are in contact.

- Insure the availability and accessibility of mental health and other emotional support services. Discouraging isolation, strengthening coping skills, and providing treatment for the psychological distress and mood disorders that can be indirectly or directly related to unsafe sexual behavior are imperative. More generally, volunteerism and participation in support activities are reported as promoting healthier emotional functioning. A recent evaluation of mental health services for PLWHA in Harris County found that more than 80% of those utilizing the services had benefited in ways that are correlated with lower behavioral risks (Sage Associates, 2000).

- Design interventions that promote and support (1) disclosure and elicitation of HIV status with sexual partners, (2) consistent condom use, and (3) a sense of responsibility to protect self and others. While disclosure does not guarantee safer behavior, difficulties with disclosure are of clear concern to local PLWHA. At least one study (Kalichman et al (2001) suggests that using interventions to build behavioral skills and enhance self-efficacy for condom use can significantly reduce sexual risk behaviors. Negotiation skills and communication should be strengthened, especially among females.

It should be noted that encouraging a greater sense of responsibility for protecting self and others from infection may challenge attitudes currently held by providers of care or prevention services. At the conclusion of capacity-building workshops held from October through December, 2001, participants were asked the following question: "In your opinion, in a new relationship, is it the responsibility of the HIV-positive person to disclose his/her status, or should the other person be responsible for safe sex practices?" Of the thirty-nine respondents, 64% said it was the responsibility of both parties to ask about HIV and use safe sex precautions, 23% felt it was the responsibility of the partner, and 13% felt it was the responsibility of the HIV-positive person (Sage, 2001). While these responses do not reveal the thinking behind the providers' attributions of responsibility, it is possible that fear of further stigmatization of or distress to clients plays a role. Published studies, however, suggest intervention strategies that avoid this unwanted outcome.

- Target interventions to specific subgroups of PLWHA. Some factors influencing sexual risk behaviors of PLWHA may vary according to subgroup. Younger MSMs and substance abusers may be particularly in need of interventions to reduce high-risk behavior; providing multiple intervention points is especially important, given the persistent nature of some risk correlates. The African-American community may have a range of needs. For some, providing comprehensive information about methods of transmission and treatment may be most appropriate. For others, discussion of homosexuality within the community may be especially useful.

  The most effective means for delivering the interventions is also likely to be different in different communities. African-American participants in local studies have suggested the church as one appropriate venue to begin discussion about the topics of HIV and homosexuality, and as a less anxiety-provoking testing site. It might be helpful to begin this process with an examination of how a small number of local black churches have introduced discussion of HIV and homosexuality and/or support for gay members; findings could provide a basis for devising a model to assist other interested churches.

- Develop more proactive approaches to encourage testing of individuals at high risk. Current testing efforts appear insufficient to reach the estimated one-third of infected persons who do not know their status. Local participants suggested, among other things, that testing should be free, heavily advertised, available in such easily accessible locations as shopping malls and churches, and encouraged through the use of incentives such as transportation assistance.

- Incorporate comprehensive HIV prevention and treatment education as a regular component of all substance abuse prevention and treatment programs. The link, direct or indirect, between substance abuse and HIV risk behavior is clear.

- Provide a means for regular review of materials used in prevention interventions. The existence of misconceptions about the transmission and treatment of HIV/AIDS may be related in part to the existence of outdated or inappropriate educational materials. Such materials should be periodically reviewed by knowledgeable and independent community members charged with considering not only accuracy and timeliness, but suitability for target audiences.

The Priority Setting Process – HIV Prevention Interventions

BACKGROUND / OBJECTIVE
All prevention interventions utilized by the City of Houston contractors must be appropriate to the population being served. Priority setting process is shown below and describes how the priority interventions were linked to the priority populations

KEY FINDINGS
During the process it became apparent that the most useful intervention in most cases was the use of Community Level Interventions (CLI). Additionally it was determined that CLIs will not work on HIV+ individuals.

KEY QUESTIONS
How can new CLIs be implemented without established scientific data? How can innovative CLIs be adapted to fit the HIV+ population?

NEXT STEPS / RECOMMENDATIONS
More research needs to be done on the use of innovative CLIs. Grants need to be searched that would allow a new and innovative CLI to be conducted that could be utilized by all.

The Prioritization of Interventions

One of the most important tasks of the Prevention Intervention Strategies and Priority Setting Committee (PI Committee) is to develop a list of interventions that address the needs and issues of the priority populations set forth by the Epidemiology Research and Priority Setting Committee. These prioritizations will be used to direct the Houston Department of Health and Human Services (HDHHS) in its funding of HIV prevention interventions in the Houston public health jurisdiction.

During the prioritization process, the PI Committee consisted of seven members. Members of the committee represented diverse communities and had a wealth of expertise providing HIV/AIDS prevention services in Houston.

The first portion of the planning process required meeting once a month. Many discussions took place that utilized the vast experience of the prevention workers on the committee and the research information brought forth by the HHPCPG's behavioral scientist. Using the guidebook developed by the Academy for Educational Development (AED), Chapter 6, 2000, the committee used a 7-step process to establish priority setting. This process allowed the committee to determine the list of effective interventions recommended for Houston. Decisions regarding the process and the final list of prioritized interventions were consistently reached by consensus.

Step 1: Identify and Define Interventions

The first step used by the PI Committee in the priority-setting process was to determine the interventions to be used in HIV prevention. The committee reviewed interventions recommended by the CDC, and agreed on prioritizing a total of 8 interventions. To provide consistency, the committee defined each intervention based on information obtained from the CDC, the behavioral scientist and the experience of committee members. Although strong evidence of effectiveness is still lacking for Prevention Case Management, the committee decided to continue with this intervention, encouraging feedback from local prevention programs and more recent effectiveness studies. A long discussion was held on whether or not to alter the definition for Health Communication/Public Information to include social marketing, but in the end the definition was altered to insist on input from the target audience when developing prevention messages.

Definitions of the interventions that were prioritized by the PI Committee are provided in Table 1, while Table 2 provides a sample of the data sources used to justify the prioritized interventions. Please see Chapter Eight of this plan for a more complete coverage of the behavioral science and social theory literature relevant to HIV prevention interventions.

The Prevention Intervention Committee decided to keep the prioritized interventions as originally approved for the planning year, and felt strongly that the entire prioritization process would be compromised by voting in new evidence-based HERR interventions solely on the basis of their inclusion in the compendium. Moreover, the committee did not feel there was sufficient time to successfully complete a new prioritization process with integrity at this point in time.

The committee also recognizes that CDC strongly recommends community planning groups and health departments include the following behavioral interventions for all priority populations -Health Communication/Public Information (HCPI) and Partner Counseling/ Referral Services (PCRS).

Table 1. Definitions of HIV Interventions Prioritized by the PI Committee

Intervention	Definition
Community-level Intervention (CLI)	This intervention is designed to target specific populations that are identified by shared risk behaviors for HIV infection. It can also be defined by race, ethnicity, gender, sexual orientation, and/or location. Its purpose is to provide health education to reduce risk behavior, increase skills building, and influence community norms. A CLI must include outreach and social marketing. It may also include aspects of other interventions, such as ILI and GLI, but any combination of these various interventions must be aimed explicitly at targeting the community as a whole.
Needle Exchange	This intervention involves the exchange of used or dirty needles for sterile, unused needles for the purpose of reducing the exposure to contaminated blood among injecting drug users who cannot or will not cease to inject.(At this time, needle exchange is illegal in Texas, but in the event that the law changes, this intervention is highly recommended in the appropriate populations.)
Prevention Counseling / Partner Elicitation (PCPE)	This client-centered HIV prevention intervention involves single or multiple counseling sessions that can be clinic or community based. Counseling is combined with HIV risk reduction education centered on the HIV test. The client may or may not choose to be tested; if he or she chooses to complete the HIV test, counseling will occur before as well as after the test and will also include voluntary partner elicitation.
Individual-level Intervention (ILI)	This intervention must involve client-centered health education, risk-reduction counseling, and skills-building activities that are provided to one individual at a time. ILI assists clients in making plans for individual behavior change and with ongoing appraisals of their own behavior. ILI also facilitates linkages to other services that support behaviors and practices that prevent transmission of HIV. It is designed to help clients make plans to obtain these services. Condoms, bleach kits, and other educational materials must be distributed as part of an ILI. (It is recommended that 30 minutes, at a minimum, is an effective time frame for conducting an individual-level intervention.)
Group-level Intervention (GLI)	This intervention must involve multiple health education, risk-reduction counseling, and skills-building sessions that shift the delivery of services from the individual to groups of varying sizes. It uses peer and non-peer models involving a range of skills, such as safer-sex negotiation and condom use, as well as education and support. (Ideally, group sessions have between three and fifteen of the same participants. Multiple sessions with the same participants are considered most effective.)
Outreach	This intervention involves HIV/AIDS educational sessions that are usually provided by peer or paraprofessional educators. It is conducted face-to-face with high-risk individuals in the clients' neighborhoods or in other places where the clients congregate. The primary features of outreach include condom distribution and demonstration, distribution of bleach and sexual responsibility kits, educational materials, and referrals and linkages to services.
Prevention Case Management	This intervention is a client-centered HIV prevention activity whose fundamental goal is promoting the adoption of risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. It is a hybrid that includes HIV risk-reduction counseling and traditional case management. It provides intensive ongoing and individualized prevention counseling, support, and referral to services.
Health Communication / Public Information	This intervention involves the delivery of planned HIV prevention messages Public Information through one or more channels to target audiences. These messages are designed to build general support for safe sex behavior, support for personal risk-reduction efforts, and/or inform persons at risk for HIV infection about the availability of specific services. Prevention messages must be based on the needs and input of the target audience.

Table 2. Reference Data Sources by Intervention

Intervention	Data Source
Community-level Intervention	CDC (1999). HIV/AIDS Prevention Research Synthesis Project, Compendium of HIV Prevention Interventions with Evidence of Effectiveness Kalichman (1998). "Community Intervention," in Preventing AIDS: A Source Book for Behavioral Interventions, Mahwah, NJ: Lawrence Erlbaum Associates.
Needle Exchange	CDC (1999). HIV/AIDS Prevention Research Synthesis Project, Compendium of HIV Prevention Interventions with Evidence of Effectiveness. Kalichman (1998). Preventing AIDS: A Source Book for Behavioral Interventions, Mahwah, NJ: Lawrence Erlbaum Associates. Wright-DeAgueero, Gorsky, and Seeman (1996). Cost of outreach for HIV prevention among drug users and youth at risk, Drugs and Society, 9(1-2), 185-197.
Prevention Counseling / Partner Elicitation	CDC (1999). HIV/AIDS Prevention Research Synthesis Project, Compendium of HIV Prevention Interventions with Evidence of Effectiveness. Higgins, Galavotti, O'Reilly, et al. (1991). Evidence for the effects of HIV antibody counseling and testing on risk behaviors, JAMA, 226(17), 2419-2429. Holtgrave, Qualls, Curran, et al. 1995). An overview of effectiveness and efficiency of HIV prevention programs, Public Health Reports, 110(2), 134-146. Kalichman (1998). Preventing AIDS: A Source Book for Behavioral Interventions, Mahwah, NJ: Lawrence Erlbaum Associates. Kamb, Fishbein, Douglas, et al. (members of Project RESPECT Study Group) (1998). Efficacy of risk-reduction counseling to prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases. A randomized controlled trail, JAMA, 280(13), 1161-1167. Wolitiski, MacGowan, Higgins, and Jorgenson (1997). The effects of HIV counseling and testing on risk-related practices and help-seeking behavior, AIDS Education and Prevention, 9(3 suppl.), 52-67.
Individual-level Intervention	CDC (September, 1997). HIV Prevention Case Management. Literature Review and Current Practice, U.S. Department of Health and Human Services. CDC (1999). HIV/AIDS Prevention Research Synthesis Project, Compendium of HIV Prevention Interventions with Evidence of Effectiveness. Grinstead (1997). HIV counseling for behavior change, AIDS Education and Prevention, 9(2), 125-132. Sikema and Bissett (1997). Concepts, goals and techniques of counseling: review and implications for HIV counseling and testing, AIDS Education and Prevention, Supplement B, 14-26.
Group-level Intervention	CDC (1999). HIV/AIDS Prevention Research Synthesis Project, Compendium of HIV Prevention Interventions with Evidence of Effectiveness. Kalichman (1998). Preventing AIDS: A Source Book for Behavioral Interventions, Mahwah, NJ: Lawrence Erlbaum Associates. Chapter 5 "Small Group Interventions," 98-129.
Outreach	CDC (1999). HIV/AIDS Prevention Research Synthesis Project, Compendium of HIV Prevention Interventions with Evidence of Effectiveness. Kalichman (1998). Preventing AIDS: A Source Book for Behavioral Interventions, Mahwah, NJ: Lawrence Erlbaum Associates. Chapter 5 "Small Group Interventions," 98-129. Wright-DeAgueero, Gorsky, and Seeman (1996). Cost of outreach for HIV prevention among drug users and youth at risk, Drugs and Society, 9(1-2), 185-197.
Prevention Case Management	CDC (1999). HIV/AIDS Prevention Research Synthesis Project, Compendium of HIV Prevention Interventions with Evidence of Effectiveness. Kalichman (1998). Preventing AIDS: A Source Book for Behavioral Interventions, Mahway, NJ: Lawrence Erlbaum Associates.
Health Communication / Public Information	CDC (1999). HIV/AIDS Prevention Research Synthesis Project, Compendium of HIV Prevention Interventions with Evidence of Effectiveness. Ling, Franklin, Linsteadt, and Gearon (1992). Social marketing: its place in public health, Annual Review of Public Health, 13, 341-362. Maibach and Holtgrave (1995). Advances in public health communication, Annual Review of Public Health, 16, 219-238.

Step 2: Determine the Factors

The second step in the process was to determine the factors to consider when identifying the priority interventions. It was decided that the factors must be easy to identify, relevant to the interventions, and straightforward. The PI Committee reviewed the factors specified by the AED guidebook and reviewed factors chosen by other planning groups. It was decided to use a total of four key factors in an effort to simply the process.

Feasibility, as a factor, was difficult to define due to the multitude of definition possibilities. The committee finally decided to use only capacity, resources and norms/values as the necessary components of what is meant by feasibility. Each component had to be discussed to fully understand how feasibility impacted the priority setting process. The committee discussed using cost effectiveness as a factor, but determined that this factor was too complex and often lacking in information to be used adequately in this process. The final list of 4 factors included some that were based strictly in behavioral science theory and some that were considered more subjective. All of them, however, were deemed important to the process. Table 3 provides the list of factors with corresponding questions that were used to provide consistency to the discussion among committee members of each factor during the prioritization process.

Table 3. Factors for Priority Setting

Factor	Questions for Discussion
Targets a specific population	Is the intervention specifically designed to reach the target population?
Targets a specific behavior	Is the intervention specifically designed to change the target behavior by targeting knowledge, beliefs, attitudes, and factors that influence behaviors (FIB)?
Effectiveness	Is there enough evidence to show that the intervention is effective in averting or reducing HIV risk behaviors?
Feasibility (Includes Capacity, Resources and Norms/Values)	Capacity: Is the intervention practical, given available expertise, funding and implementation? Resources: Are other resources available to assist the delivery of the intervention? Norms/Values: Is the intervention acceptable to the target population?

Step 3: Weight the Factors

The third step of the process was to assign a weight to each factor. The weight indicates the importance of each factor in relation to each of the other factors. A numerical scale was chose, which used ratings of one, three, and five, with one being the least important and five being the most important. The HHPCPG's behavioral scientist focused on research and published reports, while other committee members focused on their expertise as it related to HIV prevention in the city of Houston. After intensive discussion and many debates, the PI Committee assigned a weight to each factor. Table 4 provides a discussion of each factor and its assigned weight.

Table 4. Factors and their Assigned Weight

Factor	Weights	Justification
Targets a specific population	3	This factor received a medium weighting since many of the chosen interventions can be modified to target specific populations with adequate planning and evaluation.
Targets a specific behavior that will change as a result of the intervention	5	This factor received one of the highest weights because the need to assure that a particular intervention results in changes in knowledge, attitude, beliefs and factors that influence behaviors (FIBs) is very important.
Effectiveness	5	The committee determined that effectiveness should be weighted very high since the purpose of implementing interventions should be based on if the intervention effectively changes risk behaviors.
Feasibility	3	This factor was considered important on a practical and anecdotal basis. However, due to lack of specific local scientific data, this factor was given a medium weighting in comparison to other factors.

Step 4: Rate Interventions Using Factors

The fourth step that the PI Committee undertook was the use of each factor as a measure to rate each intervention. This allowed the committee to compare the different interventions using the approved set of factors. Using the expertise of committee members and behavior scientists, the committee developed a scale, ranging from one to five, for each factor. The weighted factors were used to rate each of the interventions for each of the target populations.

Table 7 provides an explanation of each factor with its rating information, scale, and weight, as determined by the PI Committee.

Table 7. Factor Definitions in Relation to Weight and Rating Scale

Factor	Rating Information	Scale	Weight
Targets a specific population	Is the intervention specifically designed to reach the target population?	1: **NO** — the intervention was designed for another population or is not population specific. 3: **SOMEWHAT** — the intervention is designed to reach a similar target population. 5: **YES** — the intervention was designed specifically to reach this target population.	3
Targets a specific behavior that will change as a result of the intervention	Is the intervention specifically designed to change the target behavior by targeting knowledge, beliefs, attitudes, and factors that influence behaviors (FIB)?	1: **NO** — the intervention barely defines specific behaviors, attitudes and factors that influence behaviors. 3: **SOMEWHAT** — the intervention partially defines specific behaviors, attitudes, and factors that influence behaviors. 5: **YES** — the intervention clearly defines specific behaviors, attitudes, and factors that influence behaviors.	5
Effectiveness	Is there enough evidence to show that the intervention is effective in averting or reducing HIV risk behaviors?	1: **NO** — There is no theoretical or experimental support. 3: **SOMEWHAT** — There is some support. 5: **YES** — There is widespread support with published results.	5
Feasibility	**Capacity:** Is the intervention practical, given available expertise, funding and implementation?	1: **NO** — The capacity does not exist in Houston to implement the intervention. 3: **SOMEWHAT** — Limited capacity exists in Houston to implement the intervention. 5: **YES** — Abundant capacity exists in Houston to implement the intervention	
	Resources: Are other resources available to assist the delivery of the interventions?	1: **NO** — Other supporting activities do not exist to supplement and assist delivery of the intervention. 3: **SOMEWHAT** — Some supporting activities may or may not exist to supplement and assist delivery of the intervention. 5: **YES** — Numerous supporting activities exist to supplement and assist delivery of the intervention.	3
	Norms/Values: Is the intervention acceptable to the target population?	1: **NO** — The intervention is not acceptable to the target population. 3: **SOMEWHAT** — The intervention may or may not be acceptable to the target population. 5: **YES** — The intervention is definitely acceptable to the target population.	

Step 5: Score the Interventions Using the Weighted and Rated Factors

The PI committee determined the final score for each factor in relation to each intervention. This was accomplished by multiplying the factor's rating by it weight (rating x weight). The committee scored each intervention in relation to the specific target populations. The committee focused on the populations as defined by the Epidemiology Research Committee, which was responsible for prioritizing the at-risk populations.

Step 6: Rank the Interventions

The PI Committee added the scores together for each intervention to determine the overall ranking. The committee decided to use High, Medium and Low rankings as opposed to numeric rankings. It was decided to prioritize those interventions that were ranked as High.

The only variation to this process was for ranking interventions for the HIV+ population. During the ranking process, only Group-level interventions were ranked as High. Due to the importance of prevention with this population, the PI committee decided to add those interventions ranked as Medium to include Prevention Case Management and Individual-level intervention.

The results of the PI Committee's prioritizing efforts are presented in Table 8.

Table 8. Priority Interventions for 2002 through 2005

1. HIV + Persons
   - Group-level interventions
   - Prevention Case Management
   - Individual-level interventions

2. African American Men
   - Group-level interventions
   - Community-level interventions
   - PCPE
   - Individual-level interventions

2. African American MSM
   - Community-level interventions
   - Group-level interventions
   - PCPE
   - Individual-level interventions

3. African American Women
   - Community-level interventions
   - Group-level interventions
   - Prevention counseling / partner elicitation
   - Individual-level interventions

4. Caucasian MSM
   - Community-level interventions
   - Group-level interventions
   - PCPE
   - Individual-level interventions

5. African American Adolescents (ages 13-19)
   - Community-level interventions
   - Group-level interventions

6. Hispanic MSM
   - Community-level interventions
   - Group-level interventions
   - PCPE

7. African American Adolescents (ages 20-24)
   - Community-level interventions
   - Group-level interventions
   - PCPE
   - Individual-level interventions

8. Hispanic Women
   - Community-level interventions
   - Group-level interventions
   - PCPE
   - Outreach

9. Hispanic Adolescents (ages 20-24)
   - Group-level interventions
   - Community-level interventions
   - PCPE
   - Individual-level interventions

10. Hispanic Adolescents (ages 13-19)
    - Community-level intervention
    - Group-level interventions

11. Hispanic Men
    - Community-level interventions
    - Group-level interventions
    - PCPE
    - Outreach

NOTE: The PI Committee believes that incentives can be very useful when conducting prevention activities and feel incentives should be incorporated into the prevention efforts of the Houston area as needed.

Demonstrated Effectiveness and Behavioral Science Justification of HIV Prevention Interventions Prioritized by the HHPCPG

Maria Eugenia Fernández-Esquer, PHD

BACKGROUND / OBJECTIVES
We have reviewed the scientific literature with respect to effective and culturally appropriate interventions for HIV prevention in our targeted priority populations. There are significant gaps in knowledge with respect to scientifically tested interventions for Latino populations, including MSM, MSW, women and adolescents.

KEY FINDINGS
In general, the HHPCPG recommends using community-level interventions (CLI) with the exception of HIV-positive individuals. In this case, the HHPCPG recommends a combination of small-group interventions (GLI), prevention case management (PCM) and individual-level interventions (ILI).

KEY QUESTIONS
We are seeking evidence for the effectiveness of scientifically proven prevention interventions targeting Latino populations.

RECOMMENDATIONS / NEXT STEPS
In the absence of such scientifically verified interventions for Houston's large and culturally diverse Latino populations, the HHPCPG will focus on adapting effective CLIs for African-American MSM, MSW, women and adolescents to the various Latino populations in Houston. In many cases, it is not clear whether these interventions are effective in African-Americans because of a culturally appropriate focus or because they target African-American communities with low economic achievement.

Introduction

Changing risk behaviors that lead to HIV infection remains the most important strategy to prevent HIV/AIDS to date. Interventions work best when implemented as a combination of specific behavior change strategies that address the needs of a target population. The purpose of this report is to provide a summary of the main conclusions drawn from the review of research evidence that supports the interventions prioritized by the HIV Prevention and Interventions (PI) Committee. A full report providing detailed information about the theoretical justification, evidence of effectiveness and a full bibliography are included in the appendix.

It must be noted that intervention effectiveness is only one of the five criteria used by the PI Committee to rank interventions. As the narrative presented in appendix will indicate, the rankings of selected interventions and the findings of intervention effectiveness are generally in agreement. However, while the rankings are primarily based on what the PI Committee and the HHPCPG consider important local needs and necessary programmatic goals and objectives, effectiveness is based on scientific evidence presented in published articles and reports.

The information included in this report should be read as a companion document to the final report submitted by the PI Committee. However, it must be noted that this report follows a slightly different organization than the one followed by the PI Committee to present the rankings of interventions by selected target populations. This report is organized according to gender, ethnicity and sexual orientation/preference, since not all types of intervention have been conducted with each of the priority target populations selected by the Epidemiology Committee. Therefore, the information has been organized in the hope that what is available can be shared and compared across similar groups.

Table 1. The "Big Four" of Behavior Change

Theory	Purpose	Authors	Strengths	Weaknesses	Relevance To HIV Intervention	Prevention Activities
Health Belief Model (HBM)	Understand participation in disease prevention programs	Rosenstock Becker, Janz and colleagues	Provides cost/ benefit analysis of behavior change	Places too much emphasis on rational decisions and objective information	Good for creating "AIDS 101" messages	Addresses barriers and benefits of behavior change
Theory of Reasoned Action (TRA)	Relationship between what people say and what they do	Fishbein, Ajzen and colleagues	Looks at behavior controlled by a person and the specific conditions for behavior change	Does not consider social context or factors outside a person's awareness.	Understand attitudes toward condoms, etc. The importance of other people	Reinforce attitudes and beliefs Diffusion of social norms
Social Cognitive Theory (SCT)	How people adopt and maintain a specific behavior	Albert Bandura and colleagues	Methods for promoting behavior change Learn by watching others	Complex theory with many concepts.	Promotes the modeling of positive behavior and the use of incentives and rewards	Uses role model stories, skill building, behavioral rehearsal and peer leaders
Trans- theoretical Model (TTM)	Individual needs at different stages of change	Proshaska, Di Clemente and colleagues	Breaks down the process of behavior change into meaningful stages	Difficult to implement all concepts. Difficult to identify the reasons why people change	Tailor prevention activities to people with different levels of readiness	Relapse Prevention approach

Description and Background of Prioritized HIV Interventions

An intervention is an activity or group of activities designed and implemented for the purpose of influencing knowledge, attitudes, beliefs and behaviors that reduce an individual's risk for HIV. The following interventions have been defined and selected by the HHPCPG Prevention Interventions Committee. The narrative provided after the definition of each intervention is intended to provide a more extended description of goals and relevant background information.

a. **Prevention Counseling/Partner Elicitation (PCPE):** This client-centered HIV Prevention intervention involves single or multiple counseling sessions that can be clinic or community based. Counseling is combined with HIV risk reduction education centered on the HIV test. The client may or may not choose to be tested; if he or she chooses to complete the HIV test, counseling will occur before as well as after the test and will also include voluntary partner elicitation.

   HIV prevention counseling blends a client-centered counseling approach with risk-reduction education and testing procedures (Bor, Miller and Goldman, 1992; Green and McCreaner, 1989). PCPE needs to accomplish five tasks: relationship building, risk assessment, dissemination of information, behavior change and emotional and coping support. No single counseling approach meets all of these tasks, but behavioral and cognitive-behavioral counseling approaches are the most helpful in preventing HIV, while client-centered and crisis counseling are more appropriate for building a relationship with the client and to provide emotional and coping support (Sikkema & Bissett, 1997).

   According to CDC guidelines, client-centered counseling is conducted before the HIV test is done to establish the reasons for testing (including an individual's prior history of risky behaviors), provide basic information about testing procedures and HIV/AIDS and explain the implications of getting the HIV test. Post-test counseling focuses on communicating test results, assess the individual's response to the results, discuss its consequences and provide risk-reduction counseling tailored to the needs of the client (CDC, 1994).

b. **Prevention Case Management (PCM):** This intervention is a client-centered HIV prevention activity whose fundamental goal is promoting the adoption of risk-reduction behaviors by clients with multiple complex problems and risk-reduction needs. It is a hybrid that includes HIV risk-reduction counseling and traditional case management. It provides intensive ongoing and individual prevention counseling, support, and referral to services.

   PCM is the most recent addition to the types of interventions recommended by CDC. Multiple research and evaluation studies are currently testing its effectiveness.

c. **Individual-Level Intervention (ILI):** This intervention must involve client-centered health education, risk-reduction counseling, and skills-building activities that are provided to one individual at a time. ILI assists clients in making plans for individual behavior change with ongoing appraisals of their own behavior. ILI also facilitates linkages to other services that support behaviors and practices and prevent transmission of HIV. It is designed to help clients make plans to obtain these services. Condoms, bleach kits, and other educational materials must be distributed as part of an ILI. (It is recommended that 30 minutes, at a minimum, is an effective time frame for an ILI intervention.)

ILI was previously called Health Education and Risk Reduction (HERR) Individual-Level Counseling. The purpose of this intervention is to provide personalized, interactive, intensive and private intervention services to a single individual. It is based on a person's needs, resources, readiness to change and circumstances. ILI counseling blends traditional psychotherapy with public health education and it emphasizes delivery of information and adoption of teaching strategies for behavior change. ILI forms the basic approach for PCPE and PCM interventions.

d. **Group-Level Intervention (GLI):** This intervention must involve health education, risk-reduction counseling, and skills-building sessions that shift the delivery of services from the individual to groups of varying sizes. It uses peer and non-peer models involving a range of skills, such as safe-sex negotiation, condom use, education, and support. Ideally, group sessions have between three and fifteen participants and multiple sessions with the same participants are considered most effective.

GLI brings individuals together to learn about HIV/AIDS, discuss safer sex, and participate in educational activities. Small groups meet in community settings and vary in terms of goals, participants, and the characteristics of facilitators. The most important attribute of this intervention is its emphasis on collective experiences and on encouraging members to learn from each other (Kalichman, 1998).

e. **Outreach:** This intervention involves HIV/AIDS educational sessions that are usually provided by peer or paraprofessional educators. It is conducted face-to-face with high-risk individuals in the clients' neighborhoods or in other places where the clients congregate. The primary features of outreach include condom distribution and demonstration, distribution of bleach and sexual responsibility kits, educational materials, and referrals and linkages to services.

Outreach covers intervention programs defined by their location and the nature of prevention activities. They may involve the participation of peer and non-peer activity leaders. Outreach interventions take place in the community environment and target people who otherwise may not receive HIV prevention messages. Conducting community outreach interventions involves taking prevention activities to neighborhoods, streets, bars, or any other place where the target community gets together. The outreach itself does not have to be a standard form of intervention, but may include a variety of interventions that share a set of techniques and characteristics. Community outreach does not impose a formal structure of activities on the target population because it occurs on the client's own terms. It is based on the face-to-face contact between the outreach worker and community members. Some outreach interventions provide information, some provide counseling, and some provide both (Kalichman, 1998).

f. **Needle Exchange:** This intervention involves the exchange of used or dirty needles for the purpose of reducing the exposure to contaminated blood among injecting drug users who cannot or will not cease to inject. At this time, needle exchange is illegal in Texas, but in the event that the law changes, this intervention is highly recommended.

Needle exchange programs may be considered a special type of community outreach because they are typically implemented in the places where IDU's congregate.

g. **Community-Level Intervention (CLI):** This intervention is designed to target specific populations that are identified by shared risk behaviors for HIV infection. It can also be defined by race, ethnicity, gender, sexual orientation, and/or location. Its purpose is to provide health education to reduce risk behavior, increase skills building, and influence community norms. A CLI must include outreach and social marketing. It may also include aspects of other interventions, such as ILI and GLI, but any combination of these various interventions must be aimed explicitly at targeting the community as a whole.

Community-Level Interventions are designed to target specific geographic areas, neighborhoods or communities. They differ from street and community outreach in that they are designed to reach a defined community with the intention of modifying social norms, attitudes and beliefs that influence the community's risk behaviors. This type of intervention may involve components from other interventions (individual or small group counseling, etc.), which can be blended as part of a single prevention approach. The impact of this intervention on entire communities may have greater public health benefits for HIV prevention than the total number of individuals that may be reached through other face-to-face interventions.

h. **Health Communication /Public Information (HC/PI):** This intervention involves the delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences. The messages are designed to build

general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection on how to obtain specific services. Prevention messages must be based on the needs and input of the target audience.

HC/PI involves the use of large (TV, radio, newspapers) and small (pamphlets, brochures, handouts, etc.) media. It can be used to target a narrow segment of the population or to reach broad audiences within a city, state, or country. Activities vary by the size of the target group and the interactiveness of the medium being used. This intervention type is most effective among low risk individuals and it is useful to maintain and reinforce low risk behaviors (Holtgrave, Qualls, Curran, et al., 1995). It is also effective among those at high risk, when accompanied by more intensive face-to-face contact.

Intervention Effectiveness: Main Findings

The research evidence that supports the prioritized HIV prevention interventions is based on a review of published scientific articles cited in MEDLINE and PSYCHINFO. Although this review yielded more than 3,000 articles, a smaller number was selected and reviewed in more detail if they discussed specific results of an HIV prevention intervention for a specific target population. Reports focusing on interventions conducted with specific at-risk populations have been prepared and made available to the PI Committee and have been used during the latest process of prioritizing interventions conducted earlier this year. The following summary describes what we have learned over the last two years.

Table 2. Stages of Behavior Change

Stage	Description
1. Precontemplation	People are not yet aware of the need to change behavior
2. Contemplation	People are aware of a problem behavior, but they are not committed to change
3. Preparation	People plan and try different ways to change, but they are not yet fully committed to change.
4. Action	This is the stage for rehearsing new behaviors.
5. Maintenance	People continue to practice what they have learned without going back to their old habits.

A. HIV-Positive Persons

The PI committee assigned the highest priority to group-level (GLI), prevention case management (PCM) and individual-level (ILI) interventions for the HIV+ population. It must be noted that although the PI Committee considered issues of gender, ethnicity and sexual orientation during the process of prioritizing interventions for this group, these criteria were not specifically required. The literature on HIV prevention intervention trials conducted with HIV+ persons is sparse because the importance of delivering prevention interventions to HIV+ individuals was not recognized until a few years ago. This may be due to the belief that HIV-infected persons would not need encouragement to practice safer sex after learning their HIV+ status. Interventions are now being implemented, and published reports have begun to appear in the last couple of years. Some studies based on small group interventions report success in increasing the use of sexual barriers and reducing unprotected intercourse in HIV+ women and youth. It is also encouraging that at present there are multiple studies testing the effectiveness of PCM in adult and adolescent HIV+ populations. Unfortunately, the results are not yet available. Some of the available information indicates that client-centered approaches to PCM, especially when clients are able to have more contact with case managers, are beneficial to the client in a variety of important ways.

A.2. Priority Rankings

HIV+ persons (141)

Intervention	Score	Rank
Group	80	H
PCM	64	H
ILI	64	H
CLI	16	L
Outreach	16	L
HC/PI	28	L

In summary

- The effectiveness of PCM efforts is improved if they are (i) client centered; (ii) provide for more contact with case managers; (iii) provide for community-based as well as hospital case management.
- It is important not to let HIV+ people of color fall through the cracks.
- Five groups of HIV+ persons with special needs are (i) women; (ii) clients infected through heterosexual contact; (iii) clients with children living with them; (iii) those with inadequate housing; and (iv) clients with no high school diploma.

B. Men Who Have Sex with Men

Community (CLI), small group (GLI), and prevention counseling and partner elicitation (PCPE) were the interventions assigned the highest priority for African American, Hispanic, and Caucasian men who have sex with men (MSM). Individual-level Interventions (ILI) were highly prioritized only for African American and Caucasian MSM. Community

and small group-level interventions have been among the most successfully implemented with MSM to date. Effective strategies used as part of CLI or GLI when working with MSM populations include

- Promoting interpersonal skills,
- Focusing on younger populations, and
- Focusing on higher-risk populations.

Some of the most successful CLI/GLI interventions with MSM have been those implemented in gay bars. Naturally, bar interventions, and small group interventions that recruit primarily through the gay media and in the gay community tend to miss MSM who are less well-integrated into the gay community (for example, non-identifying/non-disclosing MSM). Most interventions report findings either for Caucasian MSM or for MSM populations whose ethnicity is not clearly described. Although few reports are available for African American and Hispanic MSM, the evidence that exists suggests that strategies successfully implemented with Caucasian MSM can be used with positive results with minority MSM as well. Thus, it is important to note that more interventions with African American and Hispanic/Latino MSM need to be conducted, evaluated and reported. Interventions designed for African American and Hispanic MSM need to be culturally appropriate.

B.2. Priority Rankings

B.2.1. African American MSM (127)

Intervention	Score	Rank
CLI	80	H
Group	80	H
ILI	70	H
PCPE	70	H
Outreach	60	M
HC/PI	60	M
PCM	32	L

B.2.2. Caucasian MSM (123)

Intervention	Score	Rank
CLI	80	H
Group	80	H
ILI	70	H
PCPE	70	H
Outreach	60	M
HC/PI	60	M
PCM	32	L

B.2.2. Hispanic MSM (103)

Intervention	Score	Rank
CLI	80	H
Group	70	H
PCPE	70	H
Outreach	60	M
ILI	60	M
HC/PI	60	M
PCM	32	L

B.3. Justification for the priority rankings.

Most reports of intervention findings are based on interventions implemented either on populations of predominantly Caucasian MSMs, or on general populations for which little or no information about ethnicity is given. Almost no studies report the results of interventions targeting exclusively (or predominantly) African American or Hispanic MSMs. For this reason, the findings for all MSMs are presented in a general discussion in the remainder of this section. Information pertaining to specific ethnic populations (African American, Caucasian, and Hispanic) will be explicitly indicated when it is available.

In summary

- The small-group HIV prevention intervention approach has probably been the most successful in producing behavior change among MSMs, particularly those who self-identify as gay and are well-integrated into the gay community.
- Some GLIs have been less effective with bisexual men than with gay men; different identities and issues may require distinct approaches.
- Group interventions promoting interpersonal skills have been among the most effective.
- Small-group interventions have been less successful in reaching non-identifying/non-disclosing MSMs. It's important to recruit in difference places, not just in specifically gay venues. As an alternative, outreach may be more effective with this population.
- Maintenance of positive risk-reduction behaviors decreases over time. Initial prevention efforts should be reinforced by the continued delivery of HIV prevention messages.
- HIV testing is beneficial for MSMs in that it helps them find out their serostatus. Testing positive has been associated with reductions in sexually risky behaviors.
- Testing accompanied by prevention counseling can be effective in reducing risky behaviors.
- However, a small percentage of MSMs seems to be using repeat testing as a monitoring strategy, without any impact on behavior change.
- Media campaigns can increase HIV testing, especially when explicit information is provided.
- To maximize testing among MSMs prompted by partner notification, it may be important to promote different notification methods (for example, personal notification by a former partner as well as notification by health workers).

C. African American and Hispanic Women (WSM).

Small group (GLI) and community-level (CLI) interventions received the highest rank for both African American and Hispanic women who have sex with men (WSM). PCPE was also highly ranked for both groups, while ILI interventions were recommended only for African American women and outreach was highly recommended only for Hispanic women. HIV prevention interventions that have a community or small group focus have had positive outcomes primarily with adult

African American women. There are far fewer reports of effective interventions conducted with Hispanic/Latina women. Effective interventions targeting these groups report improvements in AIDS knowledge and awareness of risk, increases in the use of both male and female condoms, decreases in the number of unprotected sex acts, and reports of more frequent conversations with male sex partners about AIDS and condoms. Programs that combine skills-building (particularly negotiation skills) with AIDS or health education approaches are more effective than programs that deliver only AIDS education information. A number of studies emphasize the importance of tailoring interventions to meet the needs of women from different ethnic groups. However, it is worth noting that most interventions reported for African American and Hispanic women have targeted poor, urban women, who are often either commercial sex workers and/or drug users. Thus, it may be hard to know whether the findings for these groups can really be replicated based on ethnicity, as opposed to poverty, class, and substance abuse.

C.2. Priority Rankings

African American Women (125)

Intervention	Score	Rank
Group	80	H
CLI	80	H
ILI	70	H
PCPE	70	H
Outreach	60	M
HC/PI	60	M
PCM	42	L

Hispanic Women (89)

Intervention	Score	Rank
CLI	80	H
Group	80	H
Outreach	70	H
PCPE	70	H
ILI	64	M
HC/PI	60	M
PCM	38	L

In summary

The preceding discussion reflects the observation that the HIV literature contains very few reports of relevant interventions targeting exclusively (or even predominantly) Hispanic women, as compared with the findings reported for African American women. It seems likely that some of the interventions that have proven effective with the latter population could be tailored to met the needs of Hispanic women. It is critical that effective interventions be implemented with Hispanic women: Russell et al (2000) notes that this group represents one of the fastest growing segments of the population to become infected with HIV in the US. Russell's literature review also concludes that interventions incorporating skills building and nurse counseling components have been effective in reducing high-risk behaviors in women, regardless of ethnicity. A second recent review (Mize et al 2002) evaluated the effectiveness of 24 HIV interventions targeting women of different ethnicities, including white, African American, and Hispanic. Their meta-analysis revealed that the interventions yielded positive effects for HIV/AIDS knowledge and risk reduction behaviors for all ethnicities examined at all follow up periods. Most of the information available for Hispanic, as well as African American women is drawn from interventions targeting homeless, drug-using women and commercial sex workers.

D. African American and Hispanic Men (MSW)

Small group and CLI interventions were ranked highest for both African American and Hispanic men. PCPE was also recommended for both groups, while ILI was recommended for African American men and outreach for Hispanic men. Overall, the research literature contains more reports of effective interventions delivered to African Americans, or to mixed African American and Hispanic population, than specifically to Hispanics/Latinos. Second, while reports of interventions directed to adult heterosexual women of various ethnicities are plentiful, the intervention literature for heterosexual men in general is particularly sparse. This gap is even more pronounced for Hispanic/Latino than for African American men. It is critical to design and implement interventions to reach heterosexual men: sexual risk reduction interventions with heterosexual women can be successful only up to a point, if their male partners are not motivated to adopt safer sexual practices. A reasonable approach for heterosexual Hispanic men might be to adapt interventions that have been successful with heterosexual African American men, taking care to ensure cultural appropriateness.

D.2. Priority Rankings

African American Men (127)

Intervention	Score	Rank
Group	80	H
CLI	80	H
ILI	70	H
PCPE	70	H
Outreach	60	M
HC/PI	60	M
PCM	32	L

Hispanic Men (82)

Intervention	Score	Rank
CLI	80	H
Group	80	H
Outreach	70	H
PCPE	70	H
ILI	64	M
PCM	38	L
HC/PI	34	L

In summary

- GLIs that include skills building components have been effective in changing behavior, as well as increasing knowledge, modifying beliefs and attitudes among African American and Hispanic men.

- GLIs that include AIDS education only have been effective in increasing knowledge and modifying beliefs and attitudes, but they do not change behavior.

E. Adolescents

The intervention types ranked highest were GLI and CLI for all targeted groups of adolescents, and PCPE and ILI were recommended for African American and Latino adolescents aged 20-24. The intervention approaches for which there is the most evidence for success with adolescents, including minority youth, of all ages are the community (CLI) and small group (GLI) intervention types. Effective community-level interventions have been implemented both in schools, and in non-school-based community settings. School-based CLI have had some success in promoting abstinence and condom use and in decreasing the number of sexual partners. A strength of school-based CLI (and group interventions as well) is that in addition to adolescents in the 13-18 age group, they can also target children and pre-adolescents younger than 13. This is vitally important, since a number of studies have found that some positive effects reported for interventions directed at youth (for example, abstinence deferral and maintenance) are strongest for youth who are not yet sexually active. Other findings suggest that targeting networks of friends may be a useful intervention strategy. It must be noted that one of the most effective school-based CLIs reported, Safer Choices, was implemented in Houston. Community interventions based in settings other than schools have had greater success in reaching runaway, homeless and drug using youth who may not be attending school, as well adolescents in the 19-24 age group who are too old for the school-based programs. Some of these CLI programs have also been successful in reducing high-risk sexual and drug-using behaviors. Older adolescents aged 20-24 can be (and often are) reached not only by interventions targeting this group specifically, but also by those targeting adults more generally. For minority adolescents, positive reports of interventions directed at African American adolescents are well documented: plenty of evidence indicates that African American youth can benefit from HIV prevention intervention activities, and also that care should be taken to make interventions directed at this group culturally and educationally appropriate. On the other hand, while some studies report having reached both African American and Hispanic adolescent populations, there are almost no reports of successful interventions for Hispanic adolescents as a separate group. However, the available evidence suggests that Hispanic adolescents can benefit from approaches that incorporate elements of interventions directed at other groups. However, as with African Americans, cultural differences must be taken into account.

In summary

- Community-level interventions have been somewhat successful in changing high risk sexual and drug use practices in youth populations.
- One of the most successful school-based programs, Safer Choices, was implemented in Houston, and should therefore be studied in detail so that it can be implemented again.
- Small group interventions have been quite successful in changing and/or delaying a variety high risk sex and drug use behaviors in African American and Hispanic youth populations, as well as in promoting the adoption of safer/more positive behaviors.
- Programs for youth are especially effective when directed to adolescents who are not yet sexually active.
- Programs combining the delivery of information and skills training are more effective than information-only interventions.
- Useful strategies that have been suggested include targeting networks of friends in GLIs, and using peer as well as adult educators.
- Programs directed to African American and Hispanic youth should be culturally tailored.
- PCPE interventions have been successful in increasing testing among youth in general, although little specific information for minority youth is available. (One PCPE study claims to have increased condom carrying for Hispanic boys.)
- Some studies have shown that testing and counseling don't necessarily change risky behavior.
- Who gets tested in youth populations seems to be influenced in apparently idiosyncratic ways by demographic factors and setting.
- High risk youth, youth with more information about AIDS, and youth with more positive coping styles may be more likely to get tested for HIV.
- ILIs have had some success with African Americans as a group, and for Hispanics and African Americans in particular, or as a category "minority".
- We have found no recent ILIs targeting Hispanics as a group.

Conclusions

Although HIV interventions continue to inform and guide efforts to prevent the spread of HIV/AIDS, there are important gaps in the types of interventions that have been implemented, evaluated and published. For example, we know that small groups work effectively for many different types of populations, but we still do not know why so few individual-level interventions are effective. There are also gaps in the at-risk populations that have been included in intervention studies and as a result, we know more about what works with some groups but not others. We are fortunate to know that there are interventions that have proven to be effective among African Americans, considering the impact of the HIV epidemic on this group. Some interventions have been applied in Houston, and others could be adapted to local circumstances. Successful interventions conducted with MSM in other parts of the country could be replicated locally, and more attention needs

to be placed on replication efforts. However, there is a noticeable silence in the research literature with regards to Hispanic/Latinos. Interventions that target, or even discuss, group-specific results for Latinos are rare and this striking fact is true across all intervention types. The void in Latino-based interventions not only affects priority-setting at the local level, but also in other places with large Latino communities. This is a need that must be addressed before the increasing rate in HIV infection in this group becomes unmanageable. Ideally, specific interventions should be available and applicable to specific populations, but when this is not possible, results of interventions that work with one group should be modified and evaluated in other groups. Greater efforts need to be made to share and use information across at-risk groups to make everyone safe from the HIV epidemic.

E.2. Priority Rankings

E.2.1. African American Adolescents

13-19 (104)			20-24 (100)		
Intervention	**Score**	**Rank**	**Intervention**	**Score**	**Rank**
CLI	80	H	CLI	80	H
Group	74	H	Group	80	H
ILI	68	M	PCPE	70	H
Outreach	60	M	ILI	70	H
HC/PI	60	M	Outreach	60	M
PCPE	48	L	HC/PI	60	M
PCM	26	L	PCM	32	L

E.2.2. Hispanic Adolescents

13-19 (85)			20-24 (100)		
Intervention	**Score**	**Rank**	**Intervention**	**Score**	**Rank**
CLI	80	H	Group	80	H
Group	74	H	CLI	70	H
ILI	58	M	ILI	70	H
Outreach	60	M	PCPE	70	H
PCPE	58	M	Outreach	60	M
HC/PI	54	M	HC/PI	36	L
PCM	26	L	PCM	32	L

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Examples of Successful UL HIV Prevention Imterventions

Project Name	Factors That Influence Behavior Change	Main Result
Community-level HIV Intervention in Five Cities: ... (AIDS Community Demos; CDC Comp 1-2, UTSW 7)	Increase HIV knowledge & how to reduce risk; change community norms; condom use skills.	More consistent condom use with nonprimary partners.
AIDS and the Transition to Illicit Drug Injection – Results of a Randomized Trial Prevention. (DesJarlais; CDC Comp 1-3)	Increase knowledge of HIV & HIV/IDU risks; reduce non-injected drug use; increase treatment seeking.	Intervention participants less likely to inject heroin.
15-month Follow-up of Women Methadone Patients Taught Skills to Reduce Heterosexual HIV Transmission. (El-Bassel; CDC Comp 1-4)	Increase HIV/AIDS knowledge, condom use skills, & communication/assertiveness/problem solving skills.	Increase in condom use.
Outcomes of Intensive AIDS Education for Male Adolescent Drug Users in Jail. (Magura; CDC Comp 1-5)	Increase health/HIV/AIDS drug use knowledge; increase access to services/treatment.	Increase in condom use after release; fewer high risk partners.
AIDS Education for Drug Abusers: Evaluation of Short-term Effectiveness. (McCusker; CDC Comp 1-6)	Increase HIV/AIDS knowledge; increase risk reduction skills; enhance self-efficacy for ability to initiate & maintain risk reducing behaviors for AIDS.	Decrease in drug-& sex-related risk behaviors.
Condom Skills Education & Sexually Transmitted Disease Reinfection. (Cohen; CDC Comp 1-7)	Increase condom use skills.	Decrease in new STDs w/in 12 months.
Group Counseling at STD Clinics to Promote Use of Condoms. (Cohen; CDC Comp 1-8)	Promote condom use by changing norms, expectations, & social skills.	Fewer STD reinfections for men. No change for women.
A Randomized Controlled Trial of an HIV Sexual Risk-reduction Intervention for Young African American Women. (The SISTA Project) DiClemente; CDC Comp 1-9, UTSW 29)	Self-efficacy; self-esteem; relationship development; interpersonal power dynamics; communication & negotiation skills; peer pressure; group norms; cultural norms; social support.	Increased reported consistent condom use with partners; decreased unprotected sex; negotiated condom use.
Reducing Inner-city Women's AIDS Risk Activities; A Study of Single, Pregnant Women. (Hobfoll; CDC Comp 1-10)	Increase communication/ assertiveness/ negotiation/specialized (cleaning drug works) skills to reduce risk for HIV.	Increase in condom use.
Efficacy of Risk-reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases: A Randomized Controlled Trial. (Project RESPECT; Kamb; CDC Comp 1-11)	Attitudes; group norms; intentions; self-efficacy; expected outcomes; perceived susceptibility.	Increased condom use in both interventions; reduced STDs; greater STD reduction among adolescents than adults.
The Effects of HIV/AIDS Intervention Groups for High-risk Women in Urban Clinics. (Kelly; CDC Comp 1-12)	Perceived susceptibility; self-efficacy; expected out-comes; intentions; communication & negotiation skills; cultural norms; group norms; peer pressure; social support.	Increase in condom use greater decrease in unprotected sex.
A Community-level HIV Prevention Intervention for Inner-city Women: Results of the Women & Infants Demonstration Trial. (The RAPP Project; Lauby; CDC Comp 1-13; UTSW 38)	Increase knowledge of HIV & available resources; modify attitudes/beliefs about HIV prevention and promote condom use by increasing knowledge of successful risk prevention strategies & reinforcing behavior change.	Greater increase in consistent condom use with nonprimary partners.
Reductions in STD Infections Subsequent to an STD Clinic Visit: Using Video-based Patient Education to Supplement Provider Inter-actions. (VOICES/VOCES; O'Donnell; CDC Comp 1-14; UTSW 46)	Self-efficacy; expected outcomes; attitudes; group norms; intentions; communication & negotiating skills; access to condoms.	Decrease in new STD infection.
Reduction of High-risk Sexual Behavior among Heterosexuals Undergoing HIV Antibody Testing: ... (Wenger; CDC Comp 1-15)	Increase HIV knowledge & awareness of risk; promote condom use; increase knowledge of personal HIV seroprevalence through testing.	Decrease in unprotected intercourse.

Continued on Following Page

Examples of Successful UL HIV Prevention Imterventions (continued)

Project Name	Factors That Influence Behavior Change	Main Result
The Mpowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men. (Kegeles; CDC Comp 1-16, UTSW 15)	Increase knowledge for HIV & promote/reinforce safer sex practices through peer outreach.	Decrease unprotected insertive/receptive anal sex.
Behavioral Intervention to Reduce AIDS Risk Activities (Kelly; CDC Comp 1-17)	AIDS risk reduction and behavioral self-management.	Decrease unprotected insertive/ receptive anal sex; increase condom use.
Popular Opinion Leaders – Community AIDS/HIV Risk Reduction: (Kelly; CDC Comp 1-18, UTSW 17)	Increase knowledge, increase effectiveness in communicating info.	Decrease unprotected insertive/ receptive anal sex.
AIDS Prevention in Homosexual & Bisexual Men: ... (Valdiserri; CDC Comp 1-19)	Increase knowledge, skills, & acceptability of safer sex.	Increase in condom use during insertive anal sex.
Reductions in HIV Risk-associated Sexual Behaviors among Black Male Adolescents: (Jemmott; CDC Comp 1-20)	Increase HIV/AIDS knowledge & condom use skills.	Increase in condom use; fewer sex partners.
Reducing the Risk; Impact of a New Curriculum on Sexual Risk-taking. (Kirby; CDC Comp 1-21)	Increase knowledge; increase social skills to reduce risk taking; increase ability to make decisions; increase ability to communicate; increase peer pressure resistance.	Delay sexual onset; decrease unprotected sex.
Preventing HIV Infection Among Adolescents: Evaluation of a School-based Education Program. (Main; CDC Comp 1-22)	Increase functional HIV/ AIDS knowledge and awareness of risk; increase skills to recognize, manage, avoid or leave risky situations.	Fewer sex partners, increased condom use.
Reductions in HIV Risk among Runaway Youth. (StreetSmart; Rotheram-Borus; CDC Comp 1-23; UTSW 58)	Perceived susceptibility; self-efficacy; expected outcomes; sexual arousal; drug-induced arousal; group norms; peer pressure; social support; communication & negotiation skills; environmental factors.	Decreased unprotected sex, decreased substance use.
A Randomized Controlled Effectiveness Trial of an AIDS Prevention Program for Low-income African American Youths. (Stanton; CDC Comp 1-24)	Increase HIV/AIDS knowledge.	Increased condom use.
Cognitive-Behavioral Intervention to Reduce African-American Adolescents' Risk for HIV Infection. (St. Lawrence; CDC Comp 1-25)	Increase HIV/AIDS knowledge, awareness of decision making & values, condom use skills, & communication/assertiveness skills.	Increased condom use; decreased unprotected sex; delayed sexual onset.
Turning Point (Siegal; UTSW 9)	Perceived susceptibility, perceived severity, perceived barriers, self-efficacy.	Increased reported safer needle use behaviors.
Brief Group Counseling in HIV Risk Reduction among Homo-sexual Asian & Pacific Islander Men. (Choi; UTSW 12)	Illusion of invulnerability; self-efficacy; self-esteem; shame & guilt; communication & negotiation; cultural norms about sexuality & gender roles; group norms; social support.	Reduction number of sex partners, reduced unprotected anal sex, increased condom use during anal sex.
HIV Risk Reduction Intervention among African-American Homosexual & Bisexual Men. (Peterson; UTSW 19)	Self-efficacy; self-esteem; intentions; self-standards/ self-identity; shame & guilt; communication & negotiation; cultural norms about sexuality & gender roles; group norms; social support.	Reduced unprotected anal sex, increased condom use during anal sex; increased likelihood of HIV testing.
STD & HIV Risk in Heterosexual Adults Attending a Public STD Clinic: ... (Boyer; UTSW 23)	Perceived susceptibility; self-efficacy; intentions; communication & negotiation skills; cultural norms; expected outcomes; social support; relationship development.	Men reported increased condom use & fewer sex partners without condom use.

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Examples of Successful UL HIV Prevention Imterventions (continued)

Project Name	Factors That Influence Behavior Change	Main Result
Enhancing Motivation to Reduce the Risk of HIV Infection for Economically Disadvantaged Urban Women. (Carey; UTSW 26)	Perceived susceptibility; self-efficacy; intentions; communication & negotiation skills; substance use; group norms; cultural norms; social support; sense of community; expected outcomes.	Increased knowledge & risk awareness; strengthened behavioral intentions; communicated with partners; reduced substance use prior to sex; reduced unprotected sex.
Culturally Tailored HIV/AIDS Risk-Reduction Messages Targeted to African-American Urban Women:...(Kalichman; UTSW 31)	Perceived susceptibility; access to condoms; peer pressure; group norms; cultural norms; substance abuse; self-esteem; sense of community.	Increased awareness of personal risk; more likely to report behaviors consistent with perceived threat, reques condoms, talk with friends about AIDS, get tested for HIV, react to HIV video with concern.
Context Framing to Enhance HIV-Antibody Testing Messages Targeted to African-American Women. (Kalichman; UTSW 33)	Perceived susceptibility; perceived severity; peer pressure; substance use; intentions; group norms; cultural norms.	Increased HIV testing.
Nosotras Viviremos (Munoz-Lopez; UTSW 41)	Self-efficacy; self-esteem; expected outcomes; perceived susceptibility; social support; cultural norms about sexuality & gender roles; communication & negotiation skills; interpersonal power dynamics; environmental barriers or facilitators.	No info
Project LIGHT (UTSW 43)	Perceived susceptibility; self-efficacy; intentions; expected outcomes; communication & negotiation skills; relationship development.	Reduced unprotected intercourse; increased condom use & % reporting condom use or abstinence; fewer reported STD symptoms especially for males; fewer diagnosed STDs for population.
A Randomized, Controlled Trial of a Behavioral Intervention to Prevent Sexually Transmitted Disease Among Minority Women (Shain; UTSW 48)	Perceived susceptibility; perceived severity; self-efficacy; self-esteem; intentions; expected outcomes; communication & negotiation skills; cultural norms about sexuality & gender roles; interpersonal power dynamics; peer pressure; social support.	Decreased chlamydia & gonorrhea infections.
AIDS Risk Reduction Education & Skills Training (ARREST) Program. (Kipke; UTSW 52)	Illusion of invulnerability; self-efficacy; communication & negotiation skills; relationship development.	Increased awareness of risk & risk reduction skills; modified AIDS attitudes.
Cognitive & Behavioral Adaptations to HIV/AIDS among Gay & Bisexual Adolescents (Remafedi; UTSW 54)	Perceived susceptibility; self-efficacy; expected outcomes; social norms; peer pressure; social support; communication& negotiation skills; relationship development; substance abuse.	Decreased unprotected anal sex & substance abuse; increased more frequent condom use.
Efficacy of a Preventive intervention for Youths Living with HIV (Teens linked to Care: “Stay Healthy” & “Act Safe”). (Rotheram-Borus; UTSW 56)	Self-efficacy; substance abuse; communication & negotiation skills; positive & negative moods.	“Say Healthy” – increased social support coping styles for males and females; “Act Safe” – reduced unprotected sex & number. HIV – sex partners & substance use.
Factors Mediating Changes in Sexual HIV Risk Behaviors among Gay & Bisexual Male Adolescents. (Rotheram-Borus; UTSW 61)	HIV knowledge; self-efficacy; expected outcomes; communication & negotiation skills; peer pressure; group norms.	Reported 60% increase in protected sex acts; reduced unprotected sex 7 number of partners; long-term (at 1 year) benefits for AA but not H participants.
Comparison of Education vs. Behavioral Skills Training Interventions in Lowering Sexual HIV-Risk Behavior of Substance-dependent Adolescents. (St. Lawrence; UTSW 64)	Perceived susceptibility; attitudes; intentions; self-efficacy; expected outcomes; interpersonal dynamics;substance abuse.	Increased awareness of risk, positive attitudes toward condoms/prevention, self-efficacy, & interpersonal skills; decreased risk behaviors & STDs.

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Examples of Successful UL HIV Prevention Imterventions (continued)

Project Name	Factors That Influence Behavior Change	Main Result
Brief Behavioral Skills Intervention to Prevent HIV Infection among Chronic Mentally Ill Adults. (Kalichman; UTSW 68)	Mental illness; relationship development; social support; drug use/ addiction;interpersonal power dynamics (coercion,sex for drugs); environ-mental barriers/facilitators; social inequalities.	Increased knowledge/awareness of risk, behavioral intentions & condom use; reduced unprotected sex.
Effects of AIDS Counseling & Risk reduction Training on the Chronic Mentally Ill. (Katz; UTSW 71)	Perceived susceptibility; knowledge; self-efficacy; sexual arousal; communication & negotiation skills; mental illness.	Increased HIV/AIDS knowledge, confidence to deal with risky situations, & ability to recognize/cope with these situations.
Sex, Games & Videotape (SexG):... (Valencia et al 1996; UTSW 73)	Mental illness; sexual arousal; communication & negotiation.	Some reduction in unprotected intercourse & risk behaviors, increased condom use.
Assertiveness Skills Development for Women with Severe & Persistent Mental Illness. (Weinhardt; UTSW 75)	Intentions; interpersonal dynamics; self-efficacy.	Increased HIV knowledge, assertiveness skills, & condom use.
HIV Risk reduction for Seriously Mentally Ill Individuals. (Weinhardt; UTSW 78)	Perceived susceptibility; perceived severity; problem hierarchy; intentions; self-efficacy; mental illness; substance use; communication & negotiation; knowledge.	Increased HIV knowledge, condom use efficacy, communication skills; reduced risky behaviors.
Reducing Post-release HIV Risk among Male Prison Inmates. (Grinstead; UTSW 82)	Perceived susceptibility; access to clean works; group norms; substance abuse; intentions.	Increased condom use; reduced drug use & needle sharing.
Intervention Can Help Reduce Risky Sexual Behavior (Anon, AIDS Alert 1998).		Significantly less reported unprotected sex & increased condom use after 1 year.
Persuasive Communication about AIDS Prevention: Need for Cognition Determines the Impact of Message Format. (Bakker 1999)	Need for cognition (NFC); attitudes; group norms; social support.	Cartoon effective in modifying attitudes & subjective norms for low-NFC group; written message more effective for hi-NFC group.
A Randomized Clinical Trial of Three Intervention Models' Effectiveness in Lowering STD/HIV Risk of Substance-Dependent Adolescents. (St. Lawrence et al, 1998)	Substance abuse; knowledge; attitudes; self-efficacy; perceived susceptibility; social skills; problem-solving skills.	Substantial changes in knowledge, attitudes, & risk behavior for youth receiving all 3 inter-ventions tested in study, with greater skills acquisition for the interventions incorporating the cognitive-behavioral risk reduction intervention.
Evaluation of a Condom Campaign for Sexually Active Adolescents. (Campsmith et al 1996; Dawson et al 1996)	Access to condoms; attitudes; effect of sub-stance use on decision making.	Increase in consistent condom use.
Stages of Women's Condom Use. (Rivera et al 1994)	Self-efficacy; expected outcomes;	Increased condom use.
Effects of a Skill-based Intervention to Encourage Condom Use among High Risk Heterosexually Active Adolescents. (Gilmore et al 1997)	Communication & negotiation skills; knowledge	Few differences among conditions despite presence of elements defined as essential.

Behavioral Surveillance of STDs/HIV in Houston

Michael W. Ross, MA PHD MPH MHPED DIPTERTED DIPSTD

OBJECTIVE / SUMMARY
Behavioral surveillance is a critical component of an effective HIV/STD prevention program. While some attempts at behavioral surveillance are ongoing in Houston, several changes are recommended that would increase the effectiveness of these programs at a very modest cost.

KEY FINDING
Recent examples of emerging STD outbreaks have been significantly impacted by behavioral surveillance methodologies.

KEY QUESTIONS
Given limited resources, where and how should behavioral surveillance be incorporated in Houston to generate maximum short-term impact?

RECOMMENDATIONS
Implement limited pilot programs to test effectiveness of statistical surveillance in populations at highest risk for new STD/HIV outbreaks.

Behavioral surveillance of sexually transmissible infections (STDs) is becoming a routine part of epidemiological surveillance. The Centers for Disease Control and Prevention (CDC) has set as one of its goals the elimination of syphilis, and has noted that detection, surveillance data review, hypothesis generation, intervention development, along with service evaluation, are key elements in outbreak assessment (Finelli et al., 2001). Behavioral surveillance and assessment is key to all these.

Behavioral surveillance plays a key part in understanding trends in STDs in several different ways. First, broad demographic information such as age, race/ethnicity, and gender provide only a very broad picture of STD trends and almost completely fail to capture cultural (including subcultural) behaviors, including sexual practices that may lead to increases or decreases in particular STDs.

Second, the purpose of surveillance is to understand the behavioral basis for observed STD trends, including outbreaks. An understanding of the behaviors that are associated with a particular STD trend will allow for more effective interventions that target individuals engaging in high-risk behaviors. For example, higher rates of STDs among African Americans in the US remained unexplained until Laumann and Youm's (1999) work that described mixing patterns and STDs in samples of different races and ethnicities. They found that social networks among African Americans support substantial sexual mixing of people from "core" groups with people from groups with lower (medium or peripheral) STD rates. This behavior contrasts with Caucasian or Hispanic groups where high-risk and low-risk groups were more likely to segregate sexually. Thus, behavioral (in this case social network) data are able to provide an explanation for observed epidemiological trends. While new interventions need to be preceded by careful field work, and particularly an understanding of the context of the behavior, behavioral surveillance can provide the intelligence on which design of new prevention interventions is based.

Third, behavioral surveillance data are important in providing early information on the nature and context of outbreaks. This has become apparent in the last couple of decades, with the infectious nature of HIV being determined largely by its association with a specific sexual orientation, and particularly with the practice of anal intercourse. Recently, an outbreak of syphilis among gay men in California was, based on behavioral data, traced to the use of the Internet as a new meeting place and a new intervention based on the Internet was implemented (Klausner et al., 2000). These examples demonstrate the importance of behavioral surveillance in responding rapidly to outbreaks.

Fourth, behavioral data are critical in understanding the role of place in outbreaks. Interventions in epidemiology generally pay considerable attention to place in order to pinpoint the source of outbreaks. In STD management, the place of contact often does not coincide with the site of outbreaks, although brothels, public sex environments, erotic oases, or bathhouses generally receive a high level of attention. Place of contact is also a behavioral variable that will often impact the form of the behavior possible in that setting. For example, anecdotal evidence has suggested that sexual behavior in cars has changed as a function of changes in car design. The elimination of the large car with a bench front seat in favor of the smaller vehicle with bucket seats and a transmission hump has reportedly lead to a change in sexual behavior in cars. The changed layout has made peno-vaginal sex less accessible and oral sex more likely. McCoy and Inciardi (1995) note that oral sex in cars is sufficiently common in connection with sex for drugs transactions around crack houses in the US that women who cater to men at such locales are known as "chickenheads" because of the appearance of the woman's head through the car window.

Fifth, behavioral surveillance can also provide an indication of the broader economic context of STD increases. For example, Baseman et al. (1999) describe the transactions of sex for drugs and drugs for sex, and indicate that in some of the most disadvantaged sectors of the community, sex and drugs are one of the most important aspects of an underground economy in the relative absence of employment. The fact that sex and drugs are an important medium of exchange is based on behavioral data that describe transactions for sex (money, drugs, food, shelter).

Behavioral data also have their limitations in understanding the transmission of STDs. A general review of the literature suggests that the following factors tend to decrease the accuracy and usefulness of behavioral surveillance data:

1. Time intervals between actual infection and appearance of symptoms
2. High prevalence of "silent" infection
3. Answers about specific sexual behaviors occurring more than 3 months in the past obtained without the use of a "sexual diary".

Classes of Behavioral Data

The definition of behavioral data used here is that it does not involve demographic variables (age, gender, race/ethnicity, income, residence location, sexual orientation) and is potentially modifiable with appropriate interventions. The major classes of behavioral data with regard to STDs are sexual, drug-related, social, and transactional / situational.

Sexual Behavior Data

Critical data related to sexual behaviors includes 1) Specific nature of sexual contact, including frequency and type of barrier use; 2) Frequency of sexual encounters and number of concurrent sexual partners; 3) Type of partner; 4) Biological context data.

1. **Specific nature of sexual contact.** The main sexual behaviors of interest address the potential sites of infection: penile, oral, vaginal, or anal and whether contact is insertive or receptive. Questions related to sexual contact details are best asked regarding a short period of time, usually over the past month or three months. The questions should be asked in the form of "check all that apply" since in the one sexual encounter, a series of acts can occur or reoccur. Condom or other barrier use should also be noted – the simplest process is to use a 5-point scale such as "never, less than half the time, about half the time, more than half the time, always". Where completeness is required, the act during which ejaculation took place (if it occurred) as well as the gender of partners should also be noted. It is important that a category for transgender individuals also be supplied rather than making the assumption that all partners are unequivocally male or female. Receptive anal intercourse is more highly associated with HIV infection than insertive anal intercourse, and women are at higher risk of HIV infection per sexual act than men via vaginal sex. The risk of infection from oral sex is an order of magnitude lower than from vaginal or anal sex, although the data are sparse. A recent review (Scully & Porter, 2000) suggests that the risk of HIV transmission from oro-genital sexual practices is substantially lower than from peno-vaginal or peno-anal intercourse and that exposure to saliva presents a considerably lower risk than exposure to semen. Oral trauma and ulcerative conditions may increase the risk of HIV transmission.

2. **Frequency of sexual encounters and number of concurrent sexual partners**. Frequency of sexual behavior and number of concurrent partners are critical variables that must be included. In order to have some common reference point, it is appropriate to use one month or three months as the unit of time to measure both frequency of encounters and number of partners. Multiple partners have figured frequently in predictors of STDs and the association needs little explanation. For both juveniles (Oh et al., 1994) and college students (Joffe et al., 1992) numbers of lifetime sexual partners are among the strongest predictors of STDs. In Swedish women, number of lifetime sexual partners was the main predictor of oncogenic HPV (Silins et al., 2000). For HSV-2, Newton & Kuder (2000) found that non-monogamous interval and partner change rate were the best predictors of infection. In African American females, DiClemente et al. (2002) found a combination of inconsistent or absent condom use, sex while drinking alcohol, and multiple partners predicted STD infection. Unsafe sex with an untreated partner, lack of mutual monogamy, rapid partner turnover, and douching were all significant multivariate predictors of STD infection in women in an intervention study (Shain et al., 2002). Douching was also found as a predictor of PID in women by Miller et al. (1999), along with number of lifetime sexual partners and age of coitarche. In a study of syphilis in four research centers in the US, Koumans et al. (2001) found that a third of persons with syphilis reported two or more partners in the past month, and that 8% received money or drugs for sex in the past three months. Koumans et al. found that having concurrent partners (two or more in one week over the last month) was independently associated with being a transmitter, indicating that concurrency is an important behavioral variable to monitor.

3. **Type of sexual partner(s).** The type of partner with whom sexual encounters occur has frequently been implicated in STD rates: Rosenberg et al. (1999) found that association contact with a "core" transmitter (a small percentage of high-risk persons centrally placed in a larger group with moderately risky behavior) maintains syphilis transmission. Sometimes, members of this "core group" may be commercial sex workers and their regular partners: in a Thai study,

Nopkesorn et al. (1998) found that sex with female sex-workers and alcohol use were associated with HIV seroconversion in military conscripts. For women, sexual coercion and earlier coitarche were demonstrated to be associated with biological markers for STDs in a Peruvian study, as was drugs or alcohol being associated with sex, and having paid or being paid for sex (Caceres et al, 1997). The context of sex (paid) and specific sexual practices rather than sexual identity as such were also associated with syphilis and HIV infection in men who have sex with men in the Dominican Republic (Tabet et al., 1996). This, along with the findings of Ross et al. (2003) in Houston in four racial/ethnic groups that sexual identity was frequently not concordant with sexual behavior, confirms the primacy of behavior over identity in predicting risk and subsequent STD infection.

4. **Biological context data.** Biological considerations may also impact STD transmission, and these may include circumcision status of the index case or partner where relevant, sex during menstruation or bleeding during sex, pregnancy and douching behavior.

Drug-use behavior

Drug use in conjunction with a sexual act can significantly impact the risk level as well as have a biological impact on the likelihood for transmission of disease.

For example, crack (smokeable freebase) cocaine can cause lesions on the lips and oral mucosa from burns from the crack pipe, as well as having an impact on the replication of HIV. Thus determining the drugs which the respondent was under the influence of during sexual acts is also important. Again, where a specific act is not in question, the 5-point scale used for sexual behavior is useful, with the same proviso that all those relevant over the time period may be checked. The drug and alcohol link has proved to be a strong one with STDs, and particularly so with crack cocaine (Ross & Williams, 2002). In Houston, Ross et al. (1999), Hwang et al. (2000) and Ross et al. (2002) have reported high rates of STDs in crack-house populations, in drug users in drug treatment programs, and higher levels of oral sex among crack-using women. Ellen et al. (1996) found in San Francisco that men who were high on drugs (including crack cocaine) before or during sex were more likely to be diagnosed with syphilis. For males with gonorrhea, having sex with a crack user, among other variables, was also a significant predictor. Similarly, Cleghorn et al. (1995) found that use of crack was a predictor of STD infection in STD clinic attenders in Trinidad. Alcohol use has also been consistently associated with STDs: Zenilman et al. (1994) found that frequent drinkers were more likely to have had >2 sex partners in the past month and to have used crack, cocaine or injected drugs. They concluded that alcohol use is associated with a number of other risk variables for STDs including HIV. Marijuana has also been implicated: Liau et al. (2002) found that in adolescent African American females, marijuana was a significant predictor of gonorrhea and Chlamydia along with lack of condom use. The close associations of drug use, drug users, and sexual behavior is reviewed by Ross and Williams (2002).

Social behavior

Social behavior refers to the networks of the respondent, including the nature of the transactions involved.

This is important because the index case may not be at any other risk and under the perception that they are in a mutually monogamous relationship. Thus it is the risks one step removed – of the partner – that may be relevant. Thus, the relationship of the partner to the index case needs to be determined, for example regular or casual partner, along with the presence and nature of any transaction such as for money, drugs, shelter or food, or through force (sexual assault), and the direction of the transaction. Williams et al. (2001) have reported that it is actually the emotional closeness of the partner, rather than any classification of partner type, that is the determinant of condom use. They note that after between 3 and 4 sexual encounters, condom use declines markedly, and that the single item of closeness to the partner is probably the best predictor of risk level. Finally, partner age is an important variable to include, since older partners have been implicated in higher STD rates in younger women.

Transactional / Situational variable

The importance of situational and contextual variables has been emphasized by Ross and Ferreira-Pinto (2000) and the concept of risk situation developed by Ross and Kelly (2000). A risk situation refers to the context of the sexual behavior – where it took place geographically, the nature of the place (bar, hotel/motel, car, park, bedroom at index case's place, bathhouse, brothel) and the time of day. Leonard and Ross (1997) noted that the temporal and geographical distribution of sexual activities provided useful clues as to where and when intervention activities could be mounted. With geographical mapping software now commonly available, such data are important for determining risk locations rather than residence locations, and planning services accordingly. Zenilman et al. (1999) geomapped sexual partnerships in Baltimore for gonorrhea cases and found that they were likely to live significantly closer to each other than would be expected by chance. Situational variables are particularly important in locating targeted interventions that are suggested by the other behavioral data.

Existing behavioral surveillance data in Houston

The main records used in Houston by the Department of Health and Human Services are CDC-based forms: the CDC Interview Record CDC 73.54, 8/91, and the HIV Counseling and Testing Report Form 6543. Although the STD clinic medical records and the HIV counseling and testing databases also contain behavioral information, it is of a rudimentary form and not of much use for detailed analyses. The two main behavioral surveillance forms are dealt with in turn.

The 73.54 Interview Record

This record has been used for the past decade and is essentially a record of the DIS interview with a diagnosed case of a notifiable STD. The behavioral surveillance section is relatively truncated and seeks to ascertain, since 1978 (a date based on the first arrival of HIV in the United States) a series of "risk categories" for HIV: sex with a male, sex with a female, used IV drugs, hemophilia. The behavioral section goes on to ascertain "known heterosexual relations" with high-risk individuals, including: IVDU, bisexual male, person with hemophilia, HIV positive transfusion recipient, person with AIDS of HIV risk unknown, person born in Pattern 2 country, received blood transfusion, worked in health care setting, sex for drugs/money. The response format for initial and final interviews is yes/no.

This is behavioral surveillance at its most rudimentary, and it seeks to establish categories of risk based on HIV rather than other STDs. Indeed, the relevance of these questions to other STDs is unclear. The questions suffer from two major problems. First, they are too broad (for example, "sex with a female?" [since 1978]) and therefore relatively useless in differentiating risk categories. Second, the response option (yes/no) provides little variance and reduces the ability to discriminate most behavioral differences between infected and uninfected individuals. As a result, detecting a change in rates or an outbreak would be difficult. It is arguable that the only categories relevant to STDs other than HIV are sex with a male, sex with a female, used IV drugs, and known heterosexual relations with an IVDU or bisexual male. If these question are asked of a male, it is difficult to know if any MSM sex over the past 24 years was safe or unsafe. For the purposes of behavioral surveillance, it is difficult to find any information in this form that might be considered useful.

The HIV Counseling and Testing Report Form 6543

This form is more useful than the CDC 73.54 form in its behavioral categories, but suffers from some of the same problems, notably its focus on HIV (not surprising since it is an HIV report form!). It does, however, ascertain for sex with a male and sex with a female the three sites (oral, anal [receptive, insertive], vaginal) as well as drug use accompanying sex (heroin/opiates, cocaine/crack, alcohol, marijuana, inhalants, amphetamines/speed, other). For blood-borne HIV transmission, questions are asked in relation to injecting drug use, IDU/sharing equipment, other needle exposure, occupational exposure, blood transfusion, other blood exposure, and no known risk.

Other important factors asked include sold sex (for drugs or money), paid for sex (for drugs or money), forced sex, STDs, homeless, migrant, incarcerated, multiple partners and risk factors of partners.

Table: Behavioral Data Appropriate for STD Surveillance

Sexual behavior	Scale	In Form 6543
Anal Insertive	5-point Likert	Y
Anal receptive	5-point Likert	Y
Oral Insertive	5-point Likert	
Oral receptive	5-point Likert	
Vaginal	5-point Likert	Y
Condom use for each of above	5-point Likert	Partial
Number of partners	Continuous	Y
Concurrency of partners	Continuous	
Drug behavior		
Heroin/Opiates	5-point Likert	Y
Cocaine	5-point Likert	Partial
Crack	5-point Likert	Partial
Alcohol	5-point Likert	Y
Marijuana	5-point Likert	Y
Inhalants	5-point Likert	Y
Amphetamines/Speed	5-point Likert	Y
Club/Party Drugs	5-point Likert	
Other	5-point Likert	Y
Inject with used equipment	Binary	Y
Social behavior		
Sold sex (drugs, money, shelter)	5-point Likert	Y
Paid for sex (drugs, money, shelter)	5-point Likert	Y
Forced sex	5-point Likert	Y
Previous STDs	Continuous	Y
No. of sexual partners contactable	Continuous	
Age of partner	Continuous	
Situational Variables		
Last encounter* – time	Continuous	
Last encounter*– place	Ordinal	
Last encounter* – Zip code	Ordinal	
Residence – Zip code	Ordinal	
Biological – Behavioral		
Circumcision status	Binary	
Menstruation or bleeding	Binary	
Douching	5-point Likert	

*Or encounter leading to infection

Note that the form of scaling may alter depending on the time frame used. Time frame will to some extent depend on the target group: for example, with commercial sex workers, it may be shorter.

Future directions and recommendations

It is recommended that more detailed behavioral data are collected in the future. However, as previously noted, this must be balanced by staffing, clinical and funding realities as well. Further, it is now the case that a significant amount of data that are required to be collected by federal and state agencies are currently collected on state and federal forms for aggregation and reporting on a larger scale. Thus, a single jurisdiction cannot realistically re-tool all its questionnaires. A number of possible solutions are suggested to this issue.

First, the major federal institution involved with STD epidemiology, the CDC, could be encouraged to convene a national group of experts to determine how best to enhance behavioral surveillance. This has recently been done with the HIV risk information collected by the Surveillance Branch of the Division of HIV/AIDS Prevention of the CDC. Dialog with the CDC could reasonably promote a national approach rather than a city-level approach to the problem. Realistically, the action of cities such as Houston will be guided by the forms required by CDC and other federal and state bodies and it makes little sense to approach changes in isolation.

Second, routine collection of behavioral data would require a modest expansion of current epidemiological and clinical staff positions. For example, in Houston in 2001 for gonorrhea alone there were reports of 5,435 cases (2,821 males and 2,614 females). In order to obtain good behavioral surveillance data, a truly random selection of every fifth or tenth case for expanded behavioral surveillance would suffice to provide sufficient power to test hypotheses and determine broad behavioral trends. This would minimize the staff resources needed to obtain good behavioral data and yet ensure the collection of a sample with sufficient power to test a number of hypotheses. If investigations of subgroups, for example MSMs or particular racial/ethnic groups, was anticipated, then a one in five figure would provide sufficient power. The sample size and power would depend on the number of sub-analyses anticipated.

Third, an expanded behavioral surveillance system could be piloted as a demonstration project for a particular STD to ascertain the additional resources needed to set it and maintain this activity. Such a demonstration project might reasonably be set up with set-aside state or federal funds for a one-year trial period with additional staff, and subject to a process evaluation to determine its effectiveness, as well as any additional costs involved.

Finally, serious thought should be given to establishing a data collection system based on CAPI (computer assisted interviewing) in which the interview is presented to the case on a terminal and the cases themselves enter the data into the questionnaire. This system has several advantages:

- The approach does not tie up interviewer time
- Computer-entered data do not need to be re-entered, with a consequent saving of data entry personnel having to check and clean the data.
- The questionnaire on screen provides the range of possible values for each question, ensuring that out-of-range values are not accepted, and an answer in the appropriate range is then prompted for.
- Skip patterns are automatically entered.
- The system prompts for answers, and will not proceed until an answer is given, thus avoiding missing data.
- For sexual data, Turner et al. (1998) have shown that there is an order of magnitude of greater accuracy for sensitive questions such as those on sexual behavior and drug use.
- For respondents with low literacy levels, the questions could be posed both visually and through computer generated speech.
- There are a number of easily programmed data collection systems available from major US commercial companies such as Nova and SPSS.
- The cost of computer equipment and stations has significantly decreased and the storage space and processing speeds on computer equipment has significantly increased. A single tower with several workstations is a cheap and efficient way to collect data in a clinical setting.
- Given waiting room times, and that fact that computer data collection systems are sufficiently like computer games and popular with clients, they are popular with clients.
- There is a large body of emerging literature on computer-assisted data collection that supports its efficacy for the collection of sensitive behavioral data.

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The Quality Assurance Committee

FISCAL YEAR 2004 PLAN

The primary objectives for the Quality Assurance Committee are:

- To monitor the implementation of the HIV prevention plan
- To assess plan revisions and progress in meeting goals and objectives developed each year
- To develop new objectives for the HHPCPG and the HIV prevention providers in Houston and
- To guide and monitor the work conducted by consultants employed to conduct evaluation of the HDHHS Bureau of HIV/STD Prevention and the HIV prevention providers.

Activities for the majority of the year by the Quality Assurance Committee consisted of examining the monthly blind subcontractor outcome reports indicating units of service delivered, which is used for billing by the Houston Department of Health and Human Services (HDHHS). This information was made available by the city and the committee used it to monitor overall service delivery in respect to the objectives in the plan. Additionally, much dialogue continued within the committee about the parameters of the committee's charge to monitor the plan, the objectives, resource utilization and the community-planning group itself. The Quality Assurance Committee continues to wrestle with developing a finite description of 'what we do' and 'how much we are empowered to do it'. One of the highlights coming towards the end of the year was the announcement of a subcontractor, SUMA, beginning to put together a comprehensive Resource Inventory for the area. The QA committee had requested a comprehensive tool of this nature to help the HHPCPG make better recommendations on use of the funding that comes to the city.

With the introduction of the Resource Inventory added to the monthly blind subcontractors report, the Quality Assurance Committee will finally have all the tools necessary to begin to examine the availability of funds by populations and be better equipped to determine gaps or areas where a stronger emphasis could be placed or redirected. This next year should prove to be less of a struggle internally with the committee, since tools are now in place for the committee to use and because of those tools the committee will be better able to provide regular qualitative feedback to the other standing committees of the HHPCPG.

Continuing Evaluation of the Houston HIV Prevention Community Planning Group

BACKGROUND / OBJECTIVES
Overview of HHPCPG activities and actions by quarter and review of member evaluations. Make recommendations based on overall goals and objectives of the HHPCPG process and existing procedures.

KEY FINDINGS
Key areas must be the focus of ongoing review and evaluation for effective functioning of the planning process. Some of the areas identified are governing rules (by-laws, policies and procedures) refinements, the Health Department and HHPCPG relationship and cooperation, the availability of data and the overall value of the data needed for decision-making and recruitment, retention and training of members.

KEY QUESTIONS
How can the HHPCPG and the Health Department cooperate more effectively to achieve shared goals while recognizing sometimes-conflicting needs and constraints? What level of disparity between the epidemiological profile of the HIV/AIDS epidemic and the membership profile of the HHPCPG is acceptable? To what degree does formality of procedures hamper the creative qualities of the HHPCPG and thus add to a misdirection of energy? How granular and detailed should be the body of data that the HHPCPG needs for decision-making.

NEXT STEPS / RECOMMENDATIONS
Twenty-six recommendations were recognized as a result of the evaluation process. The recommendation focused on the four areas identified in key finding.

Overview

During this reporting period (April – June, 2002), The Request for Proposal and subsequent awards created some questions regarding how accurately the awards mirrored the intent of the HHPCPG plan. It appeared that some interventions described in the RFP were not defined the same as described in the Plan; some areas were over- or under-funded. Future funding cycles may correct for these differences.

During this reporting period (July – September, 2002), the Houston HIV Prevention Community Planning Group (HHPCPG) elected to move on recommendations made in the quarterly evaluation report. Via teleconference meeting due to inclement weather, the membership voted to concur with the Health Department application by a vote of 17 for concurrence, 3 against concurrence, and 2 abstentions. A total of 22 participated in the voting process. The co-chairs drafted the letter of concurrence and submitted the document for counter-signature by the Health Department Director. Comments related to the State of Emergency were edited; the document was signed and mailed. Members learning of the edits at the September meeting, elected to draft a letter to be sent to Houston City Council and the Centers for Disease Control and Prevention.

During this reporting period (October – December 2002) the CPG reviewed City of Houston efforts regarding the State of Emergency.

As of the first quarter of 2003 the 2002 program year ended with 22 members. In January, the HHPCPG began a new calendar year process to better coincide with the program funding year. (In prior years, October was the first month of the reporting year.) There was an orientation for six new members and seven returning members. The group received preliminary results regarding the rapid needs assessment conducted in the last quarter of 2002 and a report on the community level intervention, Project Cover-Up, now entering it's second year of operation. The Epidemiology Committee identified the priority populations: HIV+, African American males, African American MSMs, African American women, and Caucasian MSM. This year differed in that populations rather than behaviors were named as the priority populations.

Review of 2002 HHPCPG Meeting Evaluations

During the course of the year 2002, members were asked to briefly describe the meeting and the words used were divided into three groups – positive, neutral, and negative. In this context, the table below depicts the responses for the general meetings as well as those from the various committees.

Committee	Number	Positive %	Neutral %	Negative %
General	133	75	11.2	13.8
Epidemiology	52	64	7	29
Community Relations	71	95	2	3
Prevention Intervention	48	92	-0-	8
Quality Assurance	48	81	9.5	9.5

Additionally, the majority of HHPCPG members felt the committee meetings were a productive use of time:

Committee	Yes %	Uncertain %	No %
General	87.4	8.4	4.2
Epidemiology	66.7	23.5	9.8
Community Relations	92.9	7.1	-0-
Prevention Intervention	89.4	6.4	4.3
Quality Assurance	82.6	15.2	2.2

Recommendations resulting from the HHPCPG evaluation process

1. Provide ongoing training at each meeting to address internal skills building, needs assessments, gap analysis, and allocations to education on the relatedness of each activity to the overall plan.
2. Include Community Relations and Membership committees in developing concrete action plan for youth involvement.
3. Present a graphic flow chart of HHPCPG activities and update the progress visually at each meeting. Allow for some discussion time to make sure all members fully understand the activities occurring.
4. Revitalize the State of Emergency activities through correspondence with the offices of the Mayor, Health Department Director, County, and Council Representatives.
5. Include updates of the State of Emergency as a monthly agenda item.
6. Continue to monitor progress of the prevention activities against the HHPCPG plan.
7. Address member concerns regarding committee decision-making processes.
8. Address member concerns and clarify roles of City Staff and HHPCPG members.
9. Address concerns of mistrust between HHPCPG members and the Health Department.
10. Increase efforts to raise awareness about the HHPCPG and make it more visible to community stakeholders.
11. Increase the number of "community" members.
12. Make the meetings more "community" friendly.
13. Review the role of Prevention/Intervention and the need for a training manual to effectively conduct chosen interventions.
14. Make Special Task Group reports a standing agenda item.
15. Increase efforts to raise awareness about the HHPCPG and make it more visible to community stakeholders.
16. Increase the means and methods of communicating HHPCPG activities, e.g. wider e-mail distribution list of all HHPCPG meetings to social service agencies.
17. Increase effort to involve organizations in the communities that host the HHPCPG meetings, e.g. churches, schools.
18. Hold at least one evening HHPCPG meeting a quarter to better involve the general community.
19. Develop reappointment policies for members retiring/reapplying for the HHPCPG.
20. Involve the Community Relations Committee in the recruitment of new applicants, especially youth.
21. Assign mentors to new members.
22. Plot the infection testing data by public health service area (PHSA).
23. Request a special study on IDU and adolescents.
24. Create an ad hoc committee to determine HHPCPG goals and objectives.
25. Develop methodology to include data from the City clinics in the QA reports and resource inventory data
26. Review new guidance and request technical assistance.

HHPCPG committee activity summaries

Membership

The Membership Committee is responsible for member selection, review and update of the by-laws and policy and procedures manual. During second quarter of 2002 (April – June) they guided the application and interview process and identified five new members for the HHPCPG and five external membership Members of the Membership or Community Relations Committees. Each applicant was asked to complete a questionnaire regarding the interview and selection process. A total of eight responded and all rated the process as "fair". New members attended an orientation for the community planning process and 100% rated five of the six categories as "high" to "very high". The one area requiring additional clarity was that of the roles and responsibilities of the City of Houston staff and contractors. It is important to note that of the current membership, at least four are also voting members of the Ryan White Planning Council. This blending of planning bodies should encourage additional collaboration in the long-term. While the group is constantly mindful of parity, inclusion and representation (PIR), there is still a void on the HHPCPG regarding youth. Discussion has occurred regarding possible means of recruiting youth to attend the meetings, but no action plan has been formulated or enacted.

During the third quarter of 2002 (July – September) they continued work on the by-laws and policies and procedures manual. The group suggested changing the reporting year to match that of the contractual obligations (January – December). Additional concerns were voiced about the leadership role of City Staff serving as committee co-chairs and the perception of the City driving the process. This also will require further discussion to address these concerns with the full body. Other Areas of special focus are how the meetings are to operate when moving from consensus-based discussion and decisions to the more structured Roberts' Rules of Order. They are also responsible for developing criteria for implementing "conflict of interest" cards, to be used during group discussions.

During the forth quarter of 2002 (October – December) the policies and procedures manual and the document was approved by the general assembly. They also conducted interviews for HHPCPG membership. All retiring members reapplied and were reappointed to the HHPCPG – regardless of PIR needs. The group did not want to lose the experience and knowledge of these individuals. The group stepped up efforts to increase the number of applicants especially from males in all ethnic groups. To address disparities in representation, the group elected to return to the practice of assigning populations or expertise to the appropriate HHPCPG member (rather than all members having an "at-large" representation).

During the first quarter of 2003 the group conducted an orientation for one new external member and six new voting members.

Community Relations

During the second and third quarters of 2002 this committee finalized the newsletter and the HHPCPG web page is now online. They also prepared for the Unity Conference for later in the year.

During the third quarter of 2002 the committee hosted the annual Unity Conference and received evaluations from 91 participants. They also received a summary of the round table discussions that provided information useful not only in planning future conferences but also in providing qualitative information regarding current interventions and barriers to program delivery.

During the first quarter of 2003 the Community Relations Committee began working with Councilperson Ada Edwards and the State of Emergency efforts to develop an HIV prevention program for the Access Channel. They completed the quarterly newsletter and initiated plans for a Speakers' Bureau to assist in disseminating information about the HHPCPG. The plan is to include active and former members.

Quality Assurance

This committee has been working closely with the City of Houston for the past year to collect relevant data that will allow it to compare the progress of community-based organizations against the goals and objectives of the plan. During the second quarter of 2002 period, the committee began to receive reports that allowed them to review agency progress toward goals and to identify areas of concern, such as very low numbers of individual level interventions for a particular population, etc.

During the third quarter of 2002 the QA Committee continued working further with the City Staff to gain clarity and understanding of the reports.

During the forth quarter they also worked on committee goals and objectives.

During the first quarter of 2003 the Quality Assurance Committee changed their monthly meeting times to facilitate information transfer. While the reports provided information submitted by funded CBOs, there were no numbers to reflect the prevention work occurring in City of Houston clinics. This problem resurfaced during the Resource Inventory presentation. The datum reflected in the Resource Inventory do not include any information from the main HIV prevention provider, the City of Houston.

Prevention Intervention

From April 2002 through March of 2003 this committee worked on completing the definitions of interventions and reviewing information that indicates the effectiveness of interventions. As the planning progressed, this committee planned to have a joint meeting with the Epidemiology Committee regarding decisions related to factors.

Epidemiology

According to the guidance, the Epidemiology Committee of the HHPCPG has identified risk behaviors and factors to be weighted and ranked. These are:

Unprotected sex
Injection drug use
Substance use
Sex workers
Homelessness
Incarceration
Recently released

They have also identified target populations to be ranked: These are:

Transgender
Adolescents 13-19
Adolescents 20-24
MSM
Men
Women
HIV+

Other demographics to be considered are race, ethnicity, and gender.

The Epidemiology Committee will begin to set priorities in January upon receipt of the preliminary results from the needs assessment.

State of Emergency

While the Houston HIV "State of Emergency" has been in existence since 1999, very little action is taking place. During the second quarter of 2002 there was a request from HHPCPG members that this become an agenda item to be addressed at every meeting in order to learn of City of Houston governmental efforts in actions addressing the emergency.

As of the third quarter of 2002 no information has been reported to the HHPCPG regarding City of Houston (not Health Department) prevention activities and comments regarding the lack of activity about the State of Emergency were deleted from the Plan after the concurrence vote has caused a schism within the HHPCPG and the administrative agent regarding trust and the HHPCPG process. The mayor appointed a City Councilmember to chair the HIV Task Force and it meets regularly regarding HIV issues and bring together members from a variety of fields and expertise to discuss prevention efforts.

During the fourth quarter of 2002, FOX 26 News was scheduled to broadcast information every first Saturday; community meetings are being held every Friday; and during the week of World AIDS Day, the Houston Chronicle ran a front-page article that focused on the plight of African American women with HIV.

As of the first quarter of 2003 funds have been allocated to the State of Emergency, however there have been no reports made to the HHPCPG regarding progress.

Linkages and Coordination

BACKGROUND / OBJECTIVES

To assure effective coordination between HIV Prevention and HIV Care several complex issues must be addressed. The issues of substance abuse, mental health, poverty, immigration status, homelessness, and unemployment are all associated factors needing to be addressed before behavioral change can take place to reduce risk.

KEY FINDINGS

There is a strong coordinated effort between both care and prevention agencies within the City of Houston striving to reduce risky behavior, increase awareness, and increase testing to reduce the spread of HIV. There are established linkages between the HHPCPG and other planning bodies, NGOs, ASOs, and CBOs, providing a network of contact, resources, communication, and referrals between decision-making bodies.

KEY QUESTIONS

How do we maintain these efforts? What is the effectiveness of these linkages? Do these linkages provide the level of information sharing that is needed for HIV Prevention? Do these linkages facilitate/improve the HHPCPG process and or efforts?

NEXT STEPS / RECOMMENDATIONS

Continuing the established linkages to maintain the current level of information sharing. Explore the possibilities of other avenues of linkage that would enhance the level of prevention and care.

In addition to the numerous HDHHS funded agencies offering HIV Prevention, many other agencies are either directly CDC funded, funded through HRSA, funded through SAHMSA, funded through TDH, or funded through TCADA. All of these agencies combined offer linkages and referrals that would normally be impossible.

Ryan White Planning Council (RWPC)

HDHHS staff interacts with RWPC as sitting members of the council, along with participating on the various committees. Many of our HHPCPG members are also members of the RWPC. The HHPCPG collaborated with RWPC in 1999 in the development of the Comprehensive HIV Service Plan for the Houston Area (2000 through 2005) goals and objectives for HIV Prevention in the Eligible Metropolitan Area (EMA) / Health Service Delivery Area (HSDA) / Eligible Metropolitan Service Area (EMSA).

State of Texas Assembly Group East (STAGE) and The East Texas CPG

The Title II Health Services Delivery Area (HSDA) State of Texas Assembly Group East (STAGE), and the East Texas HIV Prevention Community Planning Group use each other's efforts and work to expand overall HIV services and prevention. Particular emphasis has been placed on further increasing linkages between HIV primary and secondary prevention and care and treatment planning. Voting members of the HHPCPG include voting members of the Ryan White Planning Council, STAGE and East Texas CPG. Additionally at each meeting there is a specific opportunity given to these planning bodies to report any significant changes and give updates on service delivery.

Other efforts include the joint participation of all planning groups in the development of a continuum of care comprehensive plan that includes prevention activities and primary services.

A unique planning effort, the Joint Comprehensive Planning Committee, was formed in early 2000. Comprised of representatives from HIV prevention, Title I and Title II, this group is charged with monitoring the developed continuum of care comprehensive plan that takes full consideration of HIV prevention, care and related services

Urban Coalition for HIV/AIDS Prevention Services (UCHAPS)

The Urban Coalition for HIV/AIDS Prevention Services is a coalition of community members and health departments from the six local jurisdictions that are directly funded by the Centers for Disease Control and Prevention (CDC) to conduct HIV prevention programs (Chicago, Houston, Los Angeles County, New York, Philadelphia, and San Francisco). Collectively these cities represent more than 1/3 of the nation's AIDS cases and the epicenters of the urban HIV epidemic. UHCAPS works to enhance urban HIV/AIDS issues and gives these six jurisdictions the opportunity to share best practices and other items that are unique to directly funded jurisdictions.

UCHAPS seeks to bring enhanced and focused attention and resources to cities, which have faced a disproportionate burden of infection throughout the history of the epidemic. The impact of HIV/AIDS in these cities has been compounded by the number of HIV infections among those citizens most disenfranchised from traditional systems of medical and health care. UCHAPS believes that by working together, members can enhance the federal and local responses to HIV and AIDS in urban environments. This mission can be accomplished by UCHAPS through individual and collaborative efforts to edu-

cate and inform elected and appointed leaders in all branches of the federal government. UCHAPS works to enhance efforts to stem the urban HIV epidemic through concerted advocacy activities, through jurisdictional technical assistance and technology transfer activities among member jurisdictions.

The specific purposes of UCHAPS include the following:

- Invigorating the partnership between CDC and its directly funded local jurisdictions in addressing HIV prevention issues;
- Increasing awareness of HIV prevention and program issues among federal, state, and local policy makers and legislative representatives;
- Providing information to Congress, the CDC, and the public about the need for adequate funding levels for HIV prevention activities;
- Ensuring fair and equitable distribution of prevention resources among jurisdictions and ensuring appropriate funding levels to highly impacted urban areas;
- Articulating an urban agenda related to HIV prevention and other related urban health issues such as sexually transmitted diseases and tuberculosis;
- Sharing information among the UCHAPS jurisdictions about innovative interventions addressing HIV risks for high-priority urban target populations;
- Sharing information among the UCHAPS jurisdictions about strategies for increasing the effectiveness of the HIV prevention community planning process;
- Collecting data on epidemiological trends and profiles in the local jurisdictions, comparing and contrasting those data, and developing an urban HIV prevention data portfolio;
- Receiving information from the local jurisdictions and incorporating local data, trends and best practices into national policy priorities.

HDHHS Task Forces

Several task forces exist within HDHHS to address additional needs around HIV prevention to include:

- **State of Emergency (SOE)** – The African American State of Emergency Task Force was established in April of 2002. The task force has over 50 dedicated members that consist of over 20 different organizations. Since its beginning the task force has tested over 450 individuals and has educated over 7,500 individuals in high-risk areas in Houston. The task force has helped the African American community to openly talk about the disease and provide prevention efforts to help stop the spread of HIV.
- **The Latino HIV Task Force (LHTF)** – The mission of the Latino HIV Task Force is to incorporate collaboration between public health agencies, community-based organizations, private physicians, and HIV-infected and HIV-affected individuals in order to help strengthen awareness on HIV and AIDS in the Latino community. LHTF has participated in the following four events; 17th Annual Career and Education Day, Cinco de Mayo Celebration 2003, National Latino HIV Awareness Day, Latino Book and Family Festival, carrying the message to all Hispanics.
- **Urban AIDS Ministry Task Force (UAM)** – has been instrumental in bringing the church into HIV prevention where there was previously a gap. Each year there is a local conference to coordinate HIV prevention efforts.
- **Women at Risk Task Force (WAR)** – addresses women of child bearing age, along with all women. Their annual health fair has been positive effort on all participants.
- **Youth Task Force (YTF)** – Conducting specialized HIV information for youth is a task in and of itself. This group holds an annual youth conference and poster contest and works closely with the Houston Independent School District (HISD). The efforts of this task force have been seen throughout the city.
- **Substance Abuse/Incarcerated task force (SA/ITF)** – is in the rebuilding stage. Once that process is complete, the task force is looking at targeting judges, TCADA, TDCJ, etc. The task force understands the need for testing but has decided to focus on the system that makes policies in order to increase access to service for these populations. The task force feels greater access will decrease risk, thus decreasing infection. However once the task force is revamped this may change. The task force should become a strong linkage once everything is in place.
- **Transgender Task Force** – relatively a new task force and small to date, has been able to assemble the first Transgender HIV Prevention brochure and assisted in the gathering of data for the small Transgender HIV Needs Assessment completed in 2002. This coupled with additional outreach is a major step forward and is starting to show some results.

These various task forces are facilitated by HDHHS staff and comprised of various community volunteer members who offer their time and talents to further the HIV prevention efforts within the Houston EMA.

HDHHS – Bureau of HIV/STD Prevention

Within the Bureau of HIV/STD Prevention there is a case management section comprised of three programs. The Positive Prevention Access Program (PPAP) works with newly diagnosed HIV+ clients or clients that have known of their status and have either never received care or no care services within the past year. Clients are accessed through our STD clinics and other referral sources. This is an outreach program funded through Ryan White Title 1. The staff are essentially dispatched to a clinic facility when a positive client presents for their follow-up visit to receive their status results. The Early Intervention Program (EIP) works with all HIV+ individuals. Clients are referred from PPAP and other sources within the community. EIP currently facilitates three support groups, at different levels, for HIV+ men. A Latina (Hispanic) support group is being developed for that population. The Perinatal HIV Prevention Program (PHPP) works with HIV+

and high-risk HIV- women of childbearing age (13 - 45). The emphasis of this program is to reduce the incidence of perinatal transmission. Specialty clients are those women who are HIV+ and pregnant. It is crucial that these clients obtain prenatal care and receive prophylaxis therapy as soon as possible. A support group for women is being developed to be facilitated by this program. Clients are referred from PPAP, Family Planning and other referral sources. We currently contract with three community-based agencies to provide perinatal prevention case management.

The STD Department of HDHHS works closely with the HHPCPG having a seat on the Epidemiology Committee and continually sharing information regarding the effects of STDs on the current status of HIV/AIDS in Houston. Presentations were done this year showing the correlation between STDs and HIV and how prevention of one is impacted upon the other. The EPI committee relied heavily on the STD data furnished on the various populations to accurately assess the risk of these populations.

The STD staff has been instrumental in identifying an outbreak in syphilis within the MSM population in Houston and addressing prevention and testing within this population. The STD staff has also worked with the Transgender Task Force in updating its clinical ability to identify this hard to reach population.

Other linked projects include Project Cover-Up conducted both in English and Spanish with an outreach team setting up condom distribution in high-risk areas of the city through collaboration with local businesses that agree to distribute free condoms. This program works especially well as people do not have to ask for condoms, they are in a Project Cover-Up identified bowl on store counters.

HIV Info Line

The HDHHS HIV Info Line is staffed from 8am to 5pm Monday through Friday with trained personnel to answer any questions one may have regarding HIV and STDs. All demographic data from these calls are tracked improving efforts to target prevention efforts to specific areas or populations that might be at risk.

Evaluation Process

Each year, as a component of the Houston HIV Prevention Community Planning Group evaluation, a survey is conducted with area executive directors to gauge their perceptions of the impact of the Houston HIV prevention plan upon the delivery of programs.

This year, 60 executive directors (or director of education) of 60 agencies listed in the Directory of HIV Prevention Resources in the Houston Area were contacted by telephone and asked to complete the interview. The survey lasted approximately 30 minutes and a total of 20 agency directors participated for a 33% response rate. This compares to a 30% response rate in 2001 (14 of 47).

Characteristics of Participants

- Twenty agency directors participated in an HIV Prevention Impact Study conducted by the Houston HIV Prevention Community Planning Group and the City of Houston, Bureau of HIV/STD.
- The agencies provided HIV prevention programming to a range of target populations.
- Average number of years providing HIV/AIDS programming was 12 and average years conducting HIV prevention was 10. Almost all (18 of 20) were conducting individual level interventions (ILI) along with some other types of prevention activity.
- 75% were familiar with the Houston HIV Prevention Plan; 50% reported having "good" to "excellent" understanding of the plan; 20% had made changes in their prevention activities based upon it
- Overall, 70% felt prevention programs in Houston had remained constant or improved since last year.
- 80% of respondents were "satisfied" to "very satisfied" with their agency's prevention efforts; and 45% were "satisfied to "very satisfied" with their relationship with the City of Houston, Bureau of HIV/AIDS.

Barriers to Program Delivery

- Barriers to delivering HIV prevention programming included community denial, institutional barriers, accessing difficult populations, and need for additional funding.
- Challenges to program delivery effectiveness were substance abuse and low socio-economic levels (no transportation, income, etc.).

Staff

- The average number of FTEs dedicated to prevention activities was 4.6 and 56% of those responding reported using, on average, nine volunteers in conducting prevention work.
- Most agencies offer days off, staff meetings, and employee counseling as interventions to staff burnout.
- Directors reported that staff spent about 25% of their workweek on paperwork and non-service related activities.
- The top two qualities of an effective prevention worker were good communication and listening skills.

Training

- 55% offered HIV-specific training in their agency, ranging from a one-time event to monthly sessions of up to 4 hours. The average was 24 hours annually per agency.
- Off-site trainings were facilitated through area universities, state and local health departments, or community based organizations.
- 86.6% found the trainings beneficial and effective at delivering pertinent information and building skills.

- The most important aspect of training was a thorough knowledge of HIV/AIDS.
- The most effective prevention tool was a trained and knowledgeable staff, supplied with literature and information for dissemination.

Technical Assistance Needs

- The top technical assistance need was grant writing, followed by volunteer development.

Evaluation

- 55% of the agencies conduct some sort of program evaluation.

How the HHPCPG Can Help

The respondents named multiple ways the HHPCPG could help in their HIV prevention efforts.

- Communication efforts would increase visibility and awareness and inform on available services.
- Individual HHPCPG members could be more altruistic and make the process more representative, and could participate in trainings to understand that experience.
- The process should ensure that all populations were treated equally, and consideration be given to the Latino population.
- Activities for each intervention should be clearly defined and a manual on the intervention provided to each agency.
- The HHPCPG could lobby the City for more prevention funding and conduct a study to eliminate duplication.

Addendum to the Houston HIV Prevention Community Planning Group 2004-2006 Comprehensive Plan

This addendum is included to provide clarity on the issue of updates and action taken by the City of Houston through its HIV "State of Emergency" initiative. An entry on page 55 of the Comprehensive Plan reads: "While the Houston HIV 'State of Emergency' has been in existence since 1999, very little action is taking place. During the second quarter of 2002 there was a request from CPG members that this become an agenda item to be addressed at every meeting in order to learn of City of Houston governmental efforts in actions addressing the emergency".

1. The Houston Department of Health and Human Services does not set the agenda for Community Planning Group meetings. That agenda is set in Executive Committee meetings which include the CPG community and institutional co-chairs and the co-chairs from the various CPG committees.

2. The HDHHS Bureau of HIV/STD Prevention has made reports to the HHPCPG Quality Assurance Committee regarding monthly objectives since April of 2002. That report includes objectives met in addressing the 'State of Emergency'. The following was excerpted from page 47 of the Comprehensive Plan, "Activities for the majority of the year by the Quality Assurance Committee consisted of examining the monthly blind subcontractor reports indicating units of service delivered, which is used for billing by the Houston Department of Health and Human Services (HDHHS). This information was made available by the City and the committee used it to assess overall service delivery in respect to the objectives in the plan".

Regarding the assertion that very little action has taken place. Please note the following:

- The HIV/AIDS African-American State of Emergency Task Force collaborated with pharmaceutical companies and radio stations to provide incentives to educate over 7,800 and test over 2,000 individuals in the 2002 fiscal year.
- Since the beginning of midnight outreach in August of 2002 the Task Force has educated and tested over 10,000 individuals.
- Major events conducted in 2003 included The Texas Beach Party, National HIV/AIDS Testing Day, Houston Splash and National HIV/AIDS Black Awareness Day where over 4,200 individuals were educated and tested for HIV/AIDS at these events alone.

Finally, regarding the entry on page 55 that reads: "As of the third quarter of 2002 no information has been reported to the CPG regarding City of Houston (not Health Department) prevention activities and comments regarding the lack of activity about the State of Emergency were deleted from the Plan after the concurrence vote has caused a schism within the CPG and the administrative agent regarding trust and the CPG process". Please note the following:

1. The Houston Department of Health and Human Services (HDHHS) exists as the public health arm of the City of Houston government. Therefore, actions undertaken by the HDHHS are actions taken by City government. HDHHS does not exist apart from City government. The quoted entry in number 2 above negates the assertion that "no information has been reported".
2. In a technical assistance workshop led by CDC Project Officer, Alyce Vyann Howell on August 7, 2003 it was agreed that HDHHS would make no changes to the CPG Comprehensive Plan in the future. It was further agreed that if HDHHS leadership disagrees with an entry in the plan, then that issue would be addressed through the attachment of an addendum to the plan and submitted with the application. A description of and justification for, changes to the plan that I authorized for 2002-2003 follows.

Addendum Addressing Changes to the 2002-2003 Comprehensive Plan

I authorized four editorial changes to the 2002-2003 Comprehensive Plan. That Plan was sent to the CDC under my signature two years ago with the original text. That year it did not receive the same level of scrutiny that it received last year. The 2002-2003 Comprehensive Plan went out just after September 11, 2001 and a few months past Tropical Storm Allison – a busy time for the Department. Had the Plan received the same level of scrutiny in 2001 that it received last year, the edits would have been requested at that time.

This addendum documents the language as it was originally written, changes made and the justification for the changes. It concludes with process changes I implemented to avoid these concerns in the future.

Changes:

1. Evaluation period - January through March 2000 found on page 67

The plan initially stated:

State of Emergency. The members of CPG are concentrating their planning efforts,mindful of the recent declaration of the emergency status within the African American community in

Houston. However, there has not been visible support from City of Houston political leadership to follow through on stated intentions, such as the Mayor including HIV-related messages in all his press conferences. CPG's community co-chair demonstrates diligence in keeping this topic in the forefront.

The language was changed to read:
State of Emergency. The members of CPG are concentrating their planning efforts, mindful of the recent declaration of the emergency status within the African American community in Houston. The CPG community co-chair demonstrates diligence in keeping this topic in the forefront.

Justification for change:

- Efforts to support the Call to Action were initiated shortly after the declaration and culminated in the allocation of $158,000 to the State of Emergency in 2000. It was through the Mayor and City Council that those dollars were identified, approved for use and allocated. The following was extracted from the minutes of the February 2000 CPG meeting minutes. "Glenda (Gardner) provided updates on the State of Emergency. (Councilmember) Jew Don Boney has a list of task force members under his consideration as the executive committee and will schedule a meeting with them sometime during March. Glenda said the City has designated close to $150,000 to conduct a media campaign for African Americans. She said several of the staff from the health department are visiting with ministers about how the churches and communities can become more involved with HIV prevention. At each meeting she would like to give an update on the State of Emergency. Glenda continued saying the Collaboration Forum 2000 will be held February 29, 2000 at the George R. Brown Convention Center from 9:00am-12:00 noon. Jackie Martin (United Way President) has agreed to be the keynote speaker.

  Glenda summarized the African American Leadership Summit that was sponsored by Councilmember Jew Don Boney, Jr. on February 5, 2000. There were over 700 people in attendance at the Power Center focusing on the census, HIV/AIDS in the African American community, political leadership, and voter registration. The next summit is scheduled for three months."

- On page 13 of the Call to Action there is a list of things the Mayor should do. Item number five under that heading reads, "Incorporate comments related to HIV prevention in the African American Community at every appropriate opportunity." This does not state that the Mayor is to include HIV-related messages in all his press conferences. There was nothing in the plan to indicate that the Mayor had agreed to do this. However, he was quoted in a December 2, 1999 Houston Chronicle article titled "Blacks to be focus of area AIDS battle" as stating " he would begin to include HIV prevention messages in his public talks."
- In May of 2000 Councilmember Jew Don Boney convened the first meeting of the HIV/AIDS State of Emergency Task Force.
- Written in the April - June evaluation component of the Plan was acknowledgement of forward movement on the Call to Action that required a great deal of planning on the part of HDHHS. The Houston Department of Health and Human Services exists as an agency of the City of Houston government. Therefore, activities undertaken by the department are in fact being undertaken by the leadership of the city. The document reads:

  "The State of Emergency within the African American community was still of primary concern to the members of the CPG. During this time period Dr. Mary Kendrick (HDHHS Director) reported on the activities that the Houston Department of Health and Human Services was undertaking to address the emergency, such as a targeted media campaign to the African American population, additional funding to prevention activities, and the expansion of the counseling and testing sites."

- An additional statement from the document covering this evaluation period reads: "During this period, activities initiated in response to the State of Emergency in the African American community gained headway. HDHHS launched a radio and billboard media campaign targeting African Americans; allocated additional funding to community based organizations to facilitate their efforts; and is seeking additional counseling and testing sites."

2. Evaluation period - July through September 2000 found on pages 69 and 70

The plan initially stated:
While the Mayor of Houston has been slow to address the issues around the State of Emergency, HDHHS started visible programs in support through media campaigns; and, finally, the atmosphere of collaboration continues to build in that at least two members of the CPG are also members of other area planning bodies and at each meeting, representatives are present to facilitate the communication between the different groups (Objective 5).

The language was changed to read:
Through media campaigns HDHHS initiated visible programs in support of the State of Emergency. Finally, the atmosphere of collaboration continues to build in that at least two members of the CPG are also members of other area planning bodies and at each meeting, representatives are present to facilitate the communication between the different groups (Objective 5).

Justification for change:

- HDHHS exists as the public health arm of the City of Houston government. Actions undertaken by HDHHS are in fact actions undertaken by city government. Issues around the State of Emergency are by the CPG's own admission, being addressed.
- Positive movement is further supported in an entry for the same evaluation period in which the plan reads:
  "In July, the Director of the Department of Health and Human Services presented activities undertaken by the Department to support the State of Emergency in the African American Community, including billboards and signage on department vehicles, a radio campaign, and a stronger collaboration with the Houston Independent School District regarding programs with children."

3. Evaluation period - October through December 2000 found on page 72

The plan initially read:

State of Emergency. This quarter also saw the anniversary of the State of Emergency announced December 1, 1999, by Mayor Lee Brown. There has been no progress of note from the city's government and leaders. HDHHS continued its support of the initiative through media campaigns.

The Language has been changed to read:

State of Emergency. This quarter also saw the anniversary of the State of Emergency announced December 1, 1999, by Mayor Lee Brown. HDHHS has continued its support of the initiative through media campaigns.

Justification for Change:

See bullet one of Change 2.

4. Evaluation for January through March 2001 (page 75)

The plan initially read: State of Emergency. There has been no progress of note from the City of Houston government and leaders on the State of Emergency. HDHHS continued its support of the initiative through a media campaign.

Language has been changed to read:

State of Emergency. HDHHS has continued its support of the initiative through a media campaign.

Justification for Change:

See bullet one of Change 2.

Please note that the following occurred during this year in which the Comprehensive Plan evaluation component decried the lack of progress on the part of the City leadership.

1) HDHHS worked with the Mayor and City Council to allocate approximately $158,000 dollars to be used in conjunction with the State of Emergency Plan.
2) A 24-month media campaign was launched.
3) Councilmember Jew Don Boney was instrumental in organizing an HIV/AIDS State of Emergency Task Force.
4) An educational partnership with HISD teens was launched.
5) A partnership with Glaxo Wellcome brought "Project Soul", a grassroots peer-to-peer educational program to Houston to assist in mobilizing the community around HIV testing, treatment, and access to support and healthcare.

It is unfortunate that this incident occurred at a time when it is critical that we develop strong community partnerships that work. However, I could not in good conscience submit the Comprehensive Plan with the Cooperative Agreement to the CDC as it was. It is my hope that the Houston Department of Health and Human Services and the Houston HIV Prevention Community Planning Group can move beyond this point to a place of mutual respect and trust. The following has been implemented to ensure that there is no repeat of this incident.

1) The department's institutional Co-chair will serve on the Comprehensive Plan development committee to ensure that a "City" perspective is included in its development.
2) Bureau of HIV Prevention staff responsible for assembling the information in the plan will immediately notify supervisory personnel when there are issues presented in the proposed plan that might be inflammatory or erroneous.
3) Items placed in the plan that are inflammatory but not erroneous are to be flagged for my attention when the document reaches my desk.
4 All HDHHS staff responsible for reviewing the document must read the complete document and comment as appropriate.

M. desVignes-Kendrick, MD, MPH
Director, Houston Department of Health and Human Services

Houston Department of
Health and Human Services