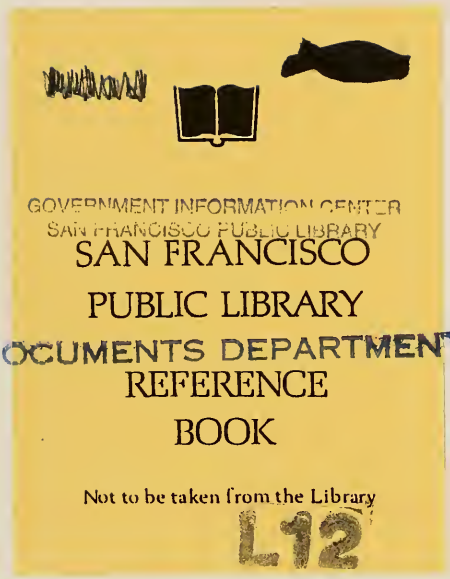
CALIFORNIA

HIV PREVENTION PLAN

California Community Planning Working Group, January 1995



California HIV Prevention Plan

Conducted by the
Community Planning Work Group

Prepared by
Harder+Kibbe Research
San Francisco

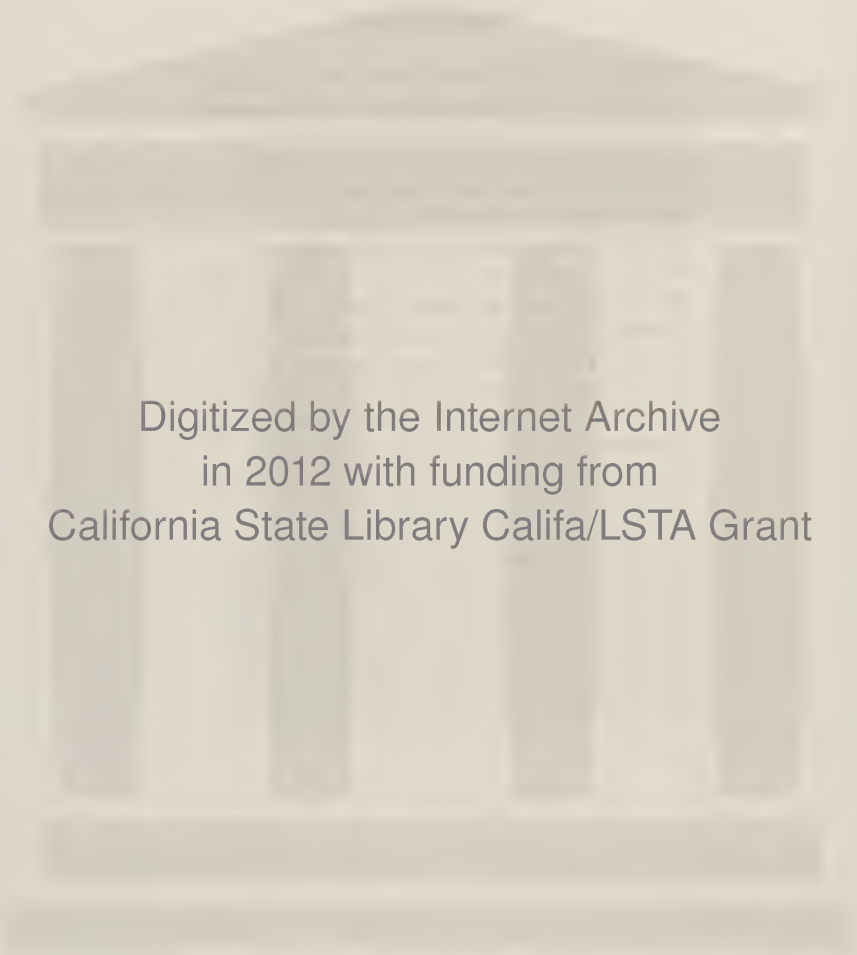
December 1994

Dedication

The California HIV Prevention Plan is dedicated to Doug Yarnon -- Community Planning Work Group member, AIDS activist, and Filipino community leader -- and all persons who have died of HIV disease in California.

Acknowledgments

The efforts of many people went into creating the California HIV Prevention Plan. The Community Planning Work Group members assisted by the staff of the Office of AIDS developed the plan. They were ably assisted by members of the Community Planning Advisory Group. Harder+Kibbe Research provided technical support to the planning process and wrote the Plan with the assistance of Robert Whirry, Judith Spiegel, Debbie Notkin, and Jeff Amory. The facilitators of the planning meetings were Noel Day of Polaris Institute and Deborah Johnson-Rolon of the Motivational Institute. The principal consultant on the HIV Prevention Community Planning Process was Pat Franks of the Institute for Health Policy Studies, University of California, San Francisco. The logistics coordination agency was RDL Enterprises. The evaluation consultant was Kathleen Roe Dr.PH, Professor, San Jose State University. Members of HIV-affected communities and HIV prevention service providers gave valuable insights at the public comment sessions of the CPWG meetings.



Community Planning Working Group Vision Statement

and

Letter of Concurrence

Wayne E. Sauseda, Chief
Office of AIDS
P.O. Box 942732
Sacramento, California 94234-7320

Dear Mr. Sauseda:

The California Department of Health Services, Office of AIDS (OA) developed and implemented a participatory community planning process (CPP) for HIV prevention per requirements specified in the Centers for Disease Control and Prevention (CDC) "Supplemental Guidance on HIV Prevention Community Planning for Noncompeting Continuation of Cooperative Agreements for HIV Prevention Projects". The CPP was accomplished through the formation of the HIV Community Planning Working Group (CPWG), comprised of individuals who represent HIV affected communities and providers of prevention services that were selected through an open nomination process based upon selection criteria developed by CDC, as well as criteria developed by OA. The CPWG is co-chaired by a representative of the California State Department of Health Services and two representatives chosen by group members.

Members of the CPWG represent state and local health departments; urban and rural populations; community-based organizations; AIDS service organizations; racial and ethnic minorities; lesbian, gay/bisexual people; people infected with HIV; public education; health care professionals; maternal and child health; transgendered persons; and various other fields including, but not limited to, social and behavioral scientists, health educators, and epidemiologists. All members are equally empowered to participate fully in the planning process and received a statement of clearly defined roles and responsibilities. Because of the tight timeframe in which to develop a plan, every member signed a Letter of Commitment to fully participate in the community planning process, thereby committing to consistent attendance and ownership of the CPWG process.

CPWG meetings were held in several locations throughout California: Oakland, Long Beach, Fresno, San Diego, Redding, San Mateo. All meetings were open to the public; four of the six meetings set aside time on the agenda for public comment. During the comment period, the public addressed issues such as: what communities are not being served, or are currently underserved, by HIV education and prevention efforts in California; what HIV education and prevention needs are not being addressed in the community and why; what HIV education and prevention strategies/interventions would work in the community; what linkages need to be established in the community to make current coordination of education and prevention programs/strategies more effective; and what technical assistance is needed to make education and

prevention programs, curriculum, and service delivery more effective in the community. Written testimony and public comments became part of the formal record of proceedings.

In order to address the components specified in the CDC Guidance, the CPWG established seven committees: Epidemiology, Needs Assessment, HIV Prevention Strategies and Interventions, Priority Setting Criteria, Technical Assistance, Coordination and Linkages, and Resource Allocation Process. An eighth committee, Community Participation, was formed to provide a forum for members of the public who were in attendance at the CPWG meetings to provide input into the process.

In concurrence with the CDC guidance, California's participatory community planning process includes essential components of effective HIV prevention programs based on HIV/AIDS epidemiologic surveillance as well as incorporates the views and perspectives of communities targeted by prevention programs. The HIV Prevention Plan includes an epidemiologic profile, target population profiles by strategy and interventions which includes unmet needs and barriers, incorporates the views and perspectives of the groups at risk for HIV infection/transmission; HIV prevention resource profiles by strategy and intervention addressing Federal, State, local, private, and volunteer resources; HIV prevention outcomes profile; linkages; coordination between public, private, state, regional and local entities; technical assistance; and evaluation.

In addition to the requirements of the CPP that were met, the CPWG membership had strong convictions about certain issues which impact HIV prevention efforts. Regardless of how many resources are made available and how many new prevention strategies are developed, success can only be attained when all issues affecting people's lives are addressed. It is because of these concerns that the vision statement which follows is included in this letter for further consideration and as a preamble to the California HIV Prevention Plan.

Preamble to Goals and Objectives

In developing the HIV Community Prevention Plan for the State of California, the CPWG recognizes that certain conditions limit people's ability to benefit from HIV prevention services and create additional challenges to HIV prevention providers. These conditions include poverty and other economic disparities, community disempowerment, anti-immigrant sentiments, xenophobia, racism, sexism, ageism, homophobia, bigotry, addiction, low self-esteem, sexual victimization, and violence (including street violence, domestic violence, and sexual assault). Too often, these social conditions limit the ability of communities and individuals to adequately respond to the epidemic and jeopardize efforts to stop the spread of the virus.

We support changes in society and in communities to reduce or remove the barriers those conditions create. Although correcting these societal barriers is beyond the scope of our HIV prevention plan, we believe they must be addressed if the HIV epidemic is to be eradicated. Therefore, the CPWG sets forth the following principles and policies which, if followed, would contribute significantly to the prevention of HIV.

Principles

All persons in California, regardless of ability to pay or immigration status, should receive **quality health care and services**. This includes:

- access to quality, long-term health care, prevention, alternative treatments, mental health services, and support services; access to quality health care services that are culturally and linguistically competent and sensitive; this is especially needed for HIV positive persons;

- support for any proven harm-reduction strategies they choose (*e.g.* condoms for youth, clean needles for injection drug users).

All persons in California, regardless of ability to pay or immigration status should have **economic rights**. This includes:

- food, adequate shelter, clothing, employment, and other necessities of life;

- safe, quality public education (K through 12);

- eradication of discrimination in housing and employment, regardless of people's sexual orientation, gender, age, race, creed, ethnicity, physical ability, health status, or mental status.

All persons in California should have the right to be **treated with respect**. This includes:

- cultural sensitivity towards gay, lesbian, bisexual, transgender, and disabled people;

- cultural competency among health and human service providers towards differences and similarities among groups;

- an understanding of the history of and support for empowerment issues related to gender, sexual orientation, age, race, ethnicity, nativity, physical/mental/cognitive ability, economic status, and HIV status.

All persons in California should be **free of violence and fear**. This includes:

- freedom from fear of acts committed against them based on intolerance of an individual's immigration status, sexual orientation, gender, economic status, race, ethnicity, religion, nativity, and HIV status;

- freedom from the threat of violence and sexual victimization on the streets, in the home, and at the workplace;

- assistance in overcoming problems caused by low self-esteem, fear, abuse, and power imbalances in relationships and in society.

We strongly encourage all people, especially prevention providers, to address these issues. All HIV prevention programs in California should understand the HIV epidemic in the context of and as a partial product of socioeconomic and cultural discrimination and oppression. Programs should contribute to the resolution of such injustices and inequities, as a way of reducing the increased risk of HIV originating from these factors.

Policies

In addition, the following specific policies are strongly recommended by the CPWG and should be enacted at the state and local level.

- Drug treatment on demand regardless of ability to pay, should be provided;

- Needle exchange should be legalized; needle exchange programs must include point-of-contact HIV and drug education, referred to HIV testing and counseling, medical and social services and drug treatment;

- Possession of needles or works should be decriminalized.

- Condoms and other harm reduction tools should be provided to incarcerated persons under specified secured conditions.

- Condoms should not be used as evidence to arrest and prosecute sex workers.

- Age-appropriate, continuing, comprehensive health education which is culturally and linguistically competent and sensitive (including sex education and HIV prevention education) should be provided in the schools.

- Access to prevention services should never be based on a person's perceived or actual immigration status.

- HIV testing should be always voluntary and not mandatory.

- Assistance for partner notification of HIV infected persons should be available, voluntary, and non-coercive.

The California HIV Prevention Community Planning Working Group concurs with the Office of AIDS, California Department of Health Services draft plan submitted with the State's continuation application for its HIV Prevention Cooperative Agreement with the CDC.

Sincerely,

Connie Norman
Co-Chair
Community Planning Working Group

Tom Lidot
Co-Chair
Community Planning Working Group

CPWG MEMBERSHIP

James Atolagbe
Lynne Barnett
Tony Barrett
Patty Blomberg
Alex Campos
Rafael Chang
Yolanda Chavers
Jeff Clingenpeel
Ross Conner
Gene Copello
Alberto Cortes
Rebecca Denison
Brian Dobrow
Corey Dubin
Yvette Flunder
Reuben Garza
Gail Gibson
Brad Gilbert
Dean Goishi
Matiana Grogan
Arturo Hernandez
Mario Hernandez
James Kahn
Andrea Learned
Estela Martinez
Julio Mastro
Gail Maurer
Frank McGarvey
Darren Megee
William Mitchell
Pat Norman
Charlie O'Malley
Robert Pardo
Erma Patterson
Gena Pennington
Harold Rasmussen
Juan Reardon
Oscar Reconco
Alice Ryan
Marylou Scavarda
John Schunhoff
Ruth Slaughter
Greg Smith
Andy Spieldenner
Hank Tavera
Alex Taylor
Sharen Trammell
Rose Vasquez
Heidi Vert

Table of Contents

List of Exhibits

SUMMARY OF CALIFORNIA HIV PREVENTION PLAN

A. DESCRIPTION OF THE PLANNING STRUCTURE FOR CALIFORNIA COMMUNITY PLANNING PROCESS

The HIV Prevention Community Planning Process (CPP) is composed of two bodies/groups. The first group is the HIV Prevention Community Planning Advisory Group (CPAG). This 20-member group functions as an advisory body to the Office of AIDS (OA). The CPAG also provided ideas for the formation of the HIV Prevention Community Planning Working Group (CPWG). Members of the CPAG were selected by OA and CPAG from various advocacy, community, and local public health representatives. The Community Planning Working Group has 53 voting members selected through specific criteria prescribed by the CDC. Fifty-one percent of CPWG membership represents communities at risk for HIV, including community-based organizations (CBOs) representation and providers of prevention services. Chapter 1 more thoroughly describes the composition of the planning groups and planning process.

The CPWG was successful in completing the major task of the community planning process and produced a comprehensive statewide HIV prevention plan, the California HIV Prevention Plan. The Plan will be used as a framework for funding and developing future prevention programs once approved by the Department of Health Services. The following is a summary of the California HIV Prevention Plan.

B. EPIDEMIOLOGIC PROFILE

An epidemiologic profile is included in the California HIV Prevention Plan as Chapter 2. The profile reflects the current and future extent of the HIV/AIDS epidemic in California. Information on trends is included and reflects the extensive work that the epidemiology Committee of the CPWG undertook with the guidance of the Epidemiology and Research Branch staff from OA and the planner. Please refer to Chapter 2 to see the tables displaying information about the distribution of AIDS cases, and studies of HIV seroprevalence.

C. TARGET POPULATIONS ADOPTED BY THE COMMUNITY PLANNING WORKING GROUP

Priority Target Populations are addressed in the California HIV Prevention Plan in Chapter 7. The Needs Assessment Committee of the CPWG was charged with the responsibility of developing a list of target populations for prevention programs. The committee used several sources of information to accomplish this task, and engaged in considerable deliberation. Their list was presented to the CPWG, which adopted the list with minor modifications. This list is presented below. The risk behaviors and barriers to

prevention for these groups are described in Chapter 3; the prioritized needs of these groups are presented in Chapter 8.

Target Populations

1. **Substance Users and Their Sex Partners**
   a. IDUs (sharing needles)
   b. Other drugs/alcohol users
2. **Gay & Bisexual Men of all Ethnicities and Ages**
   a. Gay and bisexual men of all ethnicities (African Americans, Latinos, Asians, Pacific Islanders, Native Americans, European Americans) and ages
   b. Men having sex with men, who are not identified as gay/bisexual
3. **Sex Industry Workers (Male, Female, Transgender)**
4. **Youth/adolescents**
5. **People of Color Communities**
   a. African/Americans and persons of non-African descent who are black
   b. Latinos/as
   c. Asians
   d. Pacific Islanders
   e. Native Americans (American Indians, Aleutians and Eskimos)
   f. Communities of mixed heritage
6. **Transgender/Transvestite Individuals**
7. **People in the Criminal Justice System**
8. **Homeless/Transient**
   Especially dually and multiple diagnosed (TB, HIV, emotionally or cognitively challenged)
9. **Immigrants and Undocumented Persons**
   Especially non-English Speaking
10. **Women and Their Sex Partners**
    a. Heterosexual/Lesbian/Bisexual
    b. Women of Child-bearing Ages
11. **Seasonal/Migrant Farm Workers/Agriculture-related Workers**
12. **Persons Engaging in Heterosexual Sex**
13. **People in Group Living Situations**
14. **Disabled Communities**
    a. Hearing and/or Visually Impaired
    b. Physically Challenged
    c. People living with hemophilia and their partners
    d. Mentally challenged (emotionally and cognitively)
15. **People Who Pierce or Tattoo**
16. **Children**

D. PRIORITY STRATEGIES AND INTERVENTIONS TO BE UNDERTAKEN

The priority prevention strategies and interventions to be funded in future prevention programs were addressed by the CPWG. The result of their work is reflected in Chapter 9. The list of unprioritized strategies was developed by the HIV Prevention Strategies Committee. The priority setting of these strategies was accomplished through the use by the entire CPWG of a set of criteria developed by the Priority Setting Criteria Committee. For a full description and narrative of the criteria and how they were developed and applied by CPWG please refer to Chapter 9. For a description of each strategy, please refer to Chapter 4.

All of the possible effective strategies were first identified by the HIV Prevention Strategies Committee (these follow below). Secondly, the list was applied to the 16 prioritized target populations which had been identified by the Needs Assessment Committee and voted on by the CPWG. Finally, the CPWG used the priority setting criteria and designated which sets of strategies were appropriate and relevant to each of the 16 target populations.

The unprioritized HIV prevention strategies and interventions identified and recommended by the HIV Prevention Strategies Committee are as follows:

Prevention Strategies List
(Not Prioritized)

1. **HIV Counseling, Testing, Referral and Partner Notification:** Provide opportunities for individuals to learn their serostatus and to receive prevention counseling and referral to other preventive, medical and social services.

2. **Individual Level Interventions** (culturally, socially and linguistically competent): Health education and risk reduction counseling to assist clients to learn about transmission and risk behaviors, make plans for individual behavior change and ongoing appraisals of personal behaviors, and to facilitate linkages to resources to support behavior change.

    a. Hotlines
    b. Outreach: Street and Community
    c. Peer Education (individual)
    d. On-site Risk Reduction Education and Counseling
    e. Prevention Case Management
    f. Needle Exchange Programs
    g. Bleach and Barrier Demonstration and Distribution/Accessibility
    h. Condom Demonstration and Distribution

3. **Group Level Interventions** (culturally, socially and linguistically competent): Provide education and risk reduction support to groups of clients to promote and reinforce safer behaviors, and to provide interpersonal skills training in negotiation and sustaining appropriate behavior change.

   a. Speakers Bureaus
   b. Group Presentations
   c. Multi-Session Groups
   d. Peer Education (group)

4. **Community Level Interventions** (culturally, socially and linguistically competent): Seek to reduce risk behaviors be changing attitudes, norms, and behaviors through health communications, social (prevention) marketing, community mobilization and community-wide events.

   a. Social Marketing
   b. Medial Relations
   c. Public Events
   d. Natural Opinion Leaders
   e. Community Mobilization

5. **Public Information Programs** (statewide, regional, local): Provided for the general public to dispel myths about HIV transmission, support of volunteers, reduce discrimination toward individuals with HIV/AIDS, promote support for strategies and interventions that contribute to HIV prevention.

   a. Social Marketing
   b. Media Relations
   c. Public Events

E. PROGRAM GOALS AND MEASURABLE OBJECTIVES

Program goals and objectives were developed by the CPWG and are incorporated in the California HIV Prevention Plan in Chapter 6. The CPWG as a whole developed the HIV prevention goals and objectives for the Plan through an iterative process of comment and revision. Final comments and votes were taken and the goals and objectives were approved for recommendation. The goals address the basic components of a comprehensive prevention system to include:

Goal 1.	Knowledge and skill development
Goal 2.	Norm setting among peers, groups and communities
Goal 3.	Behavior change for persons whose HIV status is negative or unknown
Goal 4.	Behavior change for persons whose HIV status is known to be positive
Goal 5.	Early intervention services for HIV positive persons

Goal 6. Capacity development to ensure the accomplishment of the preceding goals.

Within the framework of goals, objectives were developed that delineate broad populations (such as sexually active persons), services (such as counseling and testing), or approaches to service delivery (such as cultural competence). For Year One of the California Planning Process, it was decided not to make the objectives measurable or time-specific because the Plan is viewed as a policy-setting framework for development of future prevention programs.

Please refer to Chapter 6 in the California HIV Prevention Plan for a complete listing of the goals and objectives developed and recommended by the CPWG.

F. COORDINATION WITH PUBLIC AND NON-GOVERNMENTAL AGENCIES

The California HIV Prevention Plan addresses coordination and linkages with public and non-governmental agencies. Chapter 10 of the Plan describes the work of the Coordination and Linkages Committee established by the CPWG. The committee reviewed and evaluated coordination and linkages strategies from several points of view: among state agencies and department, among agencies at the local level, between State and local jurisdictions, and across multiple regions. Recommendations brought forth by the Coordination and Linkages Committee for consideration and approval by the CPWG address coordination at each of these levels, as well as systemic issues in planning and coordination and provisions for adequate funding of these processes.

G. TECHNICAL ASSISTANCE FOR COMMUNITY-BASED AND OTHER SERVICE PROVIDERS

The California HIV Prevention Plan addresses the technical assistance needs of prevention community-based organizations and other service providers. Chapter 11 of the Plan describes the work and final recommendations of the Technical Assistance Committee of the CPWG. The committee's charge was to develop a framework for a technical assistance plan for the state, county and community agencies involved in providing HIV prevention services. In order to develop the plan, a needs assessment was conducted by the Committee with the assistance of the OA, the Multicultural AIDS Resource Center (MARC) and the planner. The committee also used the recent evaluation report on HIV Education and Prevention Programs in California produced by the Institute for Health Policy at the University of California, San Francisco. The results of the needs assessment are summarized in Chapter 11 of the Plan.

H. RESOURCE ALLOCATION OF STATE PREVENTION FUNDS

The California HIV Prevention Plan includes recommendations for future allocations of prevention funds. The Resource Allocation Process Committee (and an expansion of this committee towards the end of the planning process) developed recommendations and presented them to the CPWG. Developing these recommendations entailed considerable debate among the CPWG members, but the final recommendations were adopted by an overwhelming majority with do dissenting votes. These recommendations include the percentage of funds to each of the State OA Prevention Programs (Counseling and Testing, Counselor Training, Early Intervention Program, and Education and Prevention) and the methods to allocate these funds. The method to allocate E&P funds will change dramatically from the method used in past years. These recommendations are presented in Chapter 12.

I. EVALUATION OF THE CALIFORNIA PLANNING PROCESS

The California HIV Prevention Plan addresses the evaluation activities that have been undertaken to evaluate the California Planning Process and the experiences that CPWG members have gone through in participating in that process. Findings from the evaluation of the process, outcome, and impact of the California Planning Process are described in Chapter 14 of the Plan.

SECTION I THE CALIFORNIA COMMUNITY PLANNING PROCESS

This Section describes the community planning process used to develop the California HIV Prevention Plan. It describes the function and composition of the Advisory and working groups, the role of the consultants, tasks of subcommittees, the use of public comment, and the activities of the Community Planning Working group in developing the California HIV Prevention Plan.

This section is followed by Section II which contains the needs assessment, Section III which contains the specific recommendations of the Community Planning Working Group, and Section IV which contains the evaluation of this process.

CHAPTER 1: THE CALIFORNIA COMMUNITY PLANNING PROCESS

The California Department of Health Services, Office of AIDS initiated an HIV Prevention Community Planning Process in December 1993. The California Planning Process embraces a community participatory planning process as an essential component for building an effective statewide HIV prevention program. The evidence-based planning process specified by the National Centers for Disease Control and Prevention (CDC) in the "Supplemental Guidance on HIV Prevention Community Planning for Non-Competing Continuation of Cooperative Agreements for HIV Prevention Projects,"* was followed in California to develop and implement the California Planning Process. The Office of AIDS is committed to developing and implementing a California Planning Process which incorporates the views and perspectives of providers of HIV prevention services and HIV affected groups for whom the prevention programs are intended.

The California Planning Process used a two-tier planning mechanism, very similar to the Ryan White CARE Act, Title II process which California uses to plan and allocate funds for care and treatment services. This planning process has proven to be very effective and involves community representation and input for the development of plans and allocation of funds. Although time and staff support are intensive, the process has been well accepted by the various community and local public health entities. This process supports Office of AIDS' role as a lead state agency while providing community, local governmental and provider groups/representatives with a vehicle for input and decision making.

The CARE Act Title II HIV Comprehensive Care Working Group was considered as an option for the HIV Prevention California Planning Process; however, the current 47 representatives functioning on the Title II Working Group, whose major area of expertise is care and treatment, did not seem appropriate for HIV prevention planning. This became especially apparent when the number of new members which would be needed to address prevention issues was deemed unwieldy.

The Office of AIDS' goal for the California Planning Process was to provide sufficient and appropriate community and prevention providers representation while maintaining an optimum number in the group to operate effectively. Additionally, the Office of AIDS considered the CDC *Guidance* section, "Principles of HIV Prevention Community Planning," (pages 4-7) and adopted these principles to ensure the California Planning Process is reflective of these principles in identifying unmet need and in planning future HIV prevention programs.

---

* This document forms the basis of HIV Community Prevention Plans across the nation and is referred to throughout this document as the CDC *Guidance*.

STRUCTURE OF THE CALIFORNIA PLANNING PROCESS

The HIV Prevention California Planning Process structure comprises two bodies/groups. The first group is the HIV Prevention Community Planning Advisory Group. (See Attachment 1 for list of Community Planning Advisory Group members.) This group functions as an advisory body to provide input and ideas for the formation of the planning group and California Planning Process. The Community Planning Advisory Group has been functioning since December 1993 in a quasi-informal basis, and originally had 34 members. Current membership consists of 16 active advisors. The members for this group were selected by the Office of AIDS with input from various advocacy, community, and local public health representatives. As the list for Community Planning Advisory Group membership was being formulated, outreach and communications took place among individuals being contracted by Office of AIDS staff to ensure inclusion of representatives of appropriate government and community organizations and affected community groups.

An initial meeting took place on December 15, 1993 with representatives who eventually formed the Community Planning Advisory Group. Decisions made at this meeting were as follows:

- The establishment of the HIV Prevention Community Planning Working Group to provide leadership and input for the California Planning Process and to assist in the development of a statewide comprehensive HIV prevention plan.

- The formal establishment of the Community Planning Advisory Group. This group has an advisory non-voting role only. It was also recommended that there be a maximum number of 20 members for this group.

- To avoid possible conflict of interest, membership in the Community Planning Advisory Group precludes participation in the Community Planning Working Group as voting members.

- The Community Planning Working Group membership has a voting role. A maximum number of 45 representatives was to be selected using specific criteria as prescribed in the CDC *Guidance* and criteria added as a result of discussions on December 15, 1993. (Subsequently, this number was increased to 55.) Fifty-one percent of the membership was to represent communities at risk for HIV to include community based organizational (CBO) representation.

- Establishment of a Membership Selection Committee to review nominations and to make recommendations to the Office of AIDS for Community Planning Working Group membership. Five individuals present at the meeting volunteered for the Membership Committee and were selected based on their willingness to assume this responsibility.

An intensive outreach effort was undertaken to ensure that all interested individuals and organizations involved in aspects of HIV prevention were considered for the Community Planning Working Group. The letters soliciting nominations were sent out in late December 1993; however, as early as August 1993, correspondence was sent to all state Education and Prevention contractors, local health departments and community groups soliciting their interest for participation in a statewide planning process. Names of interested parties were collected and this list was enhanced as new names were submitted for consideration. Over 200 persons were nominated.

The Membership Committee met in January 1994. Their task was to review the nominations, to discuss each person's geographical residence and expertise, to select individuals for the Community Planning Working Group based on the criteria which were developed at the December 15, 1993 meeting, and to provide any additional input into the composition and expertise of representation for the Community Planning Working Group.

The criteria developed by the Community Planning Advisory Group identified certain "clusters" which represented groups that ideally would have a role in the Community Planning Working Group. These clusters are outlined in Attachment 2. The clusters included Cultural Cluster, Sexuality Cluster, and Practitioner Cluster. In addition, the CDC *Guidance* was reviewed carefully, and all criteria specified under "Logistics of HIV Prevention Community Planning," page 8 of the *Guidance* were strictly followed. Finally, four additional criteria developed by the Community Planning Advisory Group during the December 15, 1993 meeting were used to select Community Planning Working Group members; these were as follows:

- Persons from Los Angeles and San Francisco community planning bodies (persons who have the authority to act on behalf of these entities) should be included. San Francisco and Los Angeles are cooperative agreement cities and are mandated by the Centers for Disease Control and Prevention (CDC) to engage in similar planning for their jurisdictions.

- Members must possess "hands on" experience in providing prevention services to affected populations.

- Members must engage and consult/communicate with the community they represent.

- Members must possess the ability and authority to advocate on behalf of the community they represent.

The Office of AIDS relied on the Community Planning Advisory Group to assist and provide input into the nomination process and for the selection of members for the Community Planning Working Group. The members reflect a broad base of interests and affiliations including community-based organizations, advocacy groups, state and local governmental

agencies, university researchers, legislative staff, national or statewide AIDS organizations, and others who are involved in development of local, state, or national HIV prevention policies/programs. Many of these Community Planning Working Group members represent HIV-affected communities and an effort was made to include HIV positive persons.

Attachment 3 is a list of the 52 members which finally composed the Community Planning Working Group. Originally, 55 members were selected for the Community Planning Working Group; however, due to illness and other personal commitments, two of the members resigned. One additional member died of AIDS just before the Redding meeting (August 31-September 1). Attachment 4 displays the geographic region or statewide organization and expertise the Community Planning Working Group members represent. Attachment 5 displays the geographic regions that are represented by the Community Planning Working Group members.

Following, is the Community Planning Working Group representation compared to the California population and California AIDS cases:

Ethnicity	Community Planning Working Group	California Population, 1990 Census	California AIDS Cases, July 1994
African American	21%	7%	15%
Asian/Pacific Islander	7%	9%	2%
Latino/a	28%	27%	17%
Native American	7%	<1%	<1%
White	35%	56%	66%

As compared to the 1990 Census data for California, the ethnic representation of the Community Planning Working Group is generally reflective of the ethnicity of the State's population and AIDS cases. African Americans are over-represented in terms of their proportion in the population and AIDS cases. Asians and Pacific Islanders are slightly under-represented in terms of their proportion in the population, but over-represented in terms of their proportion of AIDS cases (and no Asian or Pacific Islander women were represented in the Community Planning Working Group). Latino/as were over-represented in terms of their proportion of AIDS cases, and whites were under-represented in terms of their proportion both

in the population and of AIDS cases. Please see Attachment 6 for a graphic depiction of Community Planning Working Group ethnic representation.

Gender composition of the Community Planning Working Group membership is as follows:

Female	38%
Male	60%
Transgender	2%

HIV seropositive individuals make up 19 percent of the membership. Gay and lesbian representation on the Community Planning Working Group is 40% of the membership. Rural/suburban representation on the Community Planning Working Group is 29% of the membership. Please see Attachments 7- 9 for graphic depictions of Community Planning Working Group membership diversity.

The Community Planning Working Group is the HIV prevention planning body for the State. Although there are two Californian cities, Los Angeles and San Francisco, that receive CDC cooperative agreement prevention funds, and have separate planning processes, it was decided that these cities should have a formal role in the state Community Planning Working Group. (Likewise, the Office of AIDS also holds a formal voting seat in each respective city planning bodies.)

Although it was decided that the statewide CARE Act, Title II, HIV Comprehensive Care Working Group in California would not function as the planning body for the California Planning Process, there is membership overlap. Eight Community Planning Working Group members also sit in the Title II Working Group. This overlap will aid in coordination and integration of ideas and activities, as appropriate, between prevention and care and treatment issues.

Wayne E. Sauseda, Chief, Office of AIDS; Tom Lidot, Indian Health Council, San Diego County; and Connie Norman, AIDS Service Center, Los Angeles County were designated as the co-chairs of the Community Planning Working Group. Mr. Sauseda formally represents the Department of Health Services, Office of AIDS and functions as the statewide co-chair. Mr. Lidot and Ms. Norman, the other two co-chairs, were elected at the first Community Planning Working Group meeting on April 7-8, 1994.

IMPLEMENTATION OF THE CALIFORNIA PLANNING PROCESS

The entire $350,000 supplemental award from the CDC for the California Planning Process was contracted to a small woman-owned local business, RDL Enterprises. RDL provides professional meeting planning services as well as other logistical services to facilitate organization of meetings and other events. RDL has subcontracted with consultants for

Community Planning Working Group meeting facilitation, evaluation and for the planner who provided technical assistance for the development of the California Planning Process and wrote the statewide HIV prevention plan. The Office of AIDS did not use any supplemental funds for in-house costs. Current Office of AIDS staff working on the California Planning Process have been redirected from other prevention priorities to ensure the California Planning Process was implemented within expected time frames. At the start of the California Planning Process, the Office of AIDS assessed that CDC funds were insufficient to initiate and complete a California Planning Process for a state with such diverse populations and geography as California. An additional $300,000 in state funds was added to the award from CDC to ensure that the California Planning Process was completed.

Roles of the Consultants

RDL Enterprises, under contract with the Office of AIDS, was responsible for paying all costs associated with Community Planning Advisory Group and Community Planning Working Group meeting facilities, travel, accommodations, meals and honoraria where appropriate. RDL also had responsibility for all logistical planning and arrangements for meeting sites and travel arrangements. The logistical planning was a significant endeavor because of the geographic size of California and Community Planning Advisory Group and Community Planning Working Group members' home-base locations.

There were several functions that were contracted with consultants to implement the California Planning Process and to complete a statewide prevention plan. Contractors were selected with the assistance of the Community Planning Advisory Group. As with the Membership Committee, several committees were established within the Community Planning Advisory Group to work with the Office of AIDS in developing roles, identifying activities to be undertaken and recommending and selecting contractors. The Office of AIDS established a Planner Selection Committee to select a consultant/agency to write the statewide plan and provide technical assistance to the Community Planning Working Group to ensure that the planning process proceeded by the CDC California Planning Process Guidelines. With the Community Planning Advisory Group assistance, Harder+Kibbe Research and Consulting, a consulting firm based in San Francisco, was selected as the planning agency. Lyn Paleo, M.P.A., was the principal consultant/planner who led the planning activities for the California Planning Process.

Additionally, the Office of AIDS established a Facilitator Selection Committee to assist in defining the role of Community Planning Working Group meeting facilitators and in selecting consultants. Two consultants were selected, Noel Day, from Polaris Research and Development in San Francisco, and Deborah Johnson-Rolon, from the Motivational Institute, Aptos, California. The facilitators led the Community Planning Working Group through the meeting agendas to ensure that all items on the agenda and meeting objectives were met during the meetings. They also helped in conflict and problem resolution as such situations arose during the meetings.

The Community Planning Advisory Group also formed the Evaluation Committee to select an independent evaluation consultant whose role is to evaluate the California Planning Process and to determine whether the requisites of the *Guidance* for evaluation were met. Kathleen Roe, Dr.PH, Professor, Community Health Education, San Jose State University was selected as the evaluation consultant. Dr. Roe conducted an evaluation of the process, outcomes and selected impacts of the Community Planning Process.

Timeline and Community Planning Working Group Meetings

A timeline was developed in the early stages of the California Planning Process (see Attachment 10). The timeline included the location, dates and activities/processes for five Community Planning Working Group meetings. As soon as the planner and facilitators were hired, the Office of AIDS, with their input, developed a more complete timeline outlining the goals that would be addressed at each meeting.

The Community Planning Working Group meetings took place as originally outlined with minor modifications due to the availability of hotels and extension of meeting time in order to meet goals set for each meeting. See Attachment 11 for a map of California illustrating meeting locations. The meeting dates and locations were as follows:

1.	Oakland	April 7-8, 1994
2.	Long Beach	May 5-6, 1994
3.	Fresno	June 7-8, 1994
4.	San Diego	July 13-15, 1994
5.	Redding	August 30, 31, and September 1, 1994
6.	San Mateo	September 22-23, 1994
7.	Palm Springs	December 15-16, 1994

Meeting dates were kept as originally planned with some modifications. It was determined in Fresno, at the third Community Planning Working Group meeting, that goals for the meetings and activities undertaken to meet the goals were more time intensive than originally planned. It was decided by the Community Planning Working Group that the fourth and fifth meetings needed an additional day to accomplish planned activities and that an additional meeting would be required to review the California HIV Prevention Plan before it was submitted to CDC with the Cooperative Agreement 1995 Prevention Application. Additionally, the original intent was that the plan would be written by mid-July and that public hearings would be held in August to receive input/comments from interested parties. The public hearings were postponed until after the prevention application was submitted to the CDC. Public hearings to elicit additional comments on the plan were conducted in November 1994 and a meeting of the Community Planning Working Group was held in December to reveiw the comments and make final decisions about resource allocation processes

Community Planning Working Group Committees

Given the tasks that needed to be accomplished for the development of the California HIV Prevention Plan and the number of Community Planning Working Group members (originally 55 members), it was important that the tasks be divided among smaller working committees that could examine issues and develop recommendations more productively. With the assistance of the Community Planning Advisory Group, the Office of AIDS established eight working committees. Each of the eight committees addressed one to two of the requirements outlined in the CDC *Guidance*. Each committee was facilitated by Community Planning Advisory Group members with the assistance of several Office of AIDS staff to ensure that complex issues were resolved within the committees. The eight committees established within the Community Planning Working Group and their missions are:

1. **Epidemiology Committee.** The mission of the Epidemiology Committee was to:

   - Review the epidemiology information/data presented by the Office of AIDS to the Community Planning Working Group.
   - Provide (in conjunction with the planner and the Office of AIDS Epidemiology Branch staff) guidance about the format of the epidemiology profile for the plan.
   - Present a summary to the Community Planning Working Group of where the epidemic is going.
   - Review and comment on the epidemiology section of the plan.

   Members of the Epidemiology Committee were: Harold Rasmussen (co-chair); Juan Reardon (co-chair); Tony Barrett; Rafael Chang; Gail Gibson; and Robert Prado. Facilitator/recorders were Nan Corby and Lekky Araba.

2. **Needs Assessment Committee.** The mission of the Needs Assessment Committee was to:

   - Review behavioral studies, KABB studies, and other information about the needs of the groups at risk.
   - Take into account the public comment presented at each Community Planning Working Group meeting by public and interested parties and Community Planning Working Group members' professional experience regarding needs of the communities.

- Present to the Community Planning Working Group recommendations about the composition and location of five focus groups.

- Develop an unprioritized list of target populations.

- Review and comment on the needs assessment section of the California HIV Prevention Plan.

Members of the Needs Assessment Committee were: Darren Megee (co-chair); Rose Vasquez (co-chair); Rebecca Denison; Brian Dobrow; Frank McGarvey; Connie Norman; Oscar Reconco; and Alice Ryan. Facilitator/recorders were Hugh Rice and LaSonya Jones.

3. **Strategies and Interventions Committee.** The mission of the HIV Prevention Strategies and Interventions Committee was to:

- Review behavioral studies, effectiveness studies, public comment and Community Planning Working Group professional experience and other information about the needs of the groups at risk.

- Conduct in conjunction with the planner, a survey of California HIV prevention programs to assess the perceived effectiveness of currently available prevention programs.

- Recommend to the Community Planning Working Group an unprioritized list of strategies and interventions that are culturally and linguistically appropriate for defined target populations whose serostatus is unknown, HIV negative, and HIV positive.

- Review and comment on the strategies and interventions sections in the draft plan.

Strategies and Interventions Committee members were: Alberto Cortes (co-chair); Gail Mauer (co-chair); Alex Campos; Yolanda Chavers; Ross Conner; Yvette Flunder; Reuben Garza; and Matiana Grogan. Facilitator/recorders were Marsha Herring and David Lewis.

4. **Priority-Setting Criteria Committee.** The mission of the Priority-Setting Criteria Committee was to:

- Review the CDC *Guidance* on priority-setting criteria, and define other criteria as necessary.

- Review the *Handbook for HIV Prevention Community Planning* information relating to priority-setting.

- Recommend to the Community Planning Working Group a set of criteria and methods for use in prioritizing strategies to meet the needs of defined populations.

- Review and comment on the sections of the draft plan that relate to prioritization.

Priority-Setting Criteria Committee members were: Andy Spieldenner (co-chair); Hank Tavera (co-chair); Gene Copello; James Kahn; Estella Martinez; Pat Norman; Gena Pennington; and Heidi Vert. Facilitator/recorders were Robert Rios and Brenda Romney.

5. **Technical Assistance Committee.** The mission of the Technical Assistance Committee was to:

- Review findings from a technical assistance assessment as outlined in the evaluation report of the Office of AIDS prevention programs.

- Conduct in conjunction with the planner a survey of local HIV prevention programs to assess the need for technical assistance to conduct community wide planning, implementation and evaluation.

- Identify for the Community Planning Working Group the technical assistance needs of the Office of AIDS, local government agencies, and community based providers in the area of community planning, implementation of prevention programs and evaluation.

- Advise the planner about conducting a survey of the state organizations' technical assistance needs in the area of planning.

- Review and comment on the technical assistance section in the draft plan.

Technical Assistance Committee members were: Greg Smith (chair); Jeff Clingenpeel; Tom Lidot; Charlie O'Malley; and Ruth Slaughter. Facilitator/recorders were Barry Brinkley and Louie Campos.

6. **Coordination and Linkages Committee.** The mission of the Coordination and Linkages Committee was to:

- Give guidance to the planner about coordination issues to address with state agencies as the planner conducted a survey of state agencies.
- Discuss what coordination and linkages should occur in local communities and between local communities and state agencies in providing prevention services and programs and convey the information to the planner.
- Make recommendations to the Community Planning Working Group about what coordination should exist among state agencies, between state and local organizations (governmental and non-governmental) and within local communities.
- Review and comment on the sections of the draft plan that relate to coordination and linkages.

Coordination and Linkages Committee members were: Julio Mastro (co-chair); John Schunhoff (co-chair); James Atolagbe; Patty Blomberg; Bill Mitchell; and Sharon Trammell. Facilitator/recorders were Barbara Garcia and Vince Crisostomo.

7. **Resource Allocation Process Committee.** The mission of the Resource Allocation Process Committee was to:

- Identify different procedures that the Office of AIDS could use in allocating federal and state funds for prevention.
- Describe how each process would work, including advantages and disadvantages of each process.
- Make specific recommendations to the Community Planning Working Group about methods for resource allocation.

Resource Allocation Process Committee members were: Mario Hernandez (co-chair); Andrea Learned (co-chair); Corey Dubin; Dean Goishi; Arturo Hernandez; Erma Patterson; Mary Lou Scavarda; and Alex Taylor. Facilitator/recorders were Pat Franks, Tomiko Conner and Pat Ellerby.

8. **Community Participation Committee/Group.** The mission of the Community Participation Committee/Group was to:

- Provide information regarding local prevention and education needs to the Chief of the Office of AIDS, in his role as Community Planning Working Group Co-Chair, to ensure inclusion of local needs and concerns for Community Planning Working Group consideration.

- Ensure that Community Planning Working Group Co-Chair is aware of additional comment/information regarding local needs and concerns that were not provided during the Public Comment portion of the Community Planning Working Group agenda.

The Community Participation Committee membership changed with each meeting and location. This committee was formed at the second meeting in Long Beach and continued thereafter. This committee was made up of local community members attending the Community Planning Working Group meeting and/or providing testimony during the public comment period of each day of the meeting. Since the community members were not a formal part of the Community Planning Working Group and could not participate in the formal proceedings of the meeting nor the smaller committee work, the Community Planning Working Group felt it was important to provide an additional opportunity for members of the public to meet with Wayne Sauseda, Co-Chair and Chief of the Office of AIDS to express additional concerns and comments about the prevention needs in their local communities. The proceedings from this committee were recorded and provided as additional information to the Community Planning Working Group on community needs in the minutes of each meeting.

An Ad Hoc Allocation Committee was established during the fourth meeting in San Diego to provide recommendations for the allocation of $4.95 million new state funds. These funds are an augmentation the Office of AIDS received for HIV testing and prevention for FY 1994-95. The augmentation was not a part of the prevention funds being discussed in the development of the California HIV Prevention Plan. The Ad Hoc Allocation Committee was established at the request of the Office of AIDS to obtain Community Planning Working Group input and recommendations for the expenditure of these new funds prior to the development of the HIV Prevention Plan. These funds are required to be spent during the state FY 1994-95.

Public Comment

An integral part of the California Planning Process and the Community Planning Working Group meetings was the public comment period established at each meeting. Two to three hours were designated at four of the seven meetings for public testimony on the prevention needs of local communities and the California Planning Process. At several of the meetings, public comment was taken in the evening as well as during the morning to increase

public access. Public comment was received from 148 persons verbally and an additional seven persons in writing. The comments and testimony received was formally recorded and incorporated into the minutes of each meeting. The testimony received was used as part of the needs assessment conducted for the California Planning Process. Community Planning Working Group members used this testimony as part of their information about the needs of communities, technical assistance, and prevention strategies that would be effective for specific communities.

Prior to each meeting, correspondence was sent to an interested parties list (which included over 400 agencies/individuals) announcing the upcoming Community Planning Working Group meeting in a specific location and the time provided for public comment. The letter outlined the procedures persons wanting to testify needed to follow as well as the times that testimony would be heard. In addition, five questions were developed and distributed with the letters announcing the Community Planning Working Group meetings. The five questions were developed as a guide for the public to provide the type of information that would be useful for Community Planning Working Group consideration in developing a statewide prevention plan. The five questions were:

1. What communities are not being served, or underserved, by HIV education and prevention efforts in California?

2. What HIV education and prevention needs are not being addressed in your community and why?

3. What HIV education and prevention strategies/interventions would work in your community?

4. What linkages need to be established in your community to make current coordination of education and prevention programs/strategies more effective?

5. What technical assistance is needed to make education and prevention programs, curriculum and service delivery more effective in your community?

Individuals who were not able to attend any of the Community Planning Working Group meetings to provide testimony were encouraged to submit testimony in writing. This written testimony was mailed to the Community Planning Working Group members as received and incorporated as part of the formal record to be considered in the California Planning Process proceedings as appropriate

Community Planning Working Group Activities

At each meeting, Community Planning Working Group members listened to public comment, worked in committees, heard and discussed committee recommendations, debated

prevention planning issues, made decisions pertinent to the plan, and conducted other business necessary to maintain the planning process. The diversity of the representation of members meant a natural diversity of perspectives and opinions. Disagreement of opinions was frequent, but members took seriously their responsibility and were able to achieve their mission.

Community Planning Working Group members received reports from the Multicultural Liaison Board (MLB) which, under contract from the Office of AIDS, sought testimony from communities of color across the State of California. The MLB hearings were a valuable source of public comment for the Community Planning Process.

As the Community Planning Working Group began its work, members had to overcome several constraints in their decision-making process. These constraints included:

- **Geographic spread** of Community Planning Working Group members: meetings could be held only once a month because members were spread over a very large geographic area;

- **Short time** in which to make decisions: members needed several months of committee work and group process experience before they were ready to make certain decisions; many of the decisions were made in the last two working meetings;

- **Relative lack of certain information**: For some target populations, little information is documented. In some cases, we do not know the number of people, the number of AIDS cases, or HIV prevalence or incidence of a particular group. In light of this, the group experienced a lack of consensus about the relative value of documented and undocumented information. Some members wanted to rely on documented information such as AIDS case data and formal evaluations. Others felt that much information was not documented, for example, the growing incidence of HIV among certain populations that is known by agency line-staff but does not yet show up in AIDS case reports.

The Community Planning Working Group overcame these constraints by employing several methods of decision-making. In general, rather than asking members to come to consensus about documented versus undocumented information, Community Planning Working Group members were invited to base their decision-making on whatever sources of information they had and trusted. In doing this, some members put more weight on epidemiological data, others put more weight on public comment. (An exception was the decision about Strategies by Target Population, in which the criteria for decision-making were defined.) Members were not asked to change how they value various types of information, but rather to bring their values to the process and apply them to the decisions at hand.

For many decisions, the Community Planning Working Group used majority+one if a quorum (2/3 of voting members) was present. Majority+one was used to vote on operational

points, such as whether to extend future meetings by a day, and on whether to adopt recommendations from committees.

Certain decisions were made using worksheets. These decisions were:

- Prioritizing target populations;
- Prioritizing needs of each target population;
- Prioritizing strategies for each population using seven criteria;
- Apportioning state prevention funds by program (Counseling and Testing, Training, Education & Prevention, and Early Intervention Program).

Members received a worksheet for each of these decisions. They "cast their votes" by completing each worksheet. Individual scores were compiled and mean scores were calculated. Results were presented to the Community Planning Working Group for discussion.

Other decisions were made by single-text revision. Text, such as the Goals and Objectives, was distributed, comments were collected and integrated, and the text was redistributed. Final revisions were reviewed and adopted during a session of the whole group. After the final comments were noted, the majority+one method was used to adopt the revised text.

At each of the meetings, decisions about the plan were made. These are outlined below and more fully described in the pertinent sections.

Decisions at the Oakland meeting - April 7-8, 1994

- Co-chairs were elected

Decisions Made at the Long Beach meeting - May 5-6, 1994

- Committees were formed and mission of committees were established

Decisions Made at the Fresno meeting - June 7 and 8, 1994

- Which 5 focus groups should occur - composition / location

- How are decisions made and
  How to resolve conflicting resolutions

- What should be the goals of HIV prevention in California

Decisions Made at the San Diego meeting - July 13, 14 and 15, 1994

- Which (unprioritized) target populations should be described in the state plan
- Which (unprioritized) strategies should be described in the state plan

Decisions Made Between meetings - August, 1994

- What should be the priority target populations
- What should be the priorities for needs

Decisions Made at the Redding meeting - Aug. 30 - Sept 1, 1994

- What should be California's objectives (for goals started in June) for prevention
- What should be the technical assistance plan to serve the needs of state, county, and community agencies
- How should coordination and linkages occur:
  among state agencies
  between state agencies and local organizations
  among local organizations (governmental and non-governmental)
- What criteria and weights should be used to prioritize strategies for unmet needs
- What should be the portfolio of strategies to address needs (using the criteria)
- What should be the proportions of funds used for each of the AO's major programs

Decisions made at the San Mateo meeting - September 22-23, 1994

- Shall the Community Planning Working Group adopt the Community Prevention Plan

Decisions made at the Palm Springs meeting - December 15-16, 1994

- How shall information from the Public Testimony sessions be used
- What processes should be used to allocate state resources
- How should the Communitiy Planning Working Group continue its involvement in implementation of the California HIV Prevention Plan

The remainder of this plan discusses the needs of persons living in California for HIV prevention and education and describes the decisions made by the Community Planning Working Group to meet those needs.

SECTION II
NEEDS ASSESSMENT

Section II contains a HIV prevention needs assessment for California. This section contains an epidemiological profile of the state (Chapter 2), an assessment of need using information other than epidemiological information (Chapter 3), a description of existing and potential strategies and interventions (Chapter 4), and a description of the resources -- fiscal and programmatic -- for HIV prevention in California (Chapter 5). The information described in this section guided the recommendations of the Community Planning Working Group. These recommendations are contained in Section III.

Chapter 2 begins with a discussion of the ethnic and geographic diversity of California, and places HIV in a context of leading causes of death among men and women. Next, the demographic and regional characteristics of AIDS cases are discussed. A composite picture of persons living with AIDS is sketched, and HIV prevalence estimates are presented. The chapter continues with a discussion of several studies that provide HIV prevalence estimates for specific groups such as military recruits, women of child bearing ages, clients of publicly funded HIV antibody test sites and injection drug users. Markers of HIV-related high-risk behaviors, such as substance use, perinatal substance exposure, and STDs are described for the overall California population.

Next, the chapter delves into greater detail for each of the basic risk populations -- men who have sex with men (including homosexual men, bisexual men and those who inject drugs), heterosexual injection drug users, cases contracted through heterosexual contact, and infants and children. For each transmission group, information is provided about AIDS case distribution by demographic and regional characteristics and HIV seroprevalence studies.

Chapter 3 provides extensive discussion of each of the target groups selected by the Community Planning Working Group. For each population, a summary of the demographic characteristics is provided, risk factors are described, and key barriers to prevention are identified. Because people have multiple identifies, an assessment of need may rely on the consolidation of several target group sections -- such as Youth and Substance abusers or Women and Homeless. The information in chapters 2 and 3 coincided the needs assessments for this plan.

Chapter 4 examines the HIV prevention strategies and interventions in use or potentially in use in California. For each strategy, three elements are described: 1: An

overview of the strategy including documented or perceived need for the strategy; a discussion of the values, norms and consumer preferences related to the strategy, and an overview of applicable scientific theory related to the intervention; 2) information about the outcome effectiveness of the strategy; and 3) information about the cost-effectiveness of the strategy.

Chapter 5 provides detail on the resources to conduct HIV prevention activities in California. This chapter describes the use of state and federal funds, the HIV prevention activities in the state, and a profile of HIV prevention providers and clients.

This section is followed by Section III which describes the recommendations of the Community Planning Working Group.

CHAPTER 2: EPIDEMIOLOGIC PROFILE OF HIV/AIDS IN CALIFORNIA

CALIFORNIA AND ITS HIV-AFFECTED POPULATIONS: AN INTRODUCTION

The State of California -- diverse, complex, and geographically vast -- is by far the most populous state in the nation, with a 1990 Census population of almost 30 million people (See Exhibit 2.1). The state has 65% more residents than the country's second most populous state, New York, and experienced an expansion in total population of nearly 26% between 1980 and 1990. Three of the five most populous counties in the United States are in California, and, according to the 1990 U.S. Census, 10 of the 14 fastest growing cities in the U.S. between 1980 and 1990 were California cities. Just under 12% of all Americans, or nearly one out of every eight U.S. residents, call California home.

The 58 counties that make up California cover a total land area of over 156 million square miles, encompassing deserts, mountains, forests, coastline, and farmlands, and including urban, rural, and semi-rural population centers of all sizes and characteristics. Four California cities -- Los Angeles, San Diego, San Jose, and San Francisco -- are among America's 14 largest cities. And in a state noted for its cultural and ethnic diversity, in which nearly 50% of the total population is composed of persons of color, three of the five most racially diverse counties in the United States -- San Francisco, Los Angeles, and Alameda Counties -- are also located in California.

The state's two hardest hit cities in terms of total HIV/AIDS incidence and caseload -- Los Angeles and San Francisco -- include a combined population of over 4.2 million persons, or nearly 15% of the state's total population. Other large California cities include San Diego, the sixth largest city in the U.S. at 1,110,549 residents; San Jose, the nation's 11th largest city, with a population of 782,248 persons; and Long Beach, the 32nd most populous city in the U.S. with a 1990 Census population of 429,433 persons. Los Angeles and San Francisco are themselves the second and 14th largest cities in the U.S., respectively.

The state of California is also notable as a center of ethnic and cultural diversity within the United States. Californians of color will constitute a majority of the state's population by the year 2000, while foreign-born individuals already make up 22% of the state's overall population. Twenty-nine percent of Californians speak a language other than English at home, and 600,000 officially-recognized refugees, originating from all corners of the globe, make their home in California.

Exhibit 2.1
Race/Ethnicity Breakdown of Residents in California

Ethnic Population	Number of Residents	% of Population
White	16,812,674	56.15%
African American	2,226,867	7.44%
Native American	183,852	0.61%
Asian/Pacific Islander	2,711,989	9.06%
Latino/Latina	7,949,606	26.55%
Other	56,092	0.19%
TOTAL	**29,941,080**	**100.00%**

Source: 1990 Census

The size and diversity of the state of California present unique challenges to the planners of HIV prevention and education services. Programs must be designed to serve exceptionally varied groups and communities with specially targeted programs, while reaching sometimes massive populations in urban and suburban areas. Programs must overcome divisions brought about by geographic boundaries or health jurisdictions while simultaneously forging collaborations so large that they frequently make consensus-building a daunting task. At the same time, many of the 58 county health departments plan and execute their own separate HIV prevention strategies, while working with the State and with community agencies to form partnerships and working agreements.

The unique culture and environment of California make it a challenging site in which to implement effective HIV prevention efforts. At the same time, the special range, depth, and complexity of its populations also make it the ideal site in which to develop creative and effective prevention models that respond to the needs of an entire nation at risk for HIV.

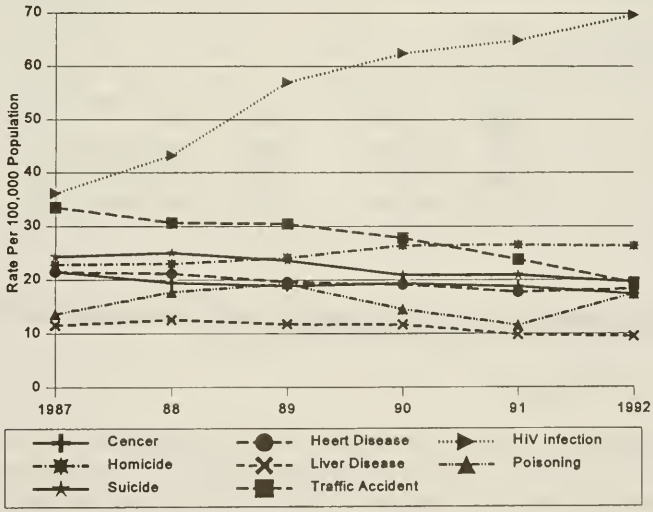
Monitoring the extent and trends of HIV and AIDS in a state the size of California, with its ethnically diverse populations, presents significant challenges. Complete, accurate and timely characterization of AIDS cases and HIV prevalence is of importance to public health policy makers, AIDS service organizations and community advocates in responding to the HIV/AIDS epidemic. HIV/AIDS data, including prevalence and incidence estimates of HIV and AIDS, and projected future trends of HIV/AIDS, can be used in estimating prevention and treatment services needs within California communities.

In the United States, AIDS was first diagnosed in Los Angeles and San Francisco among homosexual and bisexual men in the early 1980's. Since then, the number of persons affected by HIV and AIDS has increased markedly, and the number of communities affected has expanded considerably. The reach of the epidemic has now expanded to persons with hemophilia and others exposed to HIV through blood products or blood transfusions, injection

drug users and their sexual partners, heterosexual partners of HIV-infected persons, and infants born to mothers with HIV.

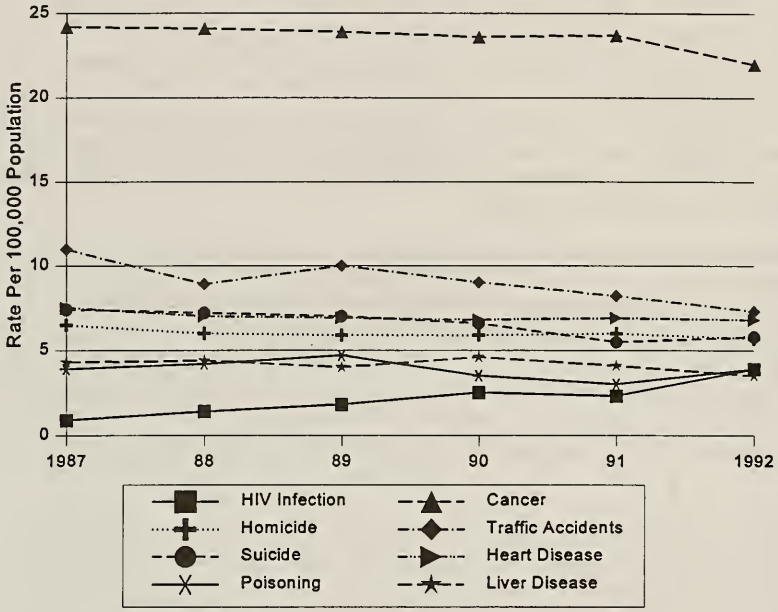
The number of AIDS cases diagnosed and reported in California has grown rapidly. Of the first 50,000 AIDS cases, the first 25,000 cases were diagnosed and reported within a ten-year period (1980-1989), the succeeding 25,000 cases occurred in less than three years (1989-1992). With over 75,000 cumulative U.S. AIDS cases, California ranks second among states in the total number of reported AIDS cases, second only to New York state. Since 1992, however, more cases of AIDS have been diagnosed and reported in California than in any other state in the U.S. Since 1987, HIV disease has become the leading cause of death among age men 25-44 years old and, since 1993, the fourth leading cause of death among women age 25-44 years old (Exhibits 2.2 and 2.3). By the end of 1993, 41,748 Californians had died of AIDS-related complications.

Exhibit 2.2
Mortality Rates of Leading Causes of Death Among Men 25-44 in California, 1987-1992



Source: California Department of Health Services, Office of AIDS
AIDS cases reported as of 3/31/94

Exhibit 2.3
Mortality Rates of Leading Causes of Death Among Women
Ages 25-44, 1987-1992



Source: California Department of Health Services, Office of AIDS

AIDS Cases in California

A cumulative total of 75,221 AIDS cases were diagnosed in California by the end of 1993, for a prevalence rate of 213.5 per 100,000 population. The geographic distribution of AIDS cases and the prevalence rate per 100,000 county population are shown in Exhibit 2.4 and 2.5, respectively. Thus far, AIDS cases have been diagnosed in all but two of California's 58 counties.

With a total of 26,675 AIDS cases, Los Angeles County accounted for the highest number of diagnosed cases, representing 35.5% of all AIDS cases reported in the State. This is followed by San Francisco County with 17,674 cases (23.5%). The remaining 30,872

AIDS cases were diagnosed from geographically diverse areas of the state, (see Exhibit 2.4). Of these, 11,246 were diagnosed in the Bay Area region; 7,176 in the Southern Metropolitan Los Angeles region; 6,778 in the remainder of the state; and 5,628 in San Diego County. The cumulative incidence rate per 100,000 population in San Francisco County is substantially higher than in the other regions of the State (Exhibit 2.6). Nonetheless, the recent impact of the AIDS epidemic is felt in both metropolitan and non-urban areas.

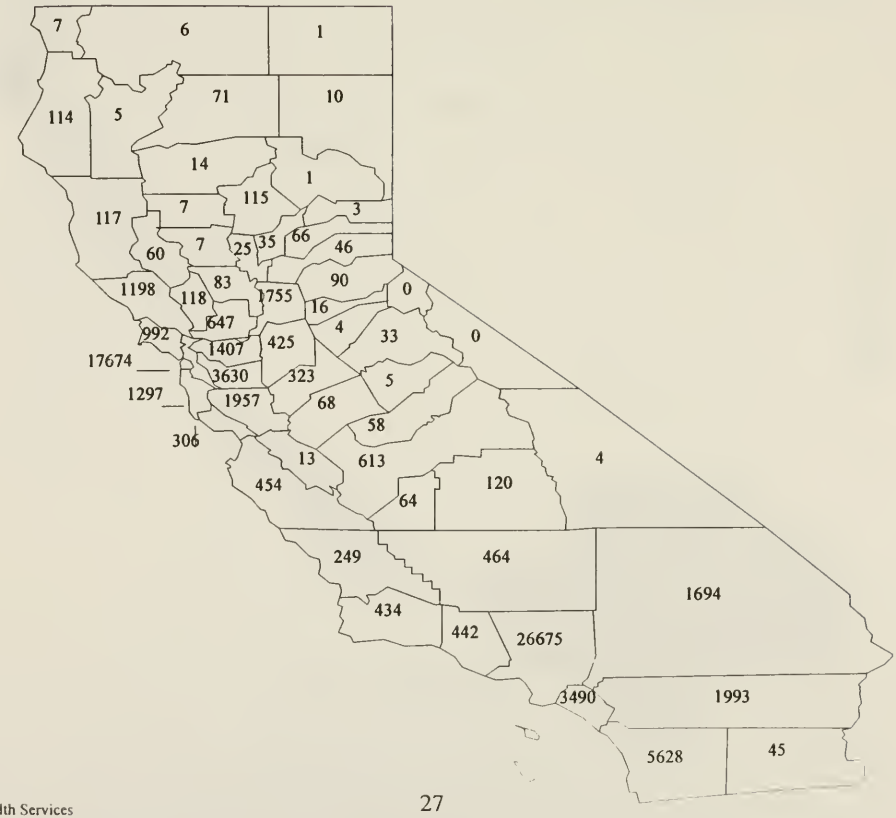
As shown in Exhibit 2.4, two-thirds of the total AIDS cases were diagnosed among whites, 16.8% Latina/os, 15.2% African Americans, 1.8% Asians and Pacific Islanders, 0.3% American Indian/Alaskan Natives, and 0.2% other. The prevalence rate of AIDS per 100,000 racial/ethnic population is highest among African Americans/Blacks (546.5) and lowest among Asians and Pacific Islanders (49.4).

Exhibit 2.4
Demographic and Regional Characteristics and Cumulative Incidence Rates per 100,000 of AIDS cases diagnosed in California through December 31, 1993 (N=75,221)

Characteristic	Cumulative AID Cases	% of AIDS Cases	Cumulative AIDS Incidence Rate Per 100,000 Population
Race/Ethnicity			
White	49,392	65.7%	290.0
African American	11,435	15.2%	546.5
Latino	12,639	16.8%	164.4
Asian Pacific Islander	1,340	1.8%	49.4
Native American	252	0.3%	136.9
Other	164	0.2%	292.4
Gender			
Female	4,125	5.5%	27.7
Male	71,097	94.5%	478.4
Age Group			
< 13	399	0.5%	6.8
13-24	2,371	3.2%	56.6
25-29	10,055	13.4%	352.3
30-49	53,477	71.0%	588.2
50 & over	8,920	11.9%	134.1
County/Region			
Los Angeles	26,675	35.5%	258.1
San Francisco	17,673	23.5%	2,189.8
San Diego	5,628	7.5%	200.3
Other Bay Area Region	11,246	15.0%	212.2
Southern Metro	7,176	9.5%	143.5
Remaining Counties	6,778	9.0%	91.9

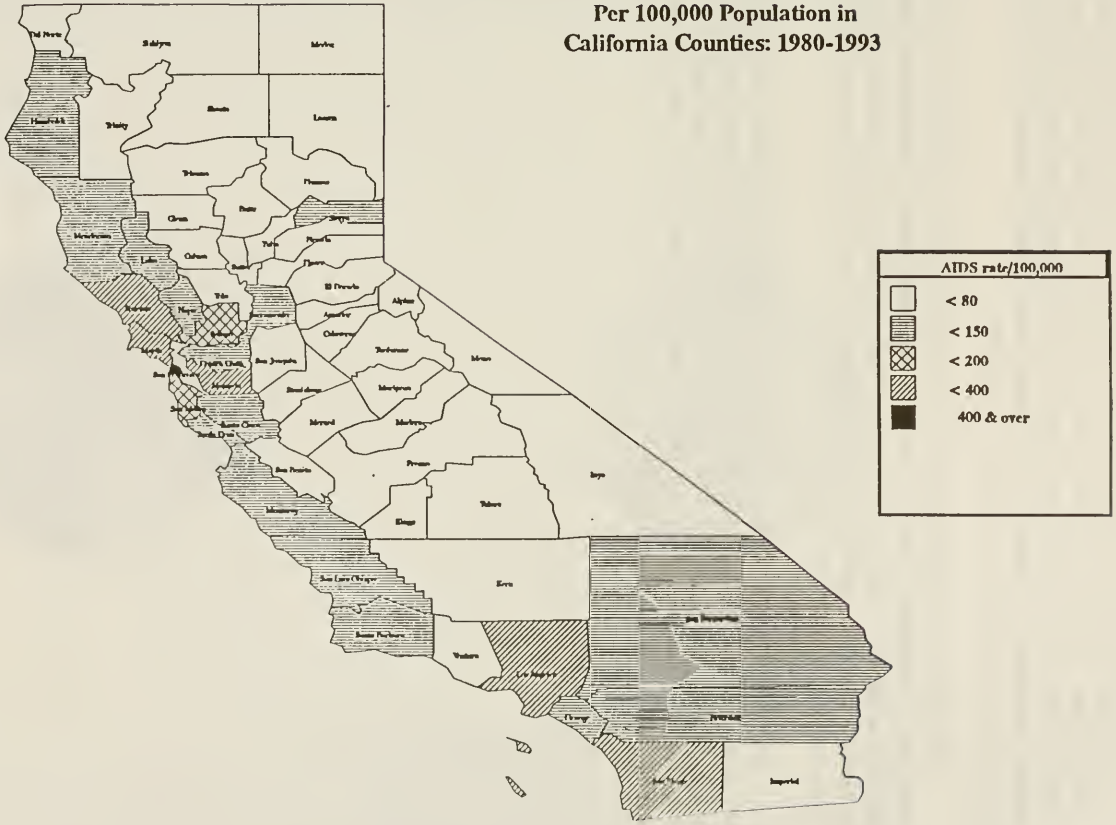
Source: California Department of Health Services, Office of AIDS

Exhibit 2.5
Cumulative AIDS Cases by County of Residence: 1980-1993



Source: California Department of Health Services

Exhibit 2.6
Cumulative Incidence Rate of AIDS
Per 100,000 Population in
California Counties: 1980-1993



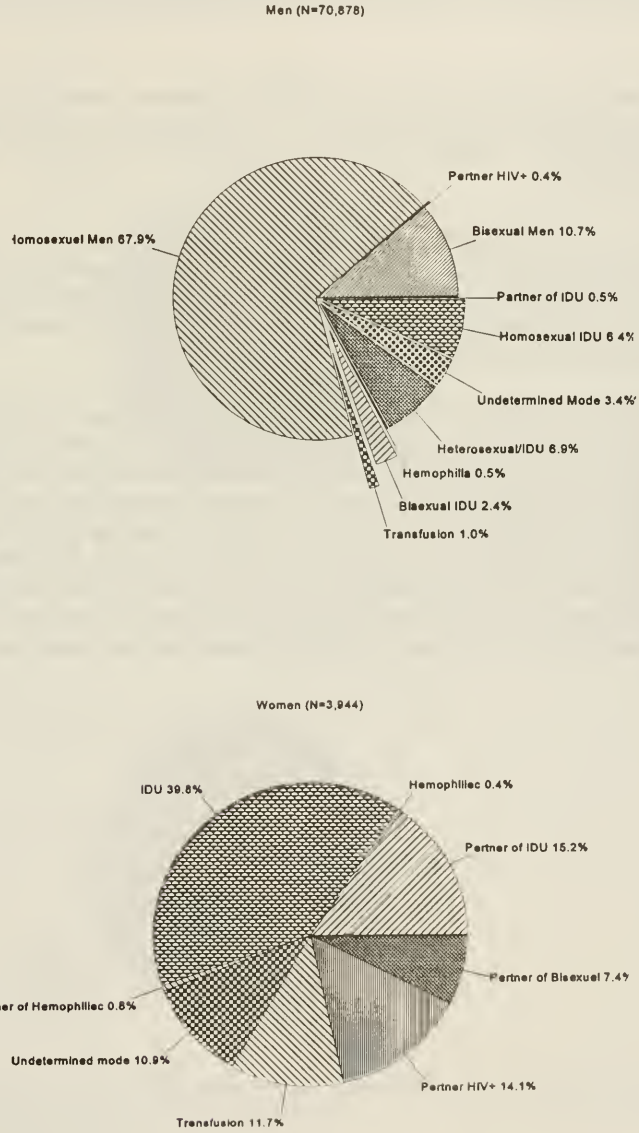
Source: California Department of Health Services, Office of AIDS

The highest number of AIDS cases were diagnosed among individuals between 30 and 49 years of age. Of the 75,221 AIDS cases, 53,477 (71%) were diagnosed in this age group. About 13% and 12% of all cases were diagnosed among persons who were 25-29 years and 50 and older, respectively. Cumulative AIDS cases among children accounted for 0.5%; of these, about 70% resulted from perinatal transmission.

Although the overwhelming majority of AIDS cases were diagnosed among men, the number and proportions of cases in women has increased sharply in the last three years. Overall, injection drug use and sexual contact with a partner at risk or infected with HIV are the two most important risk factors among women, with each risk group accounting for slightly under 40%, as Exhibit 2.7 shows.

Men reporting sex with men (homosexual and bisexual) and injection drug use among these men have been the major exposure categories reported in California, (as Exhibit 2.7 shows). While these categories account for 87.2% of all AIDS cases diagnosed in California, fewer than 60% of cases in the rest of the U.S. were as a result of men having sex with men, including those who use injection drugs.

Exhibit 2.7
Cumulative AIDS Cases Among Adolescents/Adults by Exposure Categories, 1980-1993



Source: California Department of Health Services, Office of AIDS

Persons Living with AIDS in California

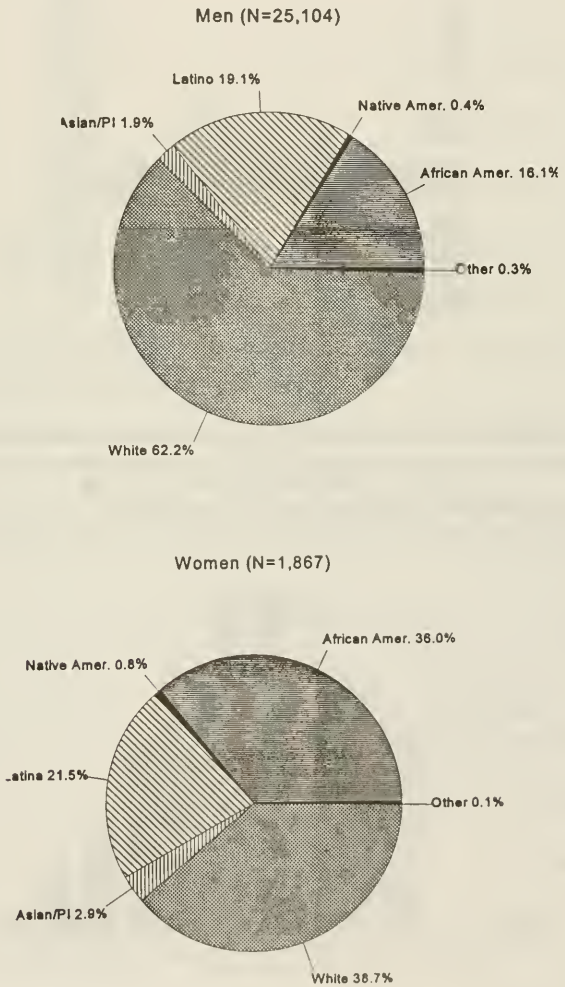
The characteristics of persons living with AIDS are shown in Exhibits 2.8 through 2.12. Exhibit 2.8 shows the ethnic distribution of cases among persons living with AIDS by gender.

Among men living with AIDS, the majority of cases are among Whites (62.2%). A substantial percentage are among Latinos (19.1%) and African American men (16.1%). Asian/Pacific Islanders and Native Americans represent 1.1% and 0.4% of men living with AIDS, respectively.

Among women living with AIDS, cases are spread more evenly than among men. White and African American/Black women living with AIDS constitute 38.7% and 36.0%, respectively. Cases among Latinas represent approximately one-fifth of the total (21.5%), while cases among Asian and Pacific Islander women (2.9%) and American Indian/Alaskan Native women (0.8%) are fewer.

As shown in Exhibit 2.9, the highest rate per 100,000 population among persons living with AIDS is in San Francisco County (843), followed by Los Angeles (101), San Diego (87), the Bay Area Region (81), Southern Metro (56) and rest of California (52). Exhibit 2.10 shows that the case rates per 100,000 population among persons living with AIDS are highest in individuals 35-39 and 40-44 years of age. The highest rates per 100,000 among men and women living with AIDS are among African Americans, as shown in Exhibit 2.11). The proportion of men who have sex with men who are living with AIDS (69.7%) is higher than in the other risk categories, as shown in Exhibit 2.12. The rates are generally higher among African Americans than in the other racial/ethnic groups for both women and men.

Exhibit 2.8
Persons Living with AIDS in California
Racial/Ethnic Distribution by Sex



Source: California Department of Health Services, Offices of AIDS
AIDS cases reported by 3/31/94

Exhibit 2.9
Persons Living with AIDS in California
Rates by County/Region

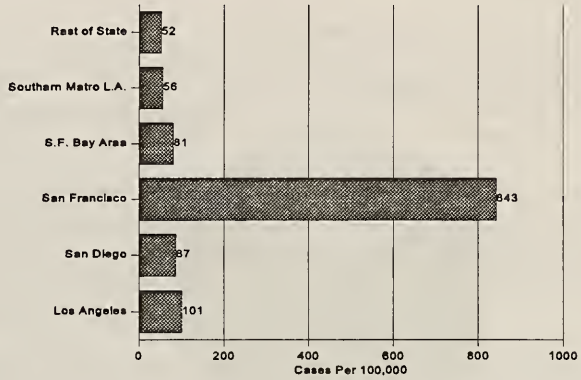
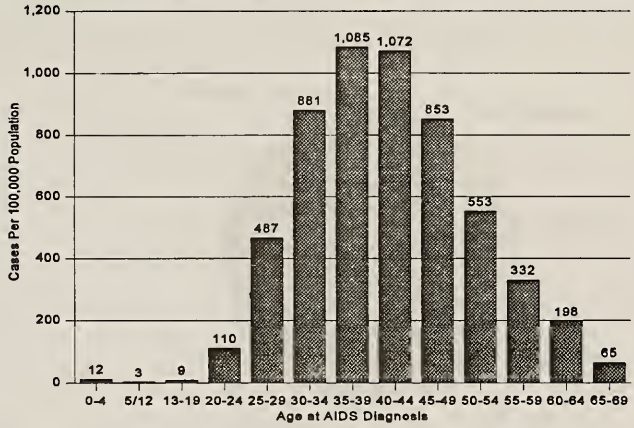
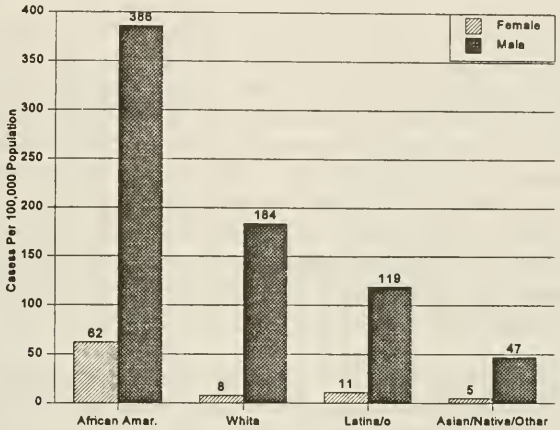


Exhibit 2.10
Case Rates per 100,000 Population Among Persons Living with AIDS by Age



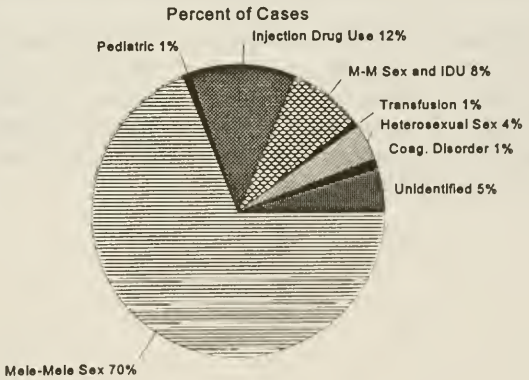
Source: California Department of Health Service, Office of AIDS
AIDS cases reported as of 3/31/94

Exhibit 2.11
Persons Living with AIDS in California
Rates by Ethnicity and Sex



Source: California Department of Health Services, Office of AIDS
AIDS cases reported as of 3/31/94

Exhibit 2.12
Persons Living with AIDS In California
Distribution by Exposure to HIV



Source: California Department of Health Services
AIDS cases reported by 3/31/94

HIV/AIDS Case Projections:

Although AIDS case reporting is relatively complete and accurate, it reflects HIV infection contracted several years earlier. Thus, AIDS cases profile only a fraction of the number of individuals with HIV disease. Since HIV infection is not reportable in California, the actual number of HIV-infected individuals is unknown. While accurate knowledge of the number and characteristics of HIV-infected persons would benefit the overall success of a community-based comprehensive HIV prevention strategy and adequate care and treatment services delivery, mandatory reporting of HIV would be problematic in California. The availability of anonymous testing serves the need of many individuals who fear disclosure but wish to know their HIV serostatus. While the actual numbers are unknown, methods exist to calculate reasonable estimates. The exhibits below summarize the projections of AIDS incidence and prevalence, and HIV prevalence in California.

By applying back-calculation statistical techniques and some simple methods suggested by the Centers for Disease Control and Prevention (CDC) to data from the AIDS registry and the HIV prevalence survey among childbearing women, projected prevalence estimates of HIV and AIDS have been obtained. Exhibit 2.13 shows projected estimates of new AIDS cases under two scenarios: (a) Pre-1993 definition and (b) 1993 definition. For each scenario, two methods of estimates are provided. First, California cases of AIDS as a percent of US cases (17.1%) is applied to CDC estimates of AIDS cases through 1994. Second, estimates were made using the back calculation methods in 1990 for pre-1993 definition cases, while for 1993 definition cases, estimates were made by adjusting AIDS cases reported as of March 31, 1994, for reporting delays by region. The back-calculation estimates for 1993 definition cases show a recent peak in incident AIDS cases in 1992. The projected number of deaths due to complications of AIDS shows a slight increase in 1993, compared to 1992.

Exhibit 2.14 shows estimates of the number of cumulative cases of AIDS, cumulative deaths, and cases alive at some time during each year, 1991-1994. The projected cumulative AIDS prevalence estimates increased by over 40,000 cases from 56,600 cases in 1991 to 97,100-108,600 in 1994. A concomitant increase in the number of AIDS deaths was estimated for the same time period. It is estimated that between 44,200 and 52,400 persons will be living with AIDS at some point in time during 1994.

Exhibit 2.13
Projected Estimates of Incident AIDS Cases and Deaths

Pre - 1993 Definition Cases:

Year	United States	CA (U.S. x 17.1%)	CA Projections (1990)
1992	64,000	11,000	7,700 - 14,800
1993	47,000 - 85,000	8,000 - 14,500	7,600 - 15,600
1994	43,000 - 93,000	7,400 - 15,900	--

1993 Definition Cases:

Year	United States	CA (U.S. x 17.1%)	CA Estimate (3/31/94)
1992	93,300	16,400	15,900
1993	51,000 - 100,000	9,000 - 17,600	15,700
1994	48,000 - 113,000	8,400 - 19,900	

AIDS Death Projections:

Year	United States	CA (U.S. x 17.4%)	CA Projections (11/91)
1992	50,100	8,700	7,100 - 11,900
1993	47,000 - 66,000	8,200 - 11,500	7,200 - 13,100
1994	45,000 - 75,000	7,800 - 13,100	--

Source: California Department of Health Services, Office of AIDS
note: all estimates were adjusted upward to reflect an estimated 85% completeness of AIDS case reporting.

Exhibit 2.14
Projected Annual Estimates of Cumulative AIDS Cases and Deaths in California and AIDS Prevalence Projections (1993 Case Definition)

Year	Cumulative Cases	Cumulative Deaths	Cases Alive at Some Time During Year
1991	56,600	36,000	--
1992	73,000	44,700	37,000
1993	88,700	52,900 - 56,200	44,000
1994	97,100 - 108,600	60,700 - 69,300	44,200 - 52,400

Source: California Department of Health Services, Office of AIDS

It is estimated that approximately 146,000 or one in every 200 Californians is HIV-infected. As shown in Exhibit 2.15, the range varies between 72,800 and 174,500 depending on the procedure used to derive the estimates. An estimated 8,500 California women (range: 5,000-11,200) and 137,400 men (range: 67,800-163,300) are HIV-infected.

Exhibit 2.16 shows estimated numbers of HIV infected persons as of January 1. 1994.The plausible ranges of HIV prevalence shown in Exhibit 2.16 were obtained by proportionate allocation of national estimates of HIV prevalence (750,000-1,000,000) using California AIDS cases diagnosed in 1993 and reported by the end of March 1994. The estimates obtained vary by demographic, geographic and HIV risk group. :

Exhibit 2.17 shows estimates of HIV prevalence by region. The regional estimates of HIV prevalence are as follow: San Francisco County, 25,800-34,800; Other Bay Area region, 22,300-30,000; Los Angeles County, 42,800-57,700; San Diego County, 9,300-12,500; Southern Urban region, 15,100-20,300; Remainder of California, 14,700-19,700. The estimated number of men who have sex with men, IDUs, and women within each region are provided in Exhibit 2.17.

Exhibit 2.15
Estimates of HIV Prevalence by Gender

	Estimate from HIV in Childbearing Women	1992 AIDS Incidence x 15 - 20	California Estimate
Women	5,000 - 9,200	8,400 - 11,200	8,500
Men	67,800 - 158,100	122,500 - 163,300	137,400
Total	**72,800 - 167,300**	**130,900 - 174,500**	**145,900**

Source: California Department of Health Services, Office of AIDS

Exhibit 2.16
Plausible Range of HIV Prevalence in California as of January 1, 1994 by Demographics and HIV-risk Population

	Percent of 1993 AIDS Cases*	Ranges of HIV Prevalence	
		Low	High
California	**100.0%**	**130,000**	**175,000**
Gay/Bisexual	0.8	101,300	136,600
White	0.5	64,100	96,500
African American	0.1	14,200	19,100
Latina/o	0.2	20,000	27,000
Asian/Pacific Islander	0.0	2,500	3,300
Native American	0.4	500	700
Injection Drug User (not Gay/Bisexual)	13.13	17,300	23,300
Heterosexual Contact (Men and Women)	5.80	7,500	10,200
Women	8.40	10,900	14,700
People of Color	**43.40**	**56,400**	**76,000**
African American	19.20	25,000	33,600
Latina/o	21.60	28,100	37,800
Asian/Pacific Islander	2.20	2,900	3,900
Native American	0.40	500	700

Source: California Department of Health Services, Office of AIDS

* AIDS cases reported by March 31, 1994 with adjustment for reporting delay and allocation of cases with no identified risk into a known HIV-exposure category.

** In 1993, the San Francisco Department of Public Health estimated HIV prevalence of 2,288 among Asian/Pacific Islanders in San Francisco, with 2,169 of these gay/bisexual men. This may indicate an increasing rate of new HIV infections among Asian/Pacific Islanders during the past 3-5 years that is not yet reflected in the AIDS data used to construct the HIV prevalence estimates presented here

Exhibit 2.17
Estimates of HIV prevalence by County/Region and HIV-risk Population Group*

County/Region	Men Having Sex with Men (includes IDU)	Heterosexual Injection Drug User (IDU)	Women (Heterosexual Contact)	Other	Total
San Francisco (a)	22,800-30,700	2,400-3,300	300-400	300-400	25,800-34,800
Other Bay Area (b)	15,600-21,100	4,200-5,600	1,200-1,600	1,300-1,700	22,300-30,000
Los Angeles	34,300-46,200	4,300-5,800	2,100-2,800	2,100-2,900	42,800-57,700
San Diego (c)	7,700-10,400	900-1,200	400-500	300-400	9,300-12,500
Southern Metropolitan (d)	11,000-14,900	2,600-3,500	700-900	800-1,000	15,100-20,300
Remaining Counties	9,900-13,300	2,900-3,900	700-900	1,200-1,600	14,700-19,700
California	101,300-136,000	17,300-23,300	5,400-7,100	6,000-8,000	130,000-175,000

* Total number of people living at all stages of HIV disease, from asymptomatic HIV infection to clinical AIDS. Plausible ranges were derived by proportionally allocating the national HIV prevalence estimate of 750,000 - 1,000,000 using California AIDS cases diagnosed in 1993 and reported by March 31, 1994. AIDS incidence in 1993 was adjusted upward using region-specific estimates of delays in case reporting. AIDS cases with an unknown exposure to HIV were allocated among HIV exposure categories according to national estimates of proportions of such cases that eventually are reclassified with an established HIV exposure category. The resulting percentages of 1993 AIDS incidence for Gay/bi men, injection drug users, and heterosexual contact were increased accordingly. ***THE HIV PREVALENCE ESTIMATES PRESENTED HERE UNDERESTIMATE THE TRUE PREVALENCE AMONG SUB-POPULATIONS IN WHICH THE NUMBER OF NEW HIV INFECTIONS HAS BEEN INCREASING IN THE PAST 3-5 YEARS.***

(a) In 1993, the San Francisco Department of Public Health estimated HIV prevalence at 27,629 (including 24,978 gay/bisexual men and 1,690 injection drug users).

(b) Alameda, Contra Costa, Marin, Napa, San Mateo, Santa Clara, Solano, and Sonoma counties.
(c) County of San Diego Department of Health Services estimates are higher than the range presented here.
(d) Orange, Riverside, and San Bernardino counties.

HIV Incidence in California

The number of new HIV infections (incidence) is perhaps the most appropriate measure for targeting and evaluating prevention programs aimed at halting the spread of HIV. However, measurement of HIV incidence requires repeated testing of the same population over time (a rather expensive proposition), or serial testing of prevalence in a population at a fixed site (from which it is difficult to estimate incidence).

Extrapolating from national estimates, there may be as many as 8,000 new HIV infections occurring annually in California. Annual rates of individuals converting from HIV

negative to HIV positive are thought to range from less than 1 to 5 per 100 person years among injections drug users in various locations in the state to 2 to 22 per 100 persons years for men who have sex with men (MSM) in San Francisco and Los Angeles. A large multi-site, longitudinal study provide data that suggests the annual rate of seroconversion among MSM is highest for men between the ages of 20 and 25 (4.4 per 100 person years) and declines thereafter to approximately 1 per 100 person years for men over age 30.

HIV Prevalence in Selected Populations

From the estimates presented in Exhibit 2.13 - 2.17, it is evident that the transmission of HIV infection continues in California. The principal routes of HIV transmission are unprotected sexual contact and sharing of injection drug paraphernalia, and from mother to neonate. HIV prevalence estimates obtained from seroepidemiologic studies and voluntary HIV testing and counseling services, show that prevalence rates very by geographic location, demographic factors, and site/setting of the study. The following sections describe these variations in military recruits, women, HIV antibody test site clients, injection drug users and blood/plasma donors. While we do not have prevalence estimates for all populations, the studies described in these sections provide valuable information.

(A) Military Recruits

In 1985, the U.S. Department of Defense began routine screening of all applicants for military service. Of 338,095 Californians who applied for service in the U.S. military between October 1985 and December 31, 1993, 409 were HIV antibody positive, for an overall prevalence rate of 12.1 per 10,000 applicants tested. Exhibit 2.18 shows that prevalence rates are higher for male applicants (13.5/10,000) than females (3.6/10,000); for African Americans (41.6/10,000); for persons older than 30 years of age (35.6/10,000); and residents of San Francisco County (37.9/10,000). The trend in HIV prevalence among military recruits declined significantly over time from 16.5/10,000 between 1985 and 1988 to 4.53/10,000 in 1992; but increased slightly in 1993 to 7.7/10,000. While applicants from Los Angeles County accounted for less than a quarter (7,628/31,188) of all applicants in 1993, about half the number of seropositives (11/24) were residents of Los Angeles County.

The potential sources of bias in the military applicant data are well documented. These include: self-deferral of applicants who suspect they have been exposed to HIV or may be HIV positive, over-representation of persons in the lower economic strata, and policies that exclude self-identified homosexuals and injection drug users from military service.

Exhibit 2.18
HIV Positivity Rates Among Civilian Applicants for Military Service By Demographic and County/Regional Characteristics

Characteristic	Number Tested	Number Positive	HIV Positivity Rate/10,000
Race/Ethnicity			
White	207,970	179	8.6
African American	41,371	172	41.6
Latino	52,925	40	7.6
Asian/Pacific Islander	25,570	5	23.7
Native American	2,113	5	2.0
Other	8,146	8	9.8
Gender			
Female	47,348	17	3.6
Male	290,747	392	13.5
Age Group			
17-19	179,875	69	3.8
20-24	99,456	149	15.0
25-29	34,315	104	30.3
30+	24,449	87	35.6
County/Region			
Los Angeles	87,631	158	18.0
San Francisco	6,064	23	37.9
San Diego	34,129	45	13.2
Other Bay Area Region	59,200	88	14.9
Southern Metro	51,303	36	7.0
Remaining Counties	99,768	59	5.9

Source: California Department of Health Services, Office of AIDS

(B) Women

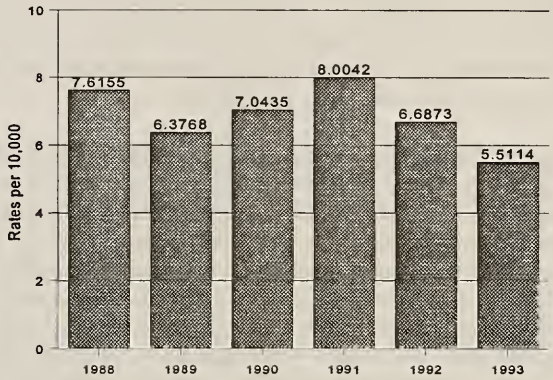
California has participated in the national survey of HIV prevalence among childbearing women since 1988. All infants born in the third quarter of each year in California are screened for HIV antibodies. Only demographic and geographic information of the mother are collected in this survey. Estimates by the CDC show that California has the fourth highest number of births by HIV positive women tested between 1988 and 1990 in the United States, next to New York, New Jersey, and Florida.

Exhibit 2.19 shows that the HIV seroprevalence rate among childbearing women was fairly stable through 1992 but declined slightly in 1993. HIV prevalence rate among African American childbearing women is disproportionately higher than the other racial/ethnic groups during each year of the survey (Exhibit 2.20). In the third quarter of 1993, of 10,652 specimens from African American neonates tested, 29 were positive for HIV antibodies, for a rate of 27 per 10,000 or one in every 395 African American childbearing mothers. However, this rate represents a 40% reduction in the prevalence rate over the 1992 rate of 44.3 per 10,000. A similar decline in the statewide HIV prevalence rate was seen among White childbearing women between 1992 (3.4 per 10,000) and 1993 (2 per 10,000). By comparison, the statewide seroprevalence rate among Latina women increased slightly from 4.3 per 10,000 in 1992 to 5 per 10,000 in 1993. The rates among Asian/Pacific Islander and Native American women were stable between 1992 and 1993. Exhibit 2.21 shows the most profound change in the 1993 results -- the observed increase in HIV prevalence among teenage childbearing women. The HIV rate of 7 per 10,000 in this age group is similar to the rate seen among women 30-34 years old.

It is estimated that between 1988 and 1992, a total of 2,050 women who had live deliveries in California were HIV-infected (Exhibit 2.22). Although the HIV prevalence rate among childbearing women is highest in the San Francisco Bay Area region, by far the largest number of HIV-infected childbearing women was estimated for Los Angeles County.

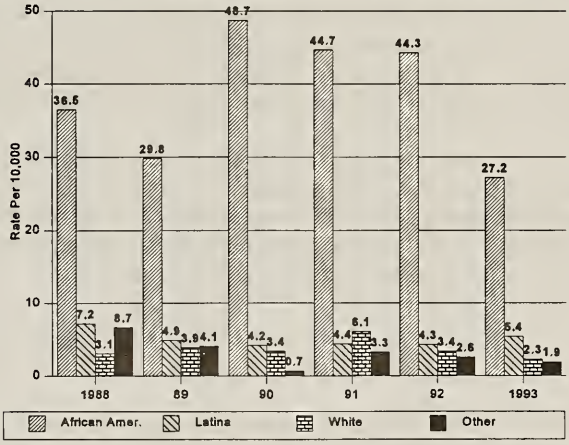
Exhibit 2.23 presents estimates of the number and prevalence percent of HIV among reproductive-age women in California. These estimates (15-44 years) were derived by applying appropriate adjustment factors to HIV seroprevalence rates among childbearing women. As shown in Exhibit 2.23, there were over 6,000 HIV-infected reproductive-age women living with HIV in California each year between 1988 and 1992.

Exhibit 2.19
HIV Seroprevalence Trend Among Childbearing Women, California 1988 - 1993



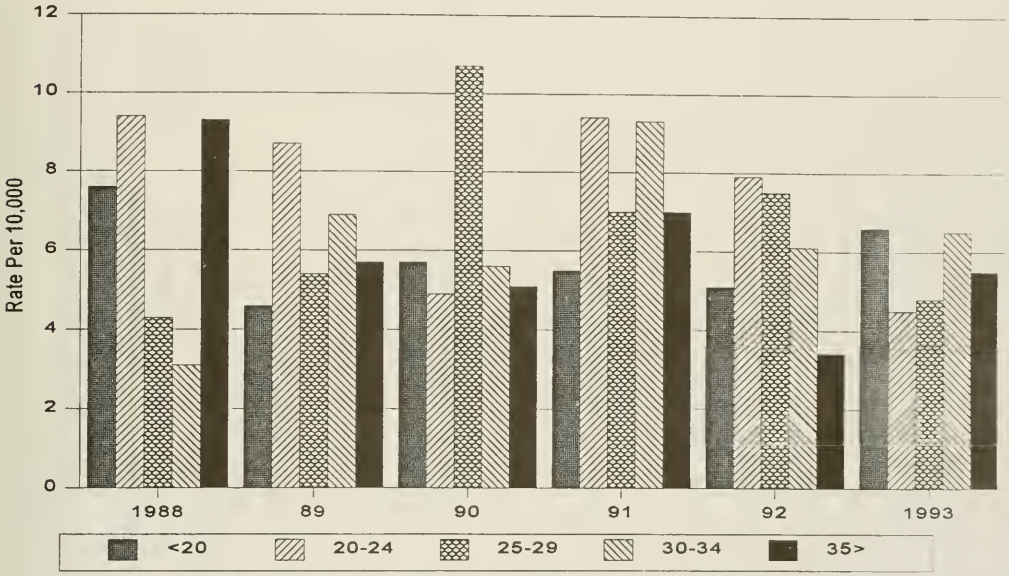
Source: California Department of Health Services, Office of AIDS

Exhibit 2.20
HIV Seroprevalence of Childbearing Women by Year and Race/Ethnicity, California, 1988-93



Source: California Department of Health Services, Office of AIDS

Exhibit 2.21
HIV Seroprevalence of Childbearing Women by Year and Age Group, California 1988-93



Source: HIV/AIDS Epidemiology Branch, Office of AIDS, California Department of Health Services

Exhibit 2.22
Regional Estimates of HIV Among Childbearing Women in California, 1988-1992

Region/County Of Residence	Estimate of HIV Positive Childbearing Women (88-92)	Overall HIV Prevalence Rate/10,000	Rank by Estimated Number of HIV+ Childbearing Women	Cumulative Number of AIDS Cases	Rank by Number of AIDS Cases
San Francisco Bay Area Region	576	11.8	2	811	2
Los Angeles County	859	8.9	1	818	1
Sacramento/San Joaquin Valley Region*	202	4.7	4	234	4
San Diego County	148	6.1	5	208	5
Southern Metropolitan Region	210	4.0	3	337	3
Rest of California Region	53	2.6	6	144	6

Source: California Department of Health Services, Office of AIDS
* includes Butte, Colusa, Glenn, Fresno, Kern, Kings, Madera, Merced, Sacramento, San Joaquin, Stanislaus, Sutter, Tehama, Tulare, Yolo, and Yuba counties

Exhibit 2.23
Estimates of HIV Prevalence Among Reproductive-Age Women (15-44) in California, 1988-1992*

Year Tested	Percent Prevalence	Ranges of HIV Prevalence Percent		Estimates of HIV Positive	Ranges of HIV Prevalence Estimates	
		Lower	Upper		Lower	Upper
1988	0.08%	0.06%	0.09%	7563	6070	9056
1989	0.06%	0.05%	0.08%	6783	5511	8373
1990	0.07%	0.06%	0.09%	6749	5582	8243
1991	0.08%	0.07%	0.10%	7705	6453	9246
1992	0.07%	0.06%	0.08%	6133	5034	7506

Source: California Department of Health Services, Office of AIDS
* Estimates were derived from the results of the survey of HIV among childbearing women after relevant adjustments were made.

(C) Anonymous and Confidential HIV Test Site Clients

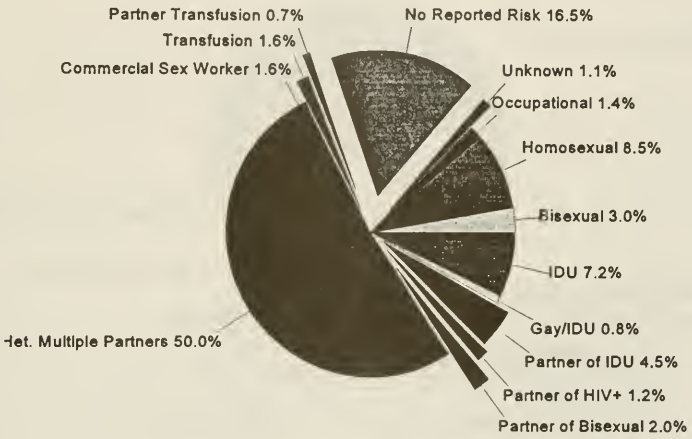
Publicly-funded voluntary HIV counseling and testing services are provided at designated Alternative Test Sites, Family Planning Clinics, Rural and Community Health Clinics, Alcohol and Drug Treatment Centers, and other sites. The majority of Californians who seek HIV testing and counseling services at publicly-funded sites use the ATS. In addition, the highest proportion of positive HIV antibody tests are reported from ATS.

Between 55% and 67% of all testing clients each year are heterosexuals with multiple partners and individuals with low or no known HIV risk. While these groups accounted for two-thirds of all clients who received HIV antibody test in 1993(Exhibit 2.24), they comprised about 14% of all HIV positive individuals. By contrast, men who reported sex with men (including those who use injection drugs) accounted for 12.3% of all individuals who received HIV antibody test at publicly-funded sites in 1993, but made up almost three-quarters of all HIV-positive results (Exhibit 2.25).

In 1993, the highest HIV positivity rate by risk group identification was recorded among men who have sex with men and also use injection drugs (17.9%) (Exhibit 2.26). As shown in Exhibit 2.27, HIV positivity rates varied by race/ethnicity, sex, age and county/region of residence. The highest rates are among African Americans, males, persons age 30-39 years, and residents of San Francisco.

In evaluating HIV seropositivity rates among clients at publicly-funded test sites, it is important to bear in mind that a number of individuals frequently re-test. This introduces a

Exhibit 2.24
HIV Risk Categories of Testing Clients, 1993

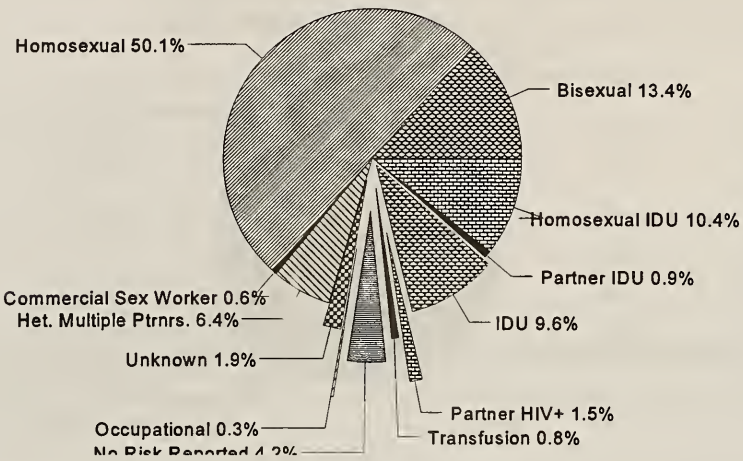


Source: California Department of Health Services, Office of AIDS

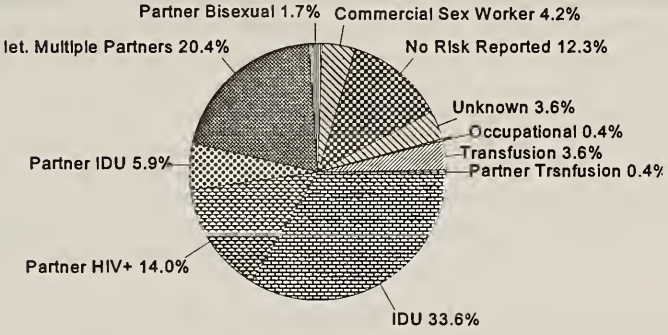
measurable bias into the observed crude seropositivity rates. As a risk category, homosexual men are more likely to seek repeat tests than other risk groups. In general, the HIV positivity rate is higher among first-time testers than among repeat-testers. For example, among homosexual men, HIV positivity rate among those who were testing for the first time in 1993 was 16.7% compared to 3.9% among those who had received prior negative test results.

Exhibit 2.25
Positive HIV Test Results by Risk Categories of Testing Clients, 1993

Men

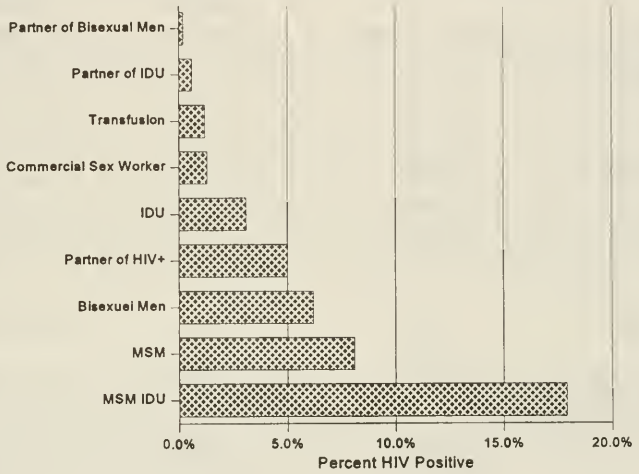


Women



Source: California Department of Health Services, Office of AIDS

Exhibit 2.26
HIV Positivity by Risk Categories Among Testing Clients at Publicly-Funded HIV Test Sites: January-December 1993



Source: California Department of Health Services, Office of AIDS

Exhibit 2.27
HIV Positivity Rates Among Clients At Publicly-Funded Test Sites By Demographic and County/Regional Characteristics: January-December 1993

Characteristic	Number Tested	Number Positive	HIV Positivity Rate (%)
Race/Ethnicity			
White	172,043	2,232	1.3%
African American	30,148	1,178	3.9%
Latino	64,063	1,079	1.7%
Asian/Pacific Islander	12,733	122	0.9%
Native American	2,522	46	1.8%
Other	4,923	65	1.3%
Gender			
Female	137,046	774	0.6%
Male	146,876	3,961	2.7%
Age Group			
12-19	30,044	86	0.3%
20-29	120,067	1,539	1.3%
30-39	82,887	2,043	2.5%
40-49	39,027	838	2.2%
50 & over	16,248	245	1.5%
County/Region			
Los Angeles	52,683	1,105	2.1%
San Francisco	22,300	1,001	4.5%
San Diego	30,215	387	1.3%
Other Bay Area Region	53,917	708	1.3%
Southern Metro	48,425	474	1.0%
Remaining Counties	82,714	1,218	1.5%

Source: California Department of Health Services, Office of AIDS

(D) Injection Drug/Substance Users

From the AIDS-related knowledge, attitudes, beliefs and behaviors (KABB) telephone surveys conducted statewide between 1987 and 1988, an estimated 300,000-500,000 Californians reported ever injecting drugs. Between 60,000 and 75,000 persons reported injection drug use within the past 12 months. However, between 2.8 million and 3.1 million people described themselves as recreational drug users. From a 1991 KABB telephone survey conducted among African Americans and Latinos, an estimated 77,000 African Americans and 99,000 Latinos reported ever using "crack cocaine", "rock" or "ice". About 1% of African Americans (12,500) and 0.5% of Latinos (25,000) claimed they had used needles to inject drugs for non-medical purposes in the past 10 years. Conceivably, the true estimates of injection drug users or substance users are several folds higher than those provided here. The estimates from KABB telephone surveys are deemed low because they were derived from self-report of behaviors that are illegal or perceived as illegal or socially unacceptable.

In-treatment Drug Users

Between 1989 and 1992, injection drug users (IDUs) entering Methadone Treatment programs were anonymously tested for HIV antibodies in six California counties (Fresno, Monterey, San Bernardino, San Diego, San Joaquin, and Santa Cruz). HIV prevalence ranged from 1.3% in San Joaquin County to 3.5% in Santa Cruz County.

Out-Of Treatment Drug Users

In studies of IDUs in out-of-treatment settings, HIV seroprevalence ranged from 4.9% in East Oakland in Alameda County to 19% in Richmond, Contra Costa County. The Office of AIDS is currently conducting a seroprevalence study of out-of-treatment IDUs in collaboration with local health departments and community-based groups. Preliminary results as of August 22, 1994 revealed the following seroprevalence rates: Fresno County, 6.3%, San Diego County 1.1%, Sacramento County, 3.0%, East Palo Alto (San Mateo County), 33%.

(E) Blood and Plasma Donors

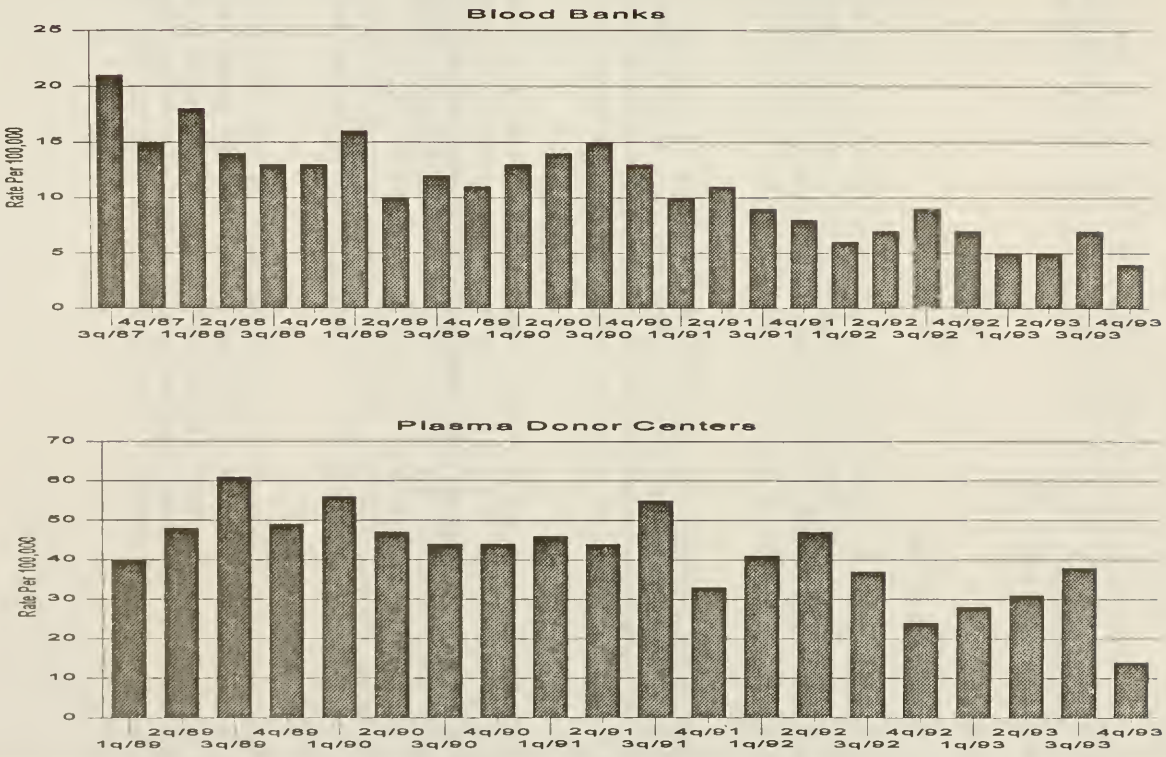
As part of its epidemiological monitoring of HIV disease in California, the State Office of AIDS has maintained quarterly statistical summaries of HIV screening results from blood banks and plasma centers by sex and region since 1989. Approximately 95%-98% of the blood banks and plasma donor centers in the state provide quarterly summaries to the Health Department.

Rates were higher for male donors and for donations at plasma centers than at blood banks. As shown in Exhibit 2.28, HIV seropositivity rates have declined significantly in both blood banks and plasma donor centers. Of 696,219 units screened at plasma donor centers in 1993, 199 were positive for HIV antibodies (0.03%). By comparison, a total of 53 out of

1,068,230 units of blood (0.005%) screened at blood banks were HIV antibody positive. The overall seropositivity in plasma donor centers was about six times higher than in blood banks.

Exhibit 2.28

Trend in HIV-1 Seropositivity Rates Among Donors in Blood Banks and Plasma Donor Centers in California, 1987-1993



Source: California Department of Health Services, Office of AIDS

Markers of HIV-Related High Risk Behaviors

The next several pages contain information about markers of high-risk behaviors, such as substance use and STDs. While these workers do not provide as specific information as does HIV prevalence estimates, they are a more generally available source of information for population groups in California.

(A) Substance Use

(I) In-treatment Substance Users

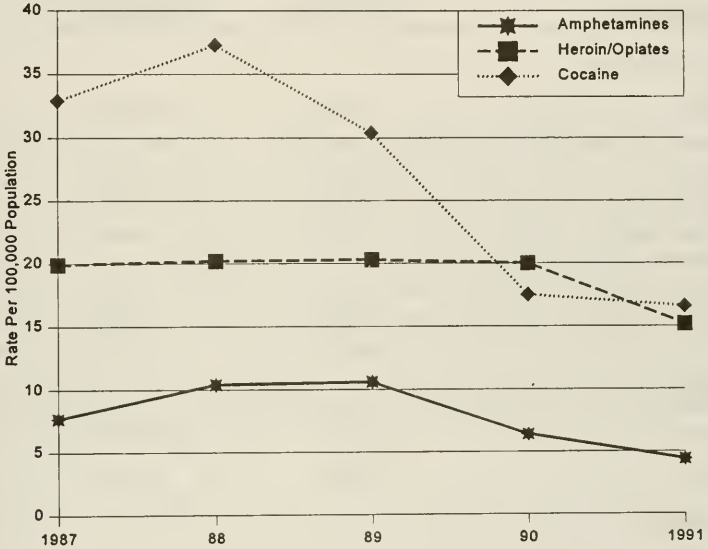
Exhibit 2.29 shows the hospital discharge rates for heroin/opiates, cocaine, and amphetamines per 100,000 population. From this exhibit, it can be seen that the hospital discharge rates of persons admitted for heroin/opiates and amphetamines remained fairly stable through 1990 but declined in 1991. The discharge rate for cocaine declined from 1988 through 1991.

Since hospital discharge records of alcohol and illicit substance use only reflect acute hospitalizations often resulting from overdose, substance users who were not hospitalized are excluded. Thus, these figures underestimate the true prevalence of substance use. A more accurate estimation in California is derived from the summary data of in-treatment substance users.

The California Alcohol and Drug Data Systems reported a total of 147,538 admissions between July 1993 and March 1994. Of these, 98,819 were determined as unduplicated admissions. Exhibit 2.30 shows that 64% of the admissions were among males, 39% among persons 26-35 years old and 50% were among Whites. Heroin was reported as the primary drug of choice in 42% of the admissions; alcohol, 31%; crack/cocaine, 11%; and methamphetamine, 9% (data not shown). About 70% of those in-treatment had used the primary drug on a daily basis. Needle use in the past year was reported by about half (49%) of all admissions.

Thirty-one percent of those currently in-treatment had received no prior treatment episodes for their substance use behaviors, 40% had 1-3 prior treatment episodes and 29% had received more than 3 treatment episodes before their current admission. Almost two-thirds of all admissions were in the out-patient programs, with half of this number being in detox and the other half in the recovery program. At the time of admission, 6% of the 2,800 of the females were pregnant.

Exhibit 2.29
Acute Hospital and Chemical Dependency Discharges
Drug Use as Principal Diagnosis, California,
1987-1991



Source: California Office of Statewide Health Planning and Development (OSHPD) and the Department of Alcohol and Drug Programs

Exhibit 2.30
Characteristics of Individuals Admitted for Alcohol and Drug Treatment in California, July 1993-March 1994

Characteristic	Number of Admissions	Percent of total Admissions
Race/Ethnicity		
White	7,399	50.2%
African American	28,177	19.1%
Latino	38,698	26.3%
Asian/Pacific Islander	227	1.5%
Native American	1,962	1.3%
Other	2,275	1.5%
Gender		
Female	52,608	35.7%
Male	94,930	64.3%
Age Group		
Under 18	6,122	4.1%
18 - 25	18,782	12.7%
26 - 35	57,219	38.8%
36 - 44	45,233	30.7%
45 - over	20,182	13.6%
Route of administration		
Oral	47,954	16.3%
Smoking	23,999	16.3%
Inhalation	11,897	8.1%
Injection	63,135	42.8%
Unknown/Other	447	0.0

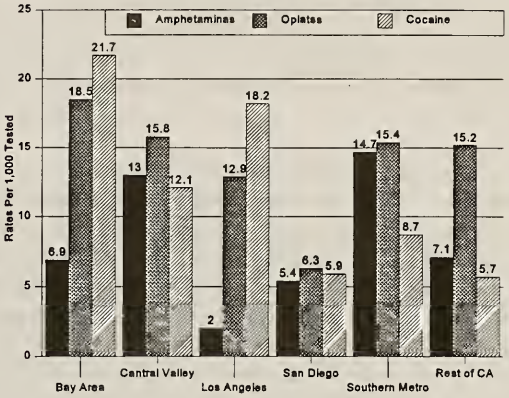
Source: California Department of Alcohol and Drug Programs

(ii) Perinatal Substance Exposure

In 1992, the California Department of Alcohol and Drug Programs conducted an epidemiologic survey of 29,494 pregnant women using rigorous sampling methodologies. The overarching goal was to estimate the prevalence of prenatal substance exposure by specific drug type in California. Using the 1990 Census statistics, population prevalence of prenatal substance exposure was determined.

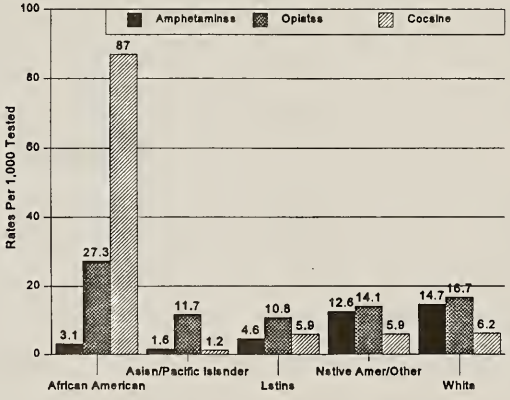
The statewide prevalence rate of perinatal substance exposure among women who had delivery in hospitals in 1992 was 11.35%, or an estimated 69,000 women. The prevalence of illicit substances such as amphetamines, barbiturates, marijuana, cocaine, methadone, and opiates was 3.5% (or an estimated 30,000 women). Exhibit 2.31 and 2.32 show regional and race/ethnicity differences in perinatal exposure to cocaine, opiates, and amphetamines. Exhibit 2.31 shows that the highest rates were in the San Francisco Bay Area. Exhibit 2.32 shows that the highest rates were African Americans. Although the prevalence of alcohol use among English speaking (6.9%) and non-English speaking (6.3%) women were similar, the prevalence of illicit drug use was eight times higher among English speaking (5.2%) than non-English speaking (0.6%) pregnant women (data not shown). Significantly higher rates of illicit substance use (22.2%) were found among women who did not receive prenatal care compared to women who did (2.9%).

Exhibit 2.31
Perinatal Substance Exposure Rates by California County/Region



Source: California Department of Alcohol & Drug Programs

Exhibit 2.32
Perinatal Substance Exposure Rates by Race/Ethnicity



Source: California Department of Alcohol & Drug Programs

(B) Sexually Transmitted Diseases

Sexually transmitted disease (STD) trends are a potential marker for HIV-related high risk behaviors in a community as they represent disease transmission from unprotected sexual intercourse. Several STDs are required by law to be reported to local health departments and to the State Department of Health Services (DHS). The specificity of information that is collected varies from one health department to another. For example, some health departments have information on the amount of rectal gonorrhea that is diagnosed, while others only collect total case counts of gonorrhea without information on the site of diagnosis. DHS collects case counts from local health departments as well as information on the gender, race, age group and dates of report associated with each case. There is also a well documented reporting bias associated with STD reporting; attendees of public clinics are more likely to be diagnosed and reported to the local health department than are individuals who seek treatment from private physicians. This tends to make persons of color over-represented in STD statistical summaries.

(I) Syphilis

Exhibit 2.33 shows the geographic distribution of cumulative primary and secondary syphilis case rates per 100,000 population in California counties. This exhibit shows that San Joaquin and San Francisco counties reported rates of more than 10 per 100,000 population -- the highest rates in the state. Cases of primary and secondary syphilis rose from 1984 through 1986 and peaked in 1987 at a rate of 28 cases per 100,000 population, then declined to a rate of 5 per 100,000 in 1992. During most of this time period, male cases exceeded female cases by approximately 1.7:1 (Exhibit 2.34). Rates among African-Americans peaked at approximately 180 cases per 100,000 population in 1987, 4.5 times higher than the rate in Latinos/as and 18 times higher than the reported rate in whites (Exhibit 2.34). The rate of syphilis in African-Americans declined to 35 cases per 100,000 by the year 1992. Exhibit 2.35 shows that regional trends were reflective of the overall steady decline in cases of syphilis with the exception of San Francisco and its surrounding Counties. San Francisco County experienced a sharp rise in reported cases from 1988-1990, peaking at 50 cases/100,000 population. Cases then declined to 13 cases/100,000 in 1992. Cases in the Bay Area rose through 1991, then leveled.

Exhibit 2.33
Primary & Secondary Syphilis by County of Residence in California, 1992

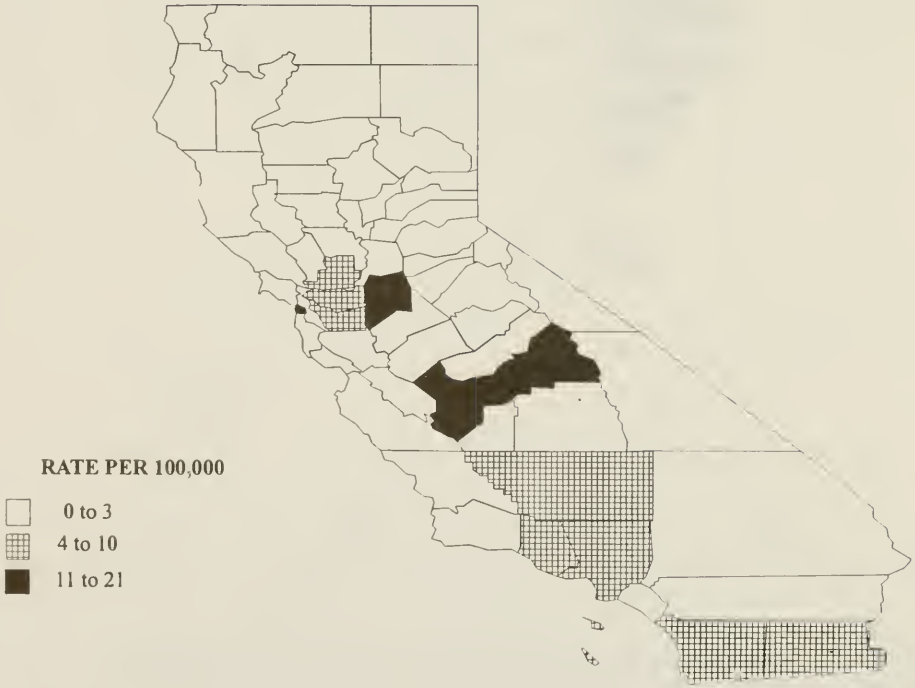
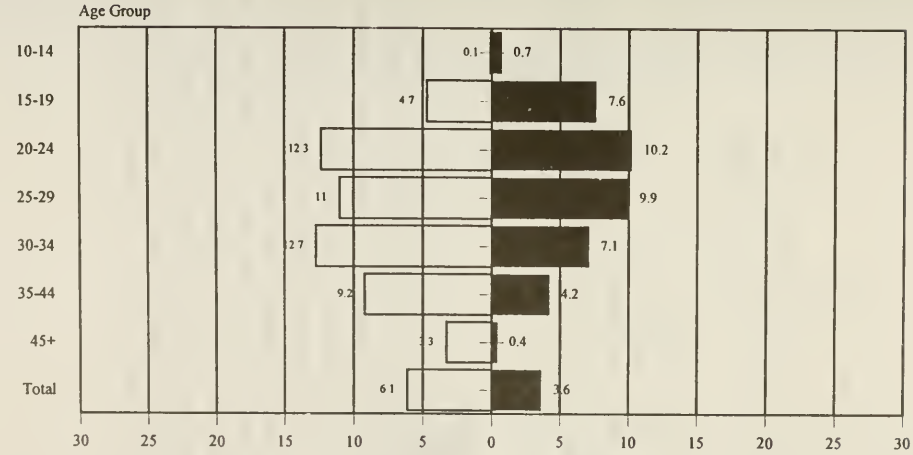
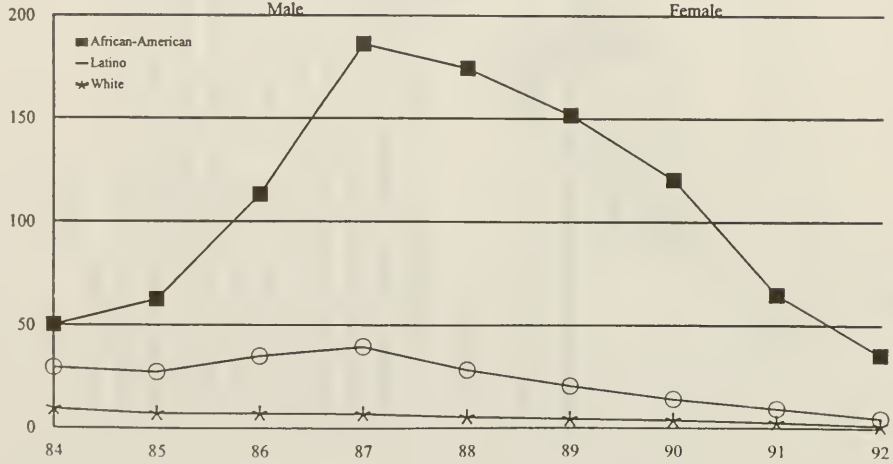


Exhibit 2.34
Primary and Secondary Syphilis Rates per 100,000 population in California



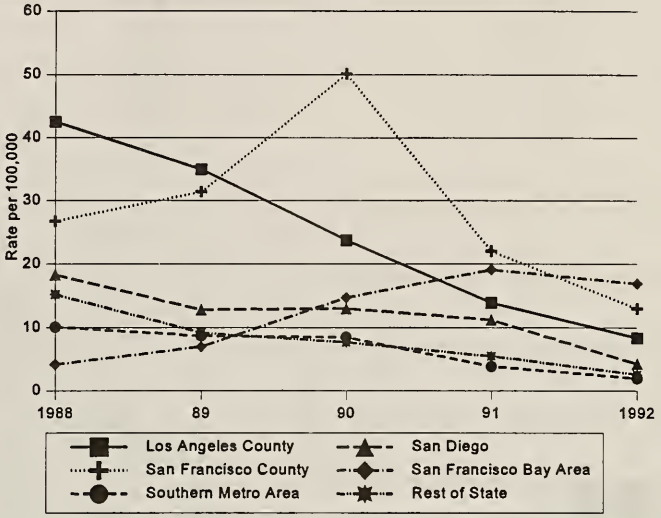
Age Group by Gender
(1992)



Trend by Race/ethnicity
(1984-1992)

Source: California Department of Health Services, STD Control Branch.

Exhibit 2.35
Trend in Primary and Secondary Syphilis Rates by County/Region in California 1988 - 1992



Source: California Department of Health Services, Office of AIDS

(ii) Gonorrhea

The distribution of cumulative gonorrhea rate per 100,000 population by County of residence is shown in Exhibit 2.36. San Joaquin, Contra Costa, San Francisco and Fresno counties reported rates greater than 200 per 100,000 population. Reported gonorrhea cases have similar increases as syphilis but the peak occurred earlier than with syphilis. Incident gonorrhea cases peaked in 1985 with a rate of 900 cases per 100,000 population, declining to 225 per 100,000 in 1992. As with syphilis, case rates among males exceeded the rates in females by about 2:1, and African-Americans had the highest case rates. In 1985, case rates for African Americans were 2,400 per 100,000 population, seven times higher than the rate in Latina/os and 19 times higher than the reported rate in whites (Exhibit 2.37). Trends in gonorrhea cases declined as well when examined by geographic region. San Francisco had the overall highest rates, with 800 cases/100,000 in 1988, declining to 373 cases/100,000 in 1992 (data not shown).

Exhibit 2.36
Total Gonorrhea Rates by County of Residence in California, 1992

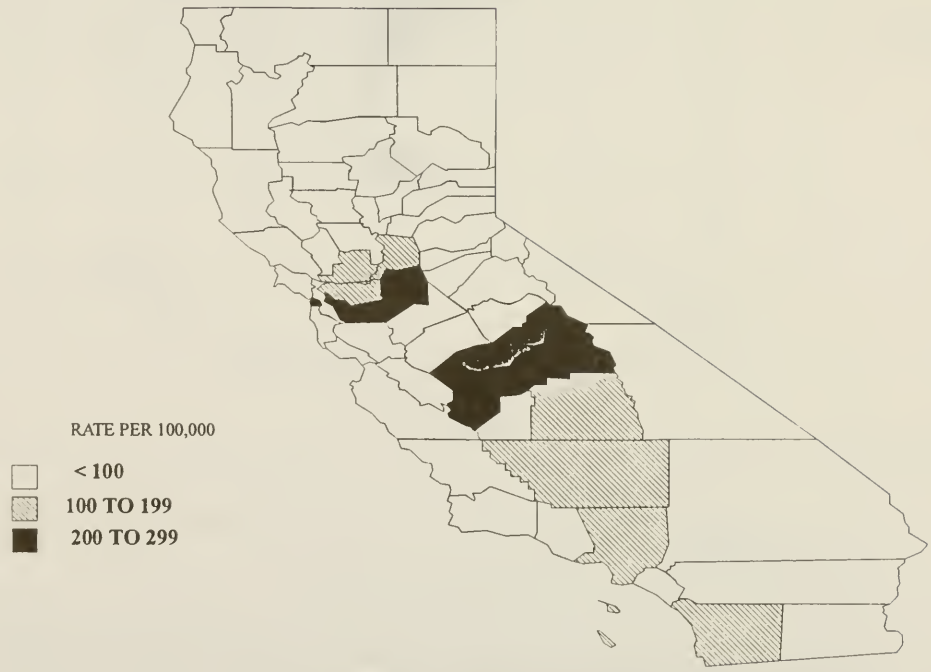
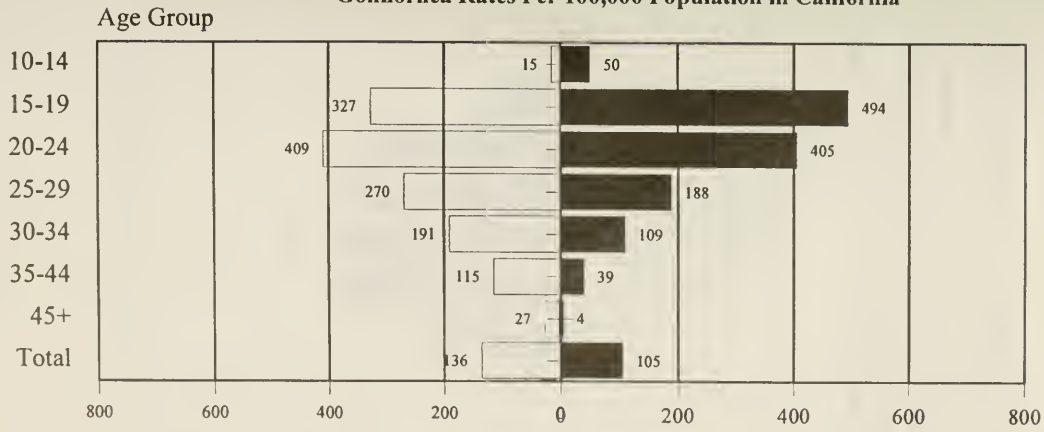
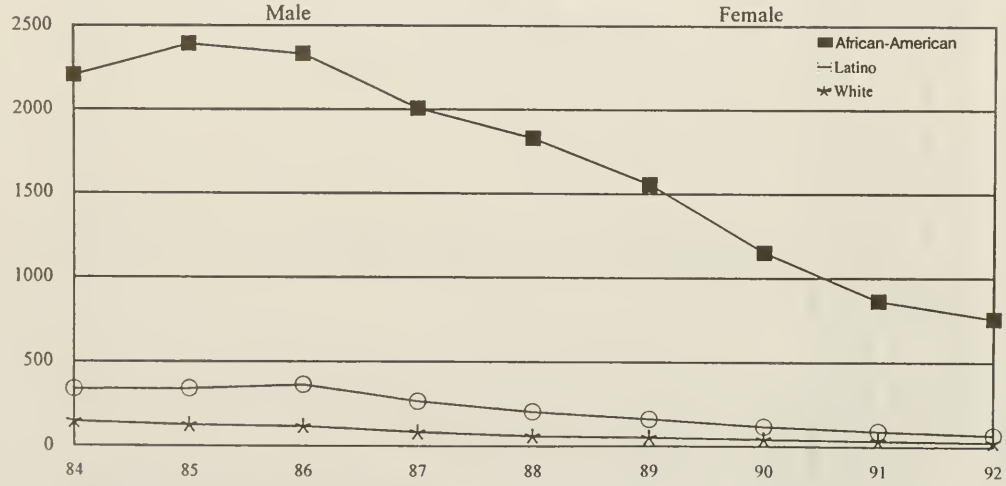


Exhibit 2.37
Gonnorhea Rates Per 100,000 Population in California



Age group by Gender
(1992)



Trend by Race/ethnicity
(1984-1992)

Note: Age and Gender "Not Specified" were 6.6% and 0.4% of total cases.
Source: CA DHS\DCDC, STD Control Branch and Surveillance & Statistics Section

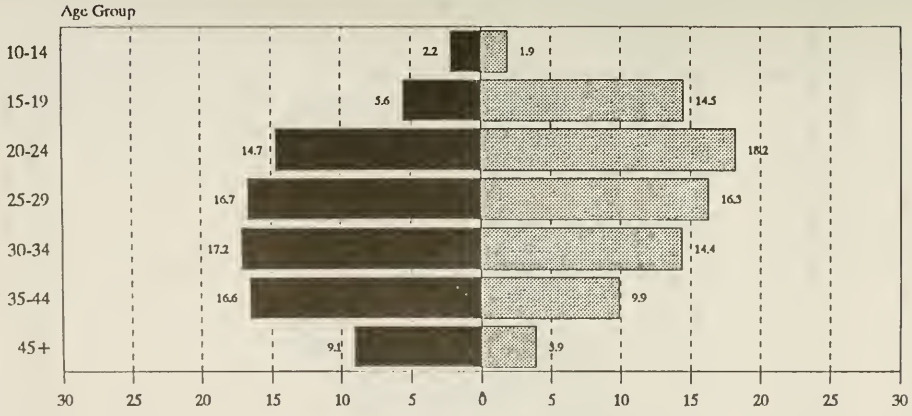
(iii) Hepatitis B

Acute hepatitis B is a viral infection that is transmitted in similar ways to HIV, typically through sharing of needles or works by injection drug users or through sexual contact. Reporting of acute infections is incomplete due to the fact that individuals infected with the hepatitis B virus have relatively mild symptoms and therefore do not seek medical care. As with STDs, some local health departments collect detailed information from hepatitis B cases; however, the State Department of Health Services (DHS) receives and reports only limited information. Beginning in 1993, DHS began obtaining and reporting the source of exposure identified in hepatitis B cases; unfortunately, the exposure category was reported as "Unknown" for 95% of the cases reported in 1993.

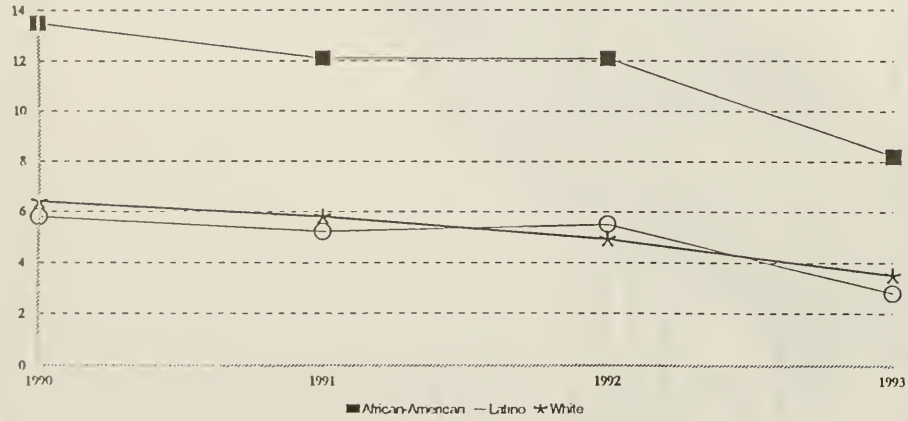
From 1990 to 1993, reported cases of hepatitis B declined from 10 cases per 100,000 to 6 cases per 100,000. Rates in males were higher than in females by about 1.3:1 (Exhibit 2.38). Rates among African-Americans were twice as high as case rates among Latinos/as and whites; case rates in Latinos/as and whites were similar, and declined from 6 per 100,000 in 1990 to 3 per 100,000 in 1993 (Exhibit 2.38). Of those cases reported in 1993 with risk information, 47% were attributable to injection drug use and 36% were attributable to sexual contact.

Exhibit 2.38

Acute Hepatitis B Rates Per 100,000 Population in California



Age group by Gender (1992)



Trend by Race/ethnicity (1984-1992)

Source: CA DHS\DCDC, Surveillance and Statistics Section

MEN WHO HAVE SEX WITH MEN (MSM) AND MSM IDU's

This section describes the impact of the epidemic among homosexual and bisexual men and homosexual and bisexual male injection drug users. Where possible, data have been separated for homosexual men and bisexual men. The term "men who have sex with men" (MSM) is used to describe men who have sex with men regardless of sexual orientation.

AIDS Cases in Men Who Have Sex With Men (MSM) and MSM IDUs

In California, the earliest cases of HIV and AIDS were reported in 1981 among homosexual men who were residents of Los Angeles and San Francisco. Since then, although AIDS has spread to a wider variety of populations and geographic areas, male-to-male sexual contact remains the leading exposure category for HIV infection in California.

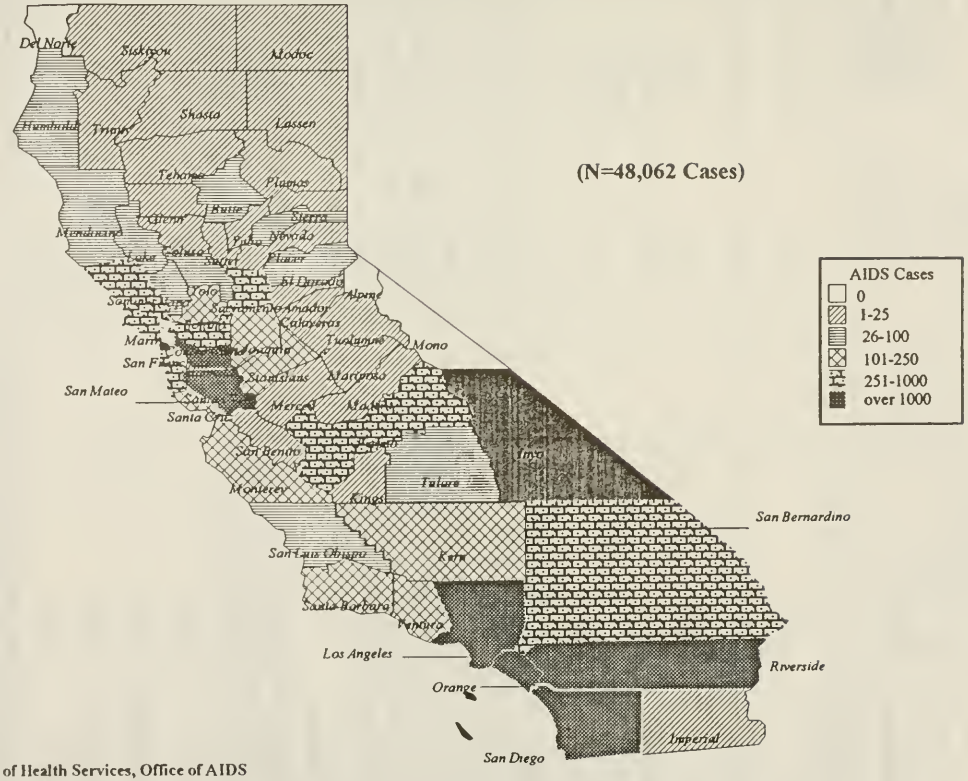
Cases among men who have sex with men were 55,810[1] or 88% of all California cases diagnosed through December 31, 1993. AIDS cases among men reporting sex with men have been reported in all except three California counties (Del Norte, Alpine and Mono), as shown in Exhibit 2.39.

The majority of AIDS cases among all men who have sex with men were reported among men who are white (74%), 30-49 years old (74%), and residents of Los Angeles and San Francisco Counties (64%). (See Exhibit 2.40.) Men who have sex with men represent at least half of the total AIDS cases reported among all racial/ethnic groups except African Americans, and in all California regions except rural California.

---

[1] AIDS statistics in this report represent the estimated number of AIDS cases diagnosed through 1993 after adjusting for delays in reporting using AIDS cases reported to California Department of Health Services, Office of AIDS by March 31, 1994.

Exhibit 2.39
Cumulative AIDS Cases Among Homosexual Men



Source: CA Dept. of Health Services, Office of AIDS

Exhibit 2.40
Demographic and Regional Characteristics of AIDS Cases Among Men Who Have Sex With Men (MSM)

Characteristic	No. of MSM AIDS Cases	% of MSM and MSM IDU AIDS Cases	Total AIDS Cases Among Each Group	MSM as % of Total Cases of Each Group
Race/Ethnicity				
White	35,706	74.3	49,392	72.3
African American	4,481	9.3	11,435	39.2
Latino	6,815	14.2	12,639	53.9
Asian Pacific Islanders	835	1.7	1,340	62.3
Native American	126	0.3	252	50.0
Age Group				
13-24	1,182	2.5	2,370	50.0
25-29	6,127	12.8	10,055	61.0
30-49	35,627	74.1	53,477	66.6
50 & Over	5,125	10.7	8,920	57.7
County/Region				
Los Angeles	17,062	35.5	26,675	64.0
San Francisco	13,800	28.7	17,674	78.1
San Diego	3,858	8.0	5,628	68.6
Bay Area Region	6,146	12.8	11,246	54.6
Southern Metro	3,940	8.2	7,176	54.9
Rest of CA (Rural)	3,240	6.7	6,778	47.8

Source: California Dept. of Health Services, Office of AIDS
AIDS Cases Reported through December 31, 1993

Although almost three-quarters of the total AIDS cases in men who have sex with men were found in men 30-49 years old, the 15% percent of cases accounted for by adolescent and young adult (13-29 years) men is notable. While 13 to 24 year old men made up 2.5% of the total AIDS cases in this group, about half of all AIDS cases among men age 24 or under resulted from male-to-male sexual contact. Because of the delay between transmission and

diagnosis, it is probable that the majority of these cases were contracted during the men's teenage years.

Exhibit 2.41 shows the distribution and trends of recent (1990-1993) AIDS cases among men who have sex with men (including IDUs). The percentage of cases is shown on the left side of the chart, while the three year average percentage increase in annual incidence is displayed on the right of the chart. Percent increases for subgroups representing less than 1% of all cases are subject to artificial fluctuations due to small numbers and should be interpreted with caution. Newly diagnosed AIDS cases in MSM and MSM IDUs showed a statewide increase of approximately 11% between 1990 and 1993.

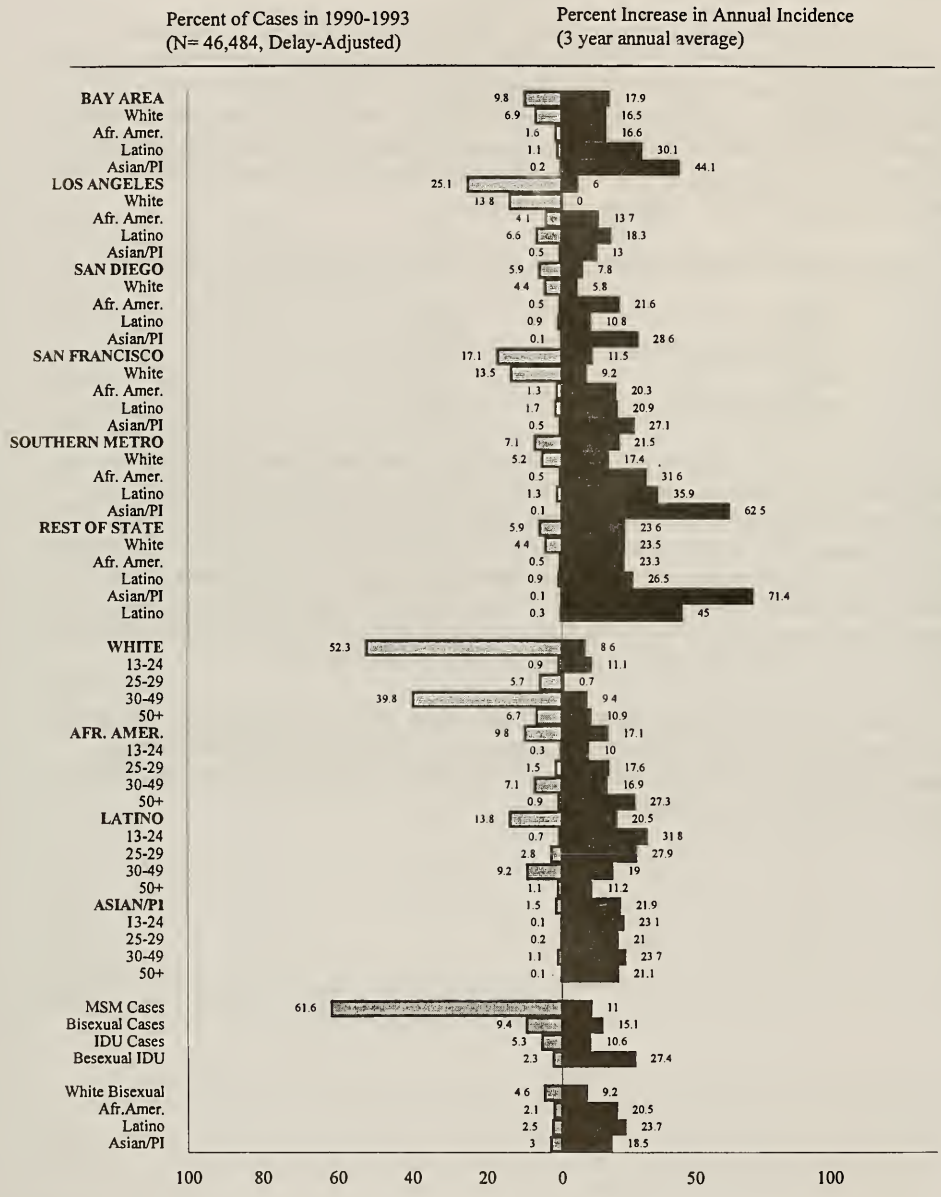
The percentage increases in these years, by racial/ethnic groups are:

Whites	8.6%
African American/Blacks	17.0%
Latinos	20.5%
Asian/Pacific Islander,	21.9%

Among whites, the highest percentage increases in cases were found in the Southern Metropolitan region (22%) and the Rest of California region (24%). The largest percentage increases among Latino men were recorded from the Southern Metropolitan region (36%), the Bay Area region (30%), and the Rest of the State (rural) region (27%). For African American men, the Southern Metropolitan region had the highest percentage increase in cases (32%), followed by the Rest of California region (23%), San Diego (22%) and San Francisco (20%). The largest percent increases among whites were recorded from the Rest of California region (24%), the Southern Metropolitan region (17%) and the Bay Area (17%).

White and Latino MSM and MSM IDUs showed the highest percentage increases in the 13 to 24-year-old age group (11% and 32%, respectively). In contrast, the highest average increase in AIDS cases seen among African American MSM and MSM IDUs was recorded in the over 50 (27%), and 25-29 (18%) age groups.

Exhibit 2.41
California AIDS Case Distribution and Trends
Men Having Sex with Men and MSM IDU's



California Department of Health Services, Office of AIDS
AIDS Cases Reported by 3/31/94

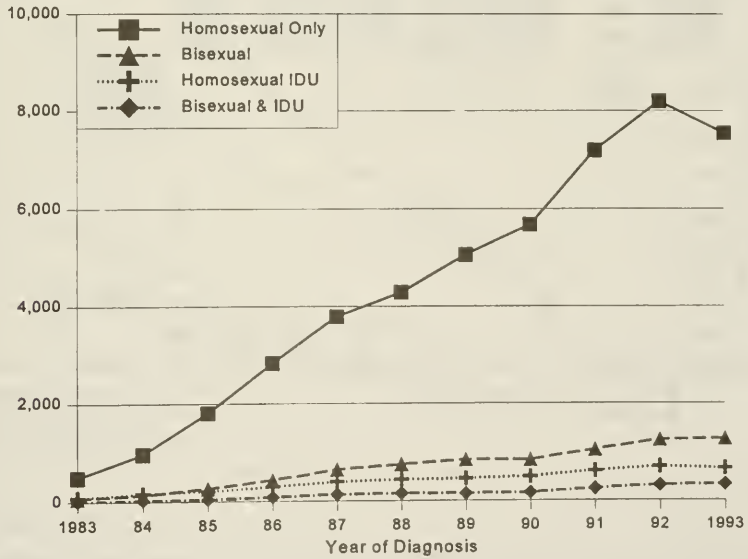
Homosexual Men

1. Trends in Recent AIDS Cases in Homosexual Men

Of the 75,221 AIDS cases diagnosed statewide through December 31, 1993, a cumulative total of 48,062 cases (64%) were reported among exclusively homosexual men.

Exhibit 2.42 shows the statewide annual trend of recently diagnosed MSM AIDS cases by sexual orientation and drug use. The number of new AIDS cases among men who are exclusively homosexual is substantially higher than among homosexual injection drug users, bisexual men, and bisexual male injection drug users. This trend has increased with time.

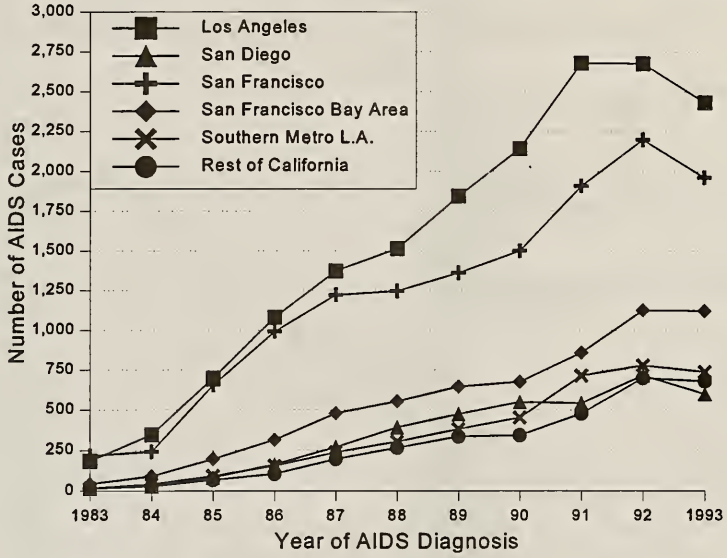
Exhibit 2.42
Trends in AIDS Incidence Among MSM by Behavioral Subgroups



Source: California Department of Health Services, Office of AIDS
AIDS cases reported by 3/31/94
Adjusted for reporting delays

The number of recently diagnosed AIDS cases in homosexual men increased substantially from 1,696 before 1985 to 8,203 and 7,549 in 1992 and 1993, respectively. Recently diagnosed AIDS cases in homosexual men increased in all California regions from 1983 through 1992. Between 1992 and 1993, the number of recently diagnosed cases in homosexual men decreased slightly in Los Angeles, San Francisco, and San Diego Counties, while the other regions of the state showed fairly stable numbers during this period. (See Exhibit 2.43.

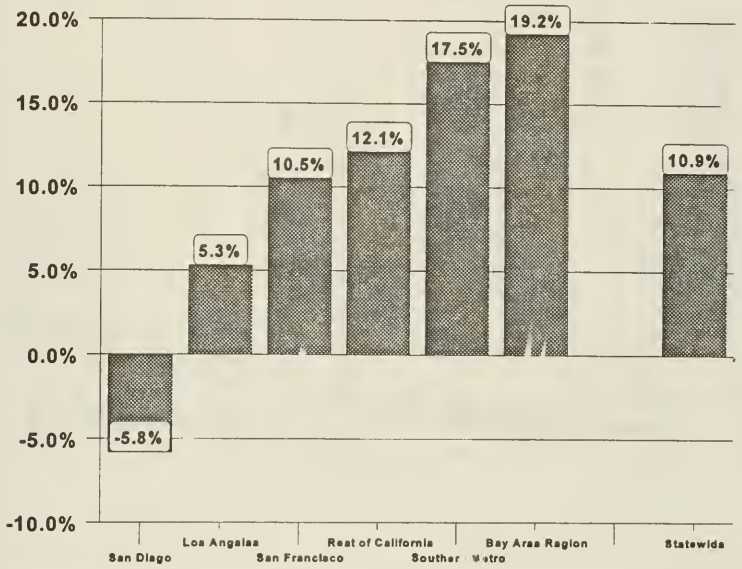
Exhibit 2.43
Trends in AIDS Incidence Among Homosexual Men by County/Region



Source: California Department of Health Services, Office of AIDS
AIDS cases reported by 3/31/94
Adjusted for reporting delays

As Exhibit 2.44 shows, all AIDS cases among homosexual men have increased at an annual average rate of 11% between 1990 and 1993, despite some declines between 1992 and 1993. AIDS cases among homosexual men grew at a faster rate in the Bay Area region (19%), Southern Metropolitan (18%) and Rest of California (12%) regions than in San Francisco (11%), Los Angeles (5.3%), and San Diego (-5.8%) Counties.

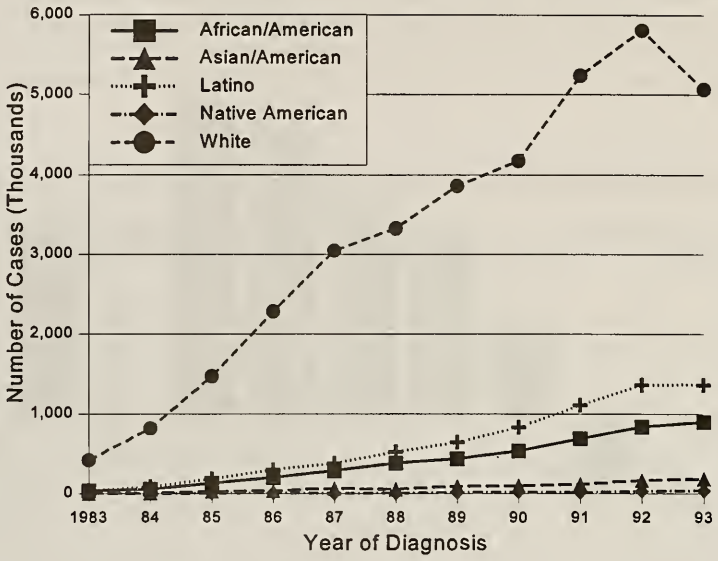
Exhibit 2.44
Average Annual Change in Recent AIDS Cases Among Homosexual Men By Region of Residence (1990-1993)



Source: California Department of Health Services, Office of AIDS
AIDS cases reported by 3/31/94
Adjusted for reporting delays

As shown in Exhibit 2.45, new AIDS cases among white homosexual men increased each year from 1983 through 1992 but decreased by about 13% in 1993. Although the number of new AIDS cases diagnosed each year are significantly fewer among homosexual men of color compared to whites, nonetheless, men of color recorded a steady increase in newly diagnosed cases from 1983-1993.

Exhibit 2.45
AIDS Incidence Among Homosexual Men by Race/Ethnicity

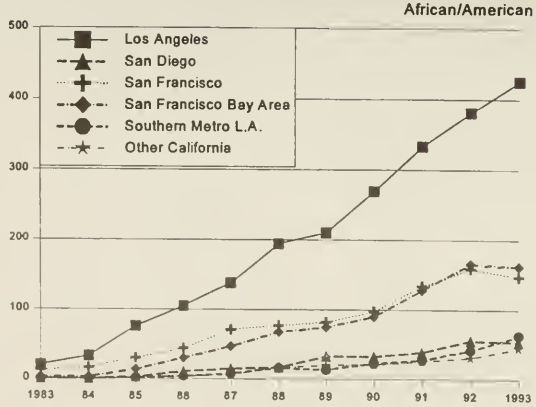


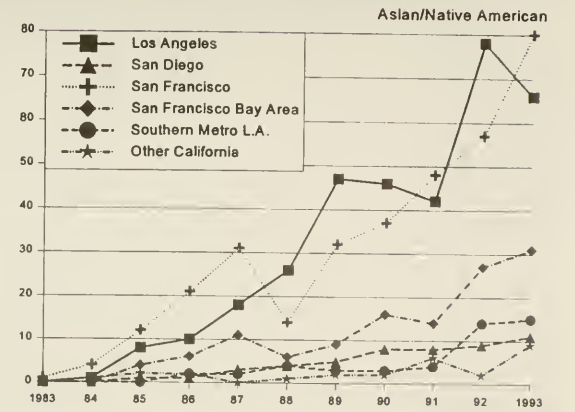
Source: California Department of Health Services, Office of AIDS
AIDS cases reported by 3/31/94
Adjusted for Reporting Delays

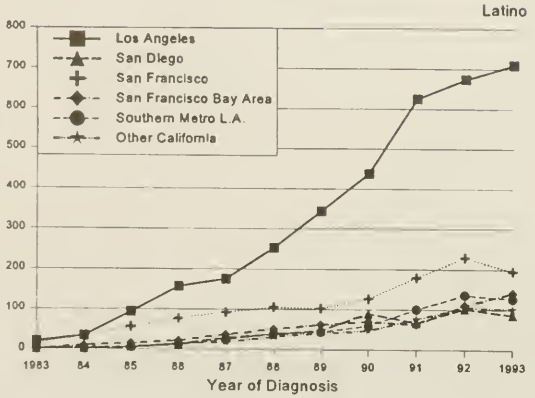
Exhibit 2.46 shows the trend in AIDS incidence among homosexual men by race/ethnicity for each county/region of residence. In Los Angeles County, recently diagnosed AIDS cases among Latino and African American homosexual men increased sharply through 1993, in contrast to other Los Angeles racial/ethnic groups. Although relatively lower, AIDS cases among Asian/Pacific Islander and Native American homosexual men show increases in all geographic regions except Los Angeles County where incident AIDS cases held a pattern of increases and decreases. Among white homosexuals, cases of AIDS decreased or leveled by 1992.

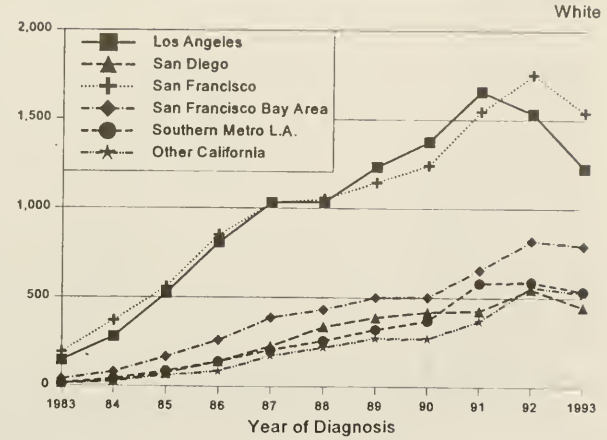
Exhibit 2.46

California AIDS Incidence Trends Among Homosexual Men
1983 - 1993





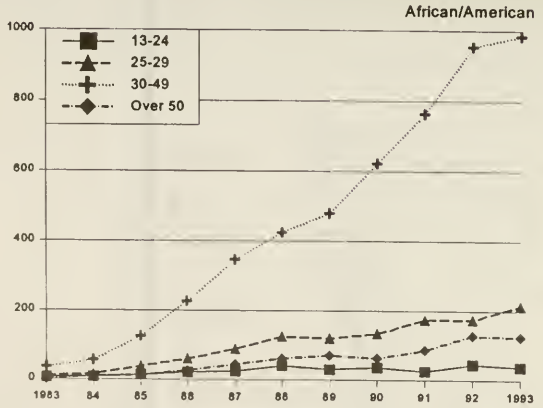


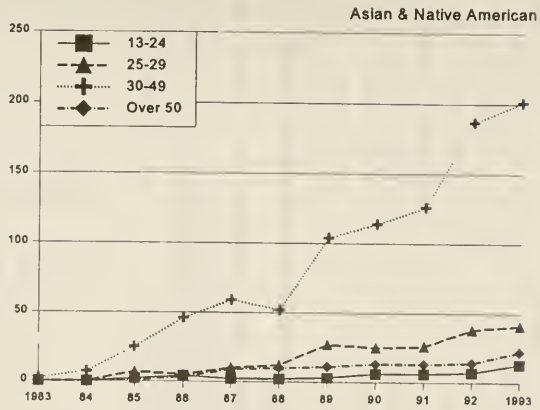


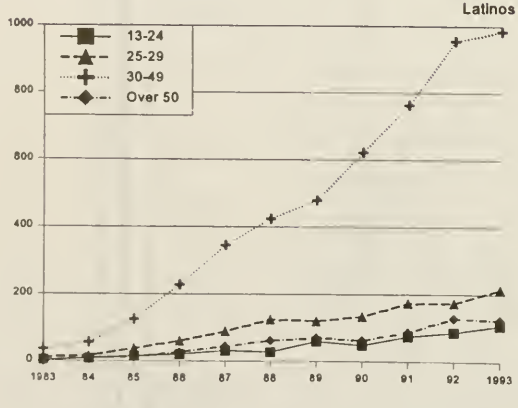
note: charts are drawn on different scales

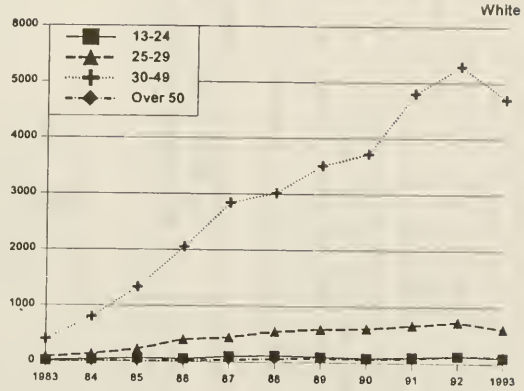
Exhibit 2.47 shows differences in the distribution of AIDS cases among racial/ethnic groups by age at diagnosis. In every racial/ethnic group, the largest number of cases were diagnosed in men between 30 and 49 years of age. However, recent AIDS cases among white homosexual men who were 25-29 and 30-49 years at time of diagnosis declined in 1993, while recent cases among homosexual men of color in these age groups increased.

California AIDS Incidence Trends - Men Reporting Sex with Men
1983 - 1993





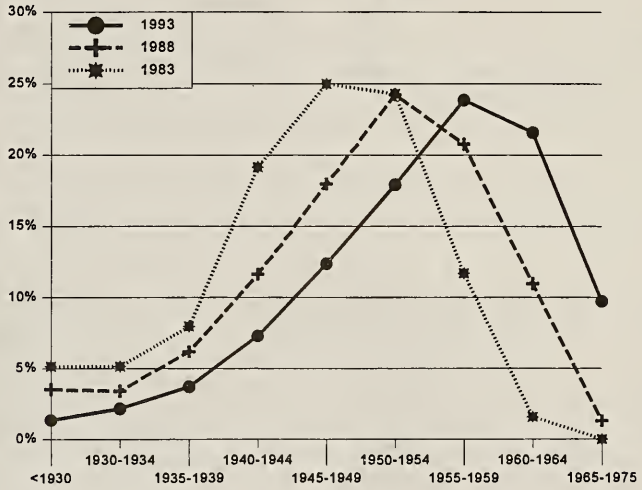




note: charts are drawn on different scales

Exhibit 2.48 shows the proportion of AIDS cases among men who have sex with men in each birth cohort, comparing cases diagnosed in 1983, 1988, and 1993. In each of the years, the highest proportion of cases were among those age 34 - 38 at time of diagnosis. Assuming a median of 10 years from HIV infection to AIDS, the highest proportion of AIDS cases were infected when the men were 20 to 30 years of age. This exhibit shows that an increasing proportion of new AIDS cases were under age 16 in 1980, the year HIV infections probably started to rise dramatically. These men were likely infected after the initial prevention messages were available by mid-1980.

Exhibit 2.48
Proportion of California Annual AIDS Incidence
By Birth Cohorts of Men Having Sex with Men
% AIDS Cases Diagnosed in 1983, 1988 and 1993

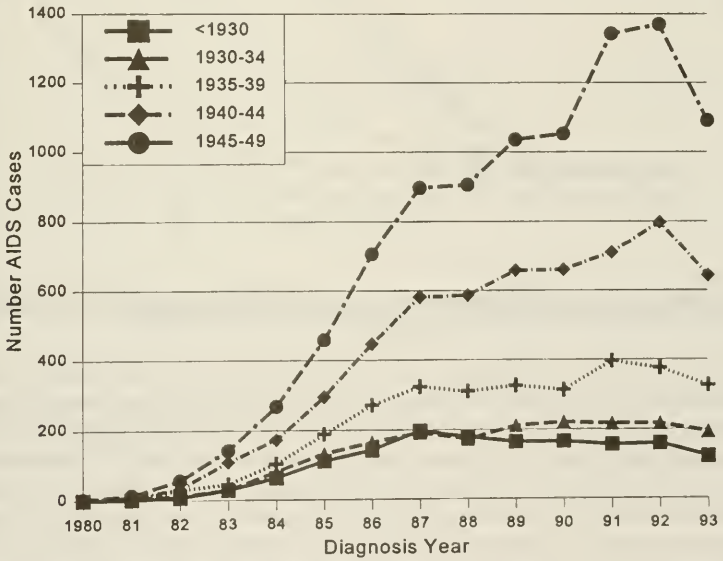


Age in 1993	>63	59-63	54-58	49-53	44-48	39-43	34-38	29-33	<29
Age in 1988	>58	54-59	49-53	44-48	39-43	34-38	29-25	24-28	<24
Age in 1983	>53	49-53	44-48	39-43	34-38	29-33	24-28	19-23	<19
Age in 1980	>50	46-50	41-45	36-40	31-35	24-30	21-25	16-20	<16

Source: California Department of Health Services - AIDS Data Extracted as of 3/31/94

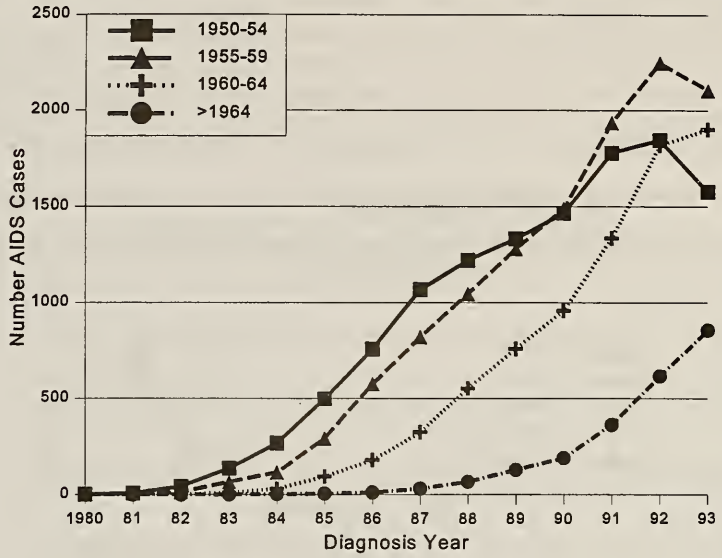
Exhibits 2.49 and 2.50 show trends in AIDS incidence among men who have sex with men by year of birth. Exhibit 2.49 shows that AIDS incidence among men (born before 1930) who have sex with men peaked in 1987. Among those born between 1930-1934, (age 59-63 in 1993) incidence peaked in 1990. Among those born between 1935-1939, (age 54-58 in 1993) incidence peaked in 1991. And for those born between 1940-49, (age 44-53 in 1993) incidence peaked in 1992. Exhibit 2.50 shows that AIDS cases among men who have sex with men born between 1950-1959, (age 34-43 in 1993) peaked in 1992. Among those born after 1960 (younger than 34 years in 1993) incidence continues to rise. Among men born before 1960, AIDS incidence peaked with the highest level among those born 1955-59. It remains to be seen whether AIDS incidence in cohorts born 1960 or later will reach this peak level.

Exhibit 2.49
California AIDS Incidence Trends by Birth Cohorts of Men Having Sex with Men Born Before 1950



Source: California Department of Health Services - AIDS Data Extracted as of 3/31/94

Exhibit 2.50
California AIDS Incidence Trends by Birth Cohorts of Men Having Sex with Men Born 1950 - 1975



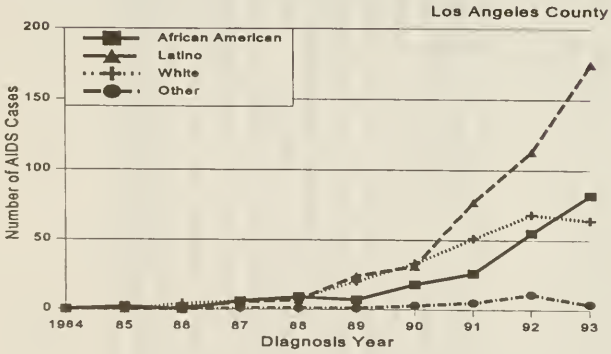
Source: California Department of Health Services - AIDS Data Extracted as of 3/31/94

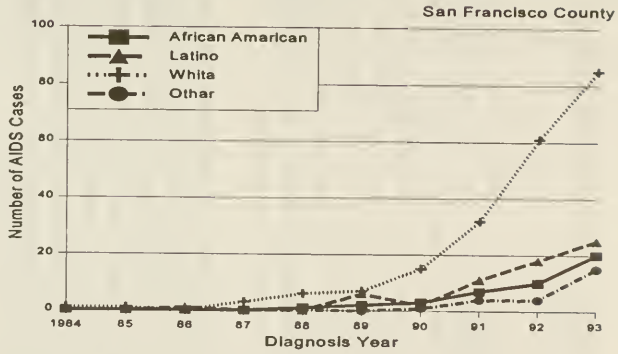
Exhibits 2.48 through 2.50 indicate that successive cohorts of men who have sex with men have peaked in AIDS incidence at younger ages (e.g. 1955-59 cohort peaked at ages 33-37; 1950-54 cohort peaked at ages 34-38). This implies that an increasing proportion of HIV infection occurred among men in their teens and early twenties, and that HIV infections are likely to peak for each cohort when the men reach their teens and early twenties. This will be reflected in AIDS incidence in cohorts born after 1960 peaking around ages 30-33. Thus, the 1960-64 cohort is expected to peak in AIDS incidence by 1995, and the 1970 cohort would peak around year 2000. It is hoped that cohorts born after 1960 will peak in AIDS incidence at lower levels than the peak levels in the 1955-59 cohort, reflecting past successes in prevention.

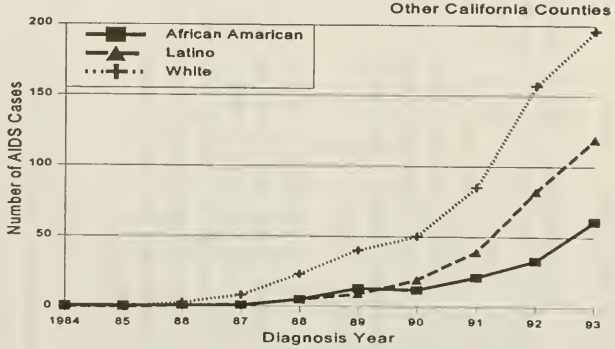
Exhibit 2.51 shows AIDS incidence among younger men who have sex with men (born 1965-1975, and age 10 in 1985) by ethnicity for three areas -- Los Angeles, San Francisco, and all other counties. This exhibit is worth close examination. In Los Angeles, AIDS incidence among men who have sex with men is lower among whites, compared to steadily

increasing cases among African-Americans and Latinos. In San Francisco and other counties, AIDS incidence among white men who have sex with men is higher, but men of color make up a larger proportion of AIDS cases among men in this younger cohort compared to those born before 1915.

Exhibit 2.51
California AIDS Incidence Among Homosexual Young Men
Born 1965 - 75 (<16 Years Old in 1980) By Region and Race/Ethnicity







Source: California Department of Health Services, Office of AIDS

Prevalence of HIV and HIV-related Risk Behaviors Among Young Homosexual Men in San Francisco

The above data show disturbing trends in increases in actual AIDS diagnosis in young homosexual men in California. Further information on this topic was obtained from a study conducted by the San Francisco Department of Public Health AIDS Office. Homosexual and bisexual men aged 17 to 22 years were enrolled in a cross-sectional study from 26 public venues (including street corners and sidewalks, dance clubs, bars, and parks) in San Francisco, Oakland and Berkeley during 1992 and 1993. The participants were interviewed and blood specimens drawn and tested for HIV, level of CD4+ T lymphocytes, and markers of hepatitis-B and syphilis infections. While the following findings of this study may not be representative of California statewide populations, the general conclusion is applicable.

The demographic characteristics of the San Francisco study population, as shown in Exhibit 2.52, indicate that participants were predominantly white (49%) and between 20 and 22 years of age (71%). The overall percentage of HIV infection was 9.4%. HIV positivity among young bisexual men (11.1%) was slightly higher than among all homosexual men (9.5%). Almost 20% of participants showed markers for hepatitis-B; 1% for syphilis. HIV positivity was significantly higher among African Americans (21.2%) than among other racial/ethnic groups. Additionally, positivity was significantly higher among those who reported a history of an STD (23.4%) or injection drug use (20%)

Approximately one third (32.7%) of the participants reported having engaged in unprotected anal intercourse, and 20% reported injection drug use. At the time of interview, of those who reported a history of unprotected anal intercourse, 35.7% of the HIV-infected men did not know that they were HIV positive (Exhibit 2.53). Furthermore, among those men who reported unprotected anal intercourse, a history of nitrite or alcohol intoxication during sex within the previous six-month period was a significant indicator of increased probability of HIV positivity.

In California, this study provides the first documented evidence of high HIV-related risk behaviors and HIV prevalence in this population. To broaden our knowledge of this population in other areas of California, and improve the effectiveness of HIV prevention services, the California Department of Health Services, Office of AIDS is currently collaborating with selected local health jurisdictions to conduct a survey of young men (17-25 years old) who have sex with men, selected from venues known to be frequented by gay and bisexual men. The study sites are in the City of Long Beach, and the Counties of Riverside, Sacramento, and Sonoma. The survey will take place between February 15, 1994 and September 15, 1994. About 500 participants will be included in the survey at each of the four sites. It will determine the prevalence of HIV infection and HIV-related risk behaviors among young homosexual and bisexual men. Information regarding behaviors and psychosocial factors that may place young homosexual and bisexual men at increased risk for HIV infection will also be provided. Although the study is still in its infancy, preliminary results indicate an overall HIV prevalence rate (9.4%) similar to that obtained from the San Francisco study.

Exhibit 2.52
Seroprevalence of HIV by Participant Characteristics, Young Homosexual and Bisexual Men, San Francisco, Oakland & Berkeley, 1992-1993

	Number in Study	% HIV Positive
Age Group		
17-19	122	4.1
20-22	303	11.6
Race/Ethnicity		
African American	52	21.2
Asian/Pacific Islander	48	4.2
Latino	95	9.5
White	210	8.1
Other	20	5.0
Sexual Orientation		
Homosexual	294	9.5
Bisexual	99	11.1
Other	42	4.8
County of Residence		
San Francisco	280	12.1
Alameda	65	3.1
Other Bay Area	80	5.0
Lifetime no male partners		
0-9	161	1.9
10-49	145	8.3
>50	116	21.6
History of anal sex with men, lifetime		
No	67	0.0
Yes	358	11.2
Age at initiation of anal sex w/men		
20-22	53	3.8
15-19	224	11.8
8-14	79	15.2
History of injecting drug use, lifetime		
No	353	7.4
Yes	70	20.0
Lifetime history of STD's		
No	288	2.8
Yes	137	23.4

Source: San Francisco County Dept. of Public Health

Exhibit 2.53
Prevalence of Unprotected Anal Intercourse in the Previous Six Months among Young Homosexual and Bisexual Men, San Francisco, Oakland & Berkeley, 1992-1993

	Number in Study	% Unprotected Intercourse
Age Group		
17-19	122	28.7
20-22	303	34.3
Race/Ethnicity		
African American	52	38.5
Asian/Pacific Islander	48	27.1
Latino	95	40.0
White	210	28.1
Other	20	45.0
Sexual Orientation		
Homosexual	294	35.9
Bisexual	99	30.3
Other	42	16.7
Years in the Bay Area		
0-1	113	33.6
2-5	113	29.2
>6	199	34.2
Nitrite intoxication during sex in last 6 months		
No	371	31.8
Yes	35	60.0
Alcohol intoxication during sex in last 6 months		
No	180	27.6
Yes	226	39.4
Received payment in return for sex with men		
No	341	32.8
Yes	84	32.1
Lifetime history of forced sex		
No	251	26.7
Yes	174	41.4
Knowledge of HIV status		
HIV+, know results	12	33.3
HIV+, do not know	28	35.7
HIV-, know results	106	30.2
HIV-, do not know	279	33.3
Peer norms regarding safe sex		
Positive	233	23.2
Negative	173	45.7
Know someone with HIV/AIDS		
Yes	324	32.1
No	96	35.4

Source: San Francisco County Department of Public Health

HIV Testing Among Homosexual Men

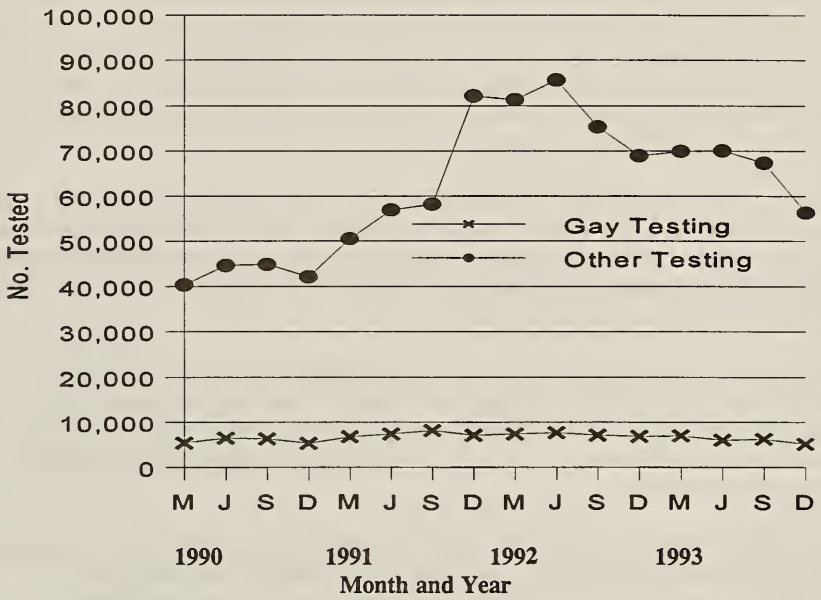
HIV testing data from publicly-funded test sites provide useful insights into HIV-related risk behaviors and level of HIV positivity among clients. These may data provide a more current picture of the epidemic than do AIDS cases. However, because the various racial, age and geographical groups do not take identical advantage of available services, these data are subject to an unknown degree of self-selection bias. Additionally, HIV testing data are affected by variable availability of funds for HIV testing, location of HIV test sites, and the different statistical implications of repeat HIV testing. Nevertheless, these data offer a prodigious amount of useful information.

Each year between 1990 and 1993 approximately 24,000 to 29,000 homosexual men obtained an HIV test from California's publicly funded sites. Homosexual men between the ages of 20 and 39 years old were more likely to have used the test site than homosexual men of other ages. White homosexual men accounted for 70% to 78% of all HIV testing obtained by homosexual men between 1990 and 1993.

While MSM only accounted for about 14% of the HIV antibody tests conducted each year, they represent 65% of all HIV-positive test results. Unlike other risk groups, the number of HIV tests obtained by homosexual men each year have been relatively unaffected by the media coverage of AIDS events. Exhibit 2.54 shows a fairly stable trend in the volume of HIV testing in this population.

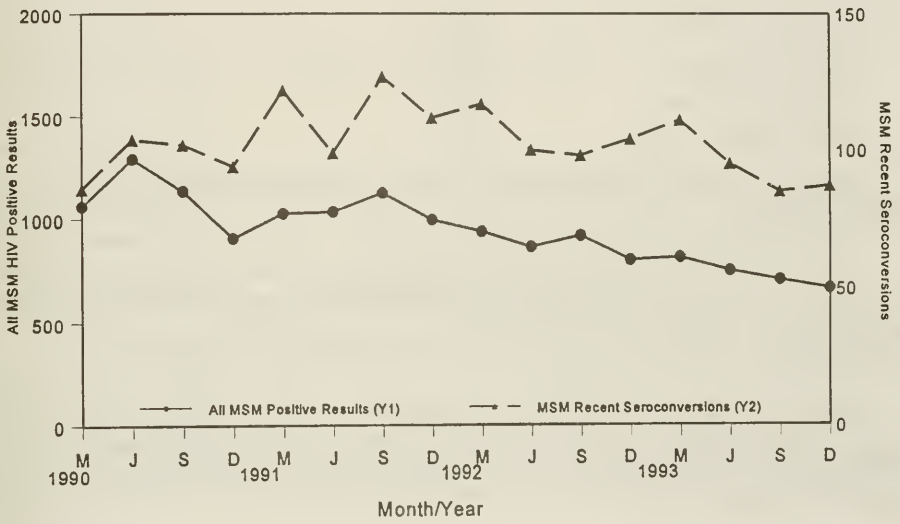
While the HIV testing volume has remained relatively stable among MSM, the number of HIV-positive results have declined. The reason for this decline is not entirely clear. Exhibit 2.55 shows the number of positive test results from 1990 to 1993 and recent seroconversions (i.e. those HIV-positive clients who reported obtaining an HIV negative result within the previous 12 months). In this chart, the number of incident cases reflects recent seroconversion among MSM. In contract to the declining HIV-positive test results, incident cases show relatively slight decline over the four-year period. MSM represented 71% of all testing clients who seroconverted during this period.

Exhibit 2.54
HIV Testing in California 1990-1993
Trends in Testing Volume



Source: California Office of AIDS

Exhibit 2.55
HIV Testing in California
All HIV Positive Results vs Annual Incident Cases for MSM
January 1990 - December 1993



Source: Office of AIDS

Men of color represented 28% of the homosexual men who obtained test results in 1993, and approximately 42% of all HIV-positive homosexual clients. In addition, homosexual men of color showed a positivity rate of 11.9%, compared to 6.5% among White homosexual men. Among homosexual men of color, the positivity rates by racial/ethnic group were:

African American	21.3%
Latino	11.6%
Native American	11.5%
Asian/Pacific Islander	5.1%
Other Groups	6.3%

These results provide further evidence of elevated rates of HIV infection among African Americans.

The age distribution of HIV-positive homosexual men is similar to that seen in AIDS cases in the same group. The highest positivity rate was seen among men between 30 and 39 years old (42%). Among the incident cases, however, the highest rate was in the 20 to 29 year category.

Homosexual men are more likely to seek repeat HIV testing at publicly-funded sites than other groups of testing clients. The following data focuses on an in-depth study conducted in 1991 on repeat testing and does not include information on repeat testers with a previous HIV positive result.

MSM are more likely to seek repeat HIV test at publicly-funded sites than other groups of testing clients. The number of MSM seeking repeat HIV test has increased over the years. In 1991, 77% of the homosexual men who obtained an HIV antibody test from publicly-funded sites had received at least one prior HIV test. This percentage increased to 83% in 1992 and 87% in 1993. Nearly 73% of homosexual HIV-negative repeat testers had received negative results after January 1, 1990; and additional 20% received their negative results before 1990.

Statewide, the HIV positivity rate in 1993 among repeat resters was 3.9%, compared to the rate of 16.7% recorded among first-time testers. MSM who are first-time testers have substantially higher seropositivity rates than repeat resters. Exhibit 2.56 shows that the highest HIV positivity rate of 25% in 1993 was recorded among first-time clients rural/less urban regions of California.

In spite of a lower HIV positivity rate, the HIV-related high risk behaviors among repeat testers are higher than in first-time testers. In 1993, 4.5% of MSM first-time testers reported a recent history of a STD, compared to 7.4% of repeat clients. Furthermore, the average annual number of sex partners of first-time testers was 3.9 compared to 4.7 for repeaters. These figures suggest that despite lower HIV positivity rate, MSM repeat testers

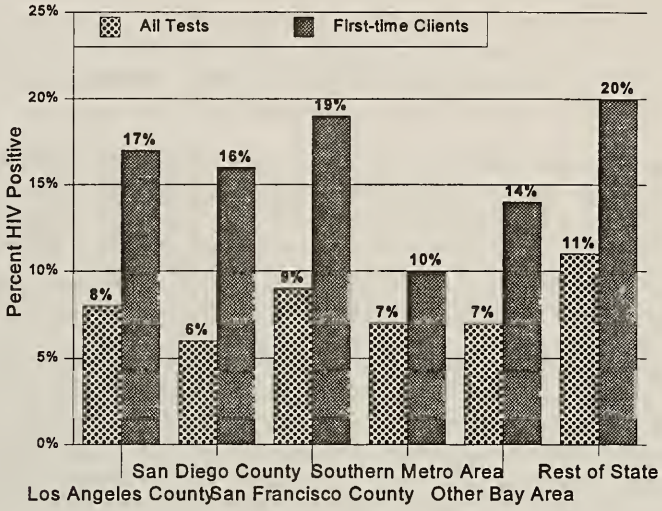
still have elevated risks of acquiring HIV infection and thus merit targeted prevention/intervention services.

In addition, the 1991 study revealed that of the 23% of MSM who reported an HIV-infected sex partner or partners, 12% tested HIV-positive. Of the 3% who reported having an IDU partner; 16% are HIV positive. Less than 2% exchanged sex for drugs or money, and 15% of men engaging in this behavior tested positive. Thus, among MSM, the secondary risk of having an IDU partner or exchanging sex for drugs or money, represent elevated risk for HIV infection, but having a known HIV-positive partner did not.

In general, MSM who have HIV-positive partners are more likely than those without HIV-positive partners to seek repeat tests. Seventeen percent of MSM who reported having an HIV-positive partner were first-time testers compared to 84% who were repeat testers. The HIV rate among first-time testers who have HIV positive partners was 31%, compared to 4.2% for repeat testers. Markers of risk behaviors such as recent episode of STDs and number of sex partners did not differ between these two groups.

In summary, although the number and rates of HIV positive tests are declining, data from California's publicly-funded HIV test sties suggest that MSM, particularly African-American MSM, are disproportionately affected by the AIDS epidemic. Incident HIV cases monitored from these test sites remain stable. First-time clients have relatively higher positivity rates than repeat testers. However, MSM repeat testers have elevated levels of high-risk behaviors such having an HIV positive partner, a recent STD and/or multiple sexual partners.

Exhibit 2.56
California HIV Testing Results in 1993 of Men Who Have Sex with Men
All Tests vs. First-time Clients



Source: California Department of Health Services, Office of AIDS

HIV Seroprevalence Studies Among Homosexual Men

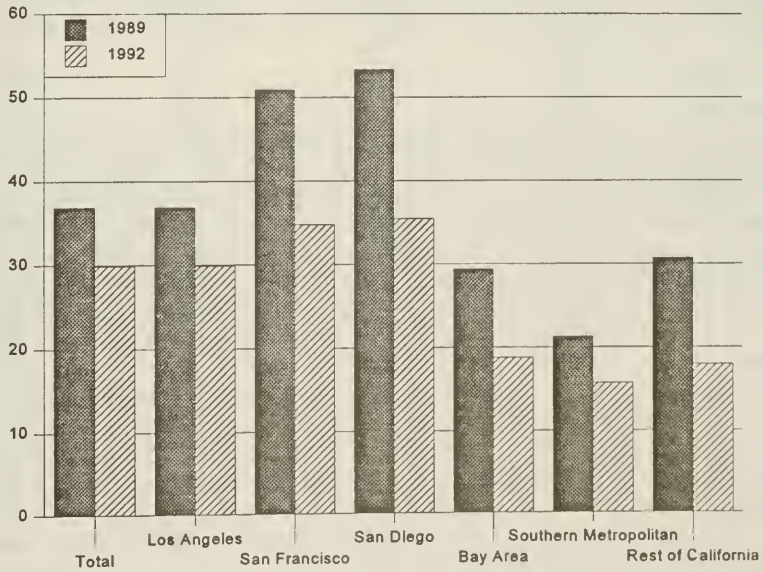
The majority of available HIV seroprevalence (HIV positivity) studies among homosexual men are based on tests performed in sentinel populations, such as in STD clinics or drug treatment centers. Thus, these data are not truly representative of the population of homosexual men in a community. It is not uncommon to observe substantial variations in seroprevalence rates between clinics even within geographically proximal areas. Nevertheless, because sentinel data chronicle the extent and likely impact of severe HIV disease in a given population, they are useful in demonstrating the need for HIV prevention programs in several communities.

1. HIV Prevalence among Clients of STD Clinics (1989-1992)

Data from unlinked (blinded) surveys among attendees of 41 STD clinics in 22 California local health jurisdictions showed high HIV prevalence rates among men reporting sex with men in all regions of the state (Exhibit 2.56). Of the 8,994 blood specimens tested between 1989 and 1992, (33.2%) were HIV seropositive. Overall, the seroprevalence rates declined from 40% in 1989 to 28% in 1992 (data not shown).

The HIV seroprevalence rate varied significantly by region of residence, race/ethnicity, and age group. Prevalence was highest in MSM clients who are residents of San Diego County (42.5%) or San Francisco County (40.8), between 30 and 44 years old (40.1%), and African Americans (41.3%) or Native Americans (39.5). (Exhibit 2.57)

Exhibit 2.57
Prevalence of HIV Among Men Who Have Sex with Men
Data from STD Clinics Surveys
1989 and 1992



Source: California Department of Health Services, Office of AIDS

Exhibit 2.58 shows that approximately 50% of all MSM clients at STD clinics during this period were White, 25% Latinos, 21% African Americans, and about 2.5% Asian/Pacific Islanders or Native Americans. HIV seroprevalence rate among the African Americans (41.3%) was higher than among the Asian/Pacific Islanders (27.7%), Latinos (30.4%), White (31.4%), or Native Americans (39.5%). The largest number of these men were between 30 and 44 years of age (40.1%) followed by 25-29 years (34.7%), less than 24 years (20.1%), and 45 years or older (25.4%).

Exhibit 2.58
HIV-1 Seroprevalence of Men Who Have Sex with Men and Men Who Have Sex With Men Who Inject Drugs: Data from Sexually Transmitted Disease Clinic Surveys, 1989 through 1992

	(MSM) 1989-1992		(MSM/IDU) 1989-1992	
	Number Tested	% Positive	Number Tested	% Positive
REGIONS				
Los Angeles	3,357	33.5	239	36.8
San Francisco	2,388	40.8	334	57.8
San Diego	703	42.5	20	65.0
Other Bay Area	958	23.5	74	16.2
Southern Metro	363	15.4	24	20.8
Rest of CA	1,225	24.9	81	16.1
AGE GROUP				
Under 24	1,804	20.1	109	29.4
25-29	2,380	34.7	203	47.8
30-44	3,916	40.1	409	43.5
45+	848	25.4	47	34.0
Unknown	54	16.7	4	25.0
RACE				
White	4,480	31.4	468	41.5
African American	1,922	41.3	146	39.7
Latino	2,297	30.3	131	40.8
Asian/P.I.	195	27.7	13	61.5
American Indian	38	39.5	9	77.8
Other/Unknown	62	27.4	7	57.1
TOTAL	**8,994**	**33.2**	**772**	**42.0**

Source: California Department of Health Services, Office of AIDS

Seroprevalence rates among MSM in the STD Clinic Survey declined in all California regions from 1989 to 1992. Los Angeles County figures dropped from 36.9% to 29.9%, San Francisco from 50.9% to 34.8%, San Diego from 53.3% to 35.5%, the Bay Area region from 29.4% to 18.8%, the Southern Metropolitan region from 21.3% to 15.8%, and the rest of California from 30.7% to 18.0%.

As part of the STD sentinel survey, a total of 772 blood specimens from men who have sex with men and also inject drugs were collected. Exhibit 2.58 shows these data. Of these, 42.0% were HIV positive. Seroprevalence rates among this group decreased each year from 1989 (49.0%) through 1992 (30.7%) (data not shown).

Among MSM who also inject drugs the highest seroprevalence rates were among those in San Diego; however, only 20 blood samples were tested there and these data may not be reliable. High seroprevalence rates were also found in San Francisco (57.8%) and Los Angeles (36.8%).

The highest seroprevalence rates were found among Native American (77.8%) and Asian/Pacific Islander (61.5%)MSM IDUs; again, the low number of cases among these groups may make these findings unreliable. Please see Exhibit 2.58 for further information.

Bisexual Men

Men who have sex with men and women represent the second largest subgroup of AIDS among MSM. In the United States, a relatively small number of studies suggest that bisexual men, especially men of color, may play significant roles in HIV transmission to women in some communities. Of the 1,466 AIDS cases diagnosed among heterosexual women in California, 20% resulted from sexual contact with bisexual men. However, a recently published paper on the men's cohort study in San Francisco indicates that bisexual men in the City have adopted safer sexual lifestyles with both male and female partners, and thus may not be not an important source for recent infection to women of San Francisco.

A cumulative total of 7,555 AIDS cases have been diagnosed among bisexual men in California through December 1993. These account for about 10% of all AIDS cases diagnosed in California. These cases appear in 50 of California's 58 counties (Exhibit 2.59), with the highest number in Los Angeles and San Francisco Counties. Exhibit 2.60 shows that bisexual AIDS cases are more widely distributed over the six designated regions of the state than are homosexual AIDS cases; the regions outside of Los Angeles and San Francisco accounted for approximately half of all cases. Among homosexuals, the same regions account for less than 40% of all cases. Bisexual AIDS cases represent over 13% of all cases diagnosed among people of color.

AIDS cases among bisexual men have increased significantly from 69 cases in 1983 to 749 cases in 1988 and 1,267 cases in 1993. As shown in Exhibit 2.61 the rate of increase in new AIDS cases among bisexual men of color is growing, while the rate of increase in cases among bisexual whites may have stabilized or slightly decreased in 1993. Overall, there has been a 15% increase in the number of AIDS cases in bisexuals from 1990 to 1993. By comparison, the number of recent AIDS cases among homosexual men grew by 11%.

Cumulative AIDS Cases Among Bisexual Men in California, 1980-1993

(N=7,546 Cases)

AIDS Cases

- 0
- 1-49
- 50-199
- 200-299
- 300 & over

Source: CaliforniaDepartment of Health Services, Office of AIDS

Exhibit 2.60
Demographic and Regional characteristics of AIDS cases among Bisexual men: Data through December 31, 1993

Characteristic	No. of Bisexual AIDS Cases	% of Bisexual AIDS Cases	Total AIDS Cases	Bisexual as a % of total
Race/Ethnicity				
White	4,082	54.0%	49,392	8.3%
African American	1,563	20.7%	11,435	13.7%
Latino	1,692	22.5%	12,639	13.4%
Asian Pacific Islanders	183	2.5%	1,340	13.7%
Native American	22	0.3%	252	8.0%
Age Group				
13-24	236	3.1%	2,370	10.0%
25-29	1,014	13.4%	10,055	10.1%
30-49	4,913	65.0%	53,477	9.2%
50 & over	1,394	18.5%	8,920	15.6%
County/Region				
Los Angeles	3,059	40.5%	26,675	11.5%
San Francisco	760	10.1%	17,674	4.3%
San Diego	553	7.3%	5,628	9.8%
Bay Area Region	1,335	17.7%	11,246	11.9%
Southern Metro	988	13.1%	7,176	13.8%
Rest of CA.	852	11.3%	6,778	12.6%

Source: California Department of Health Services, Office of AIDS

Rural and Urban Issues among Homosexual Men and Bisexual Men

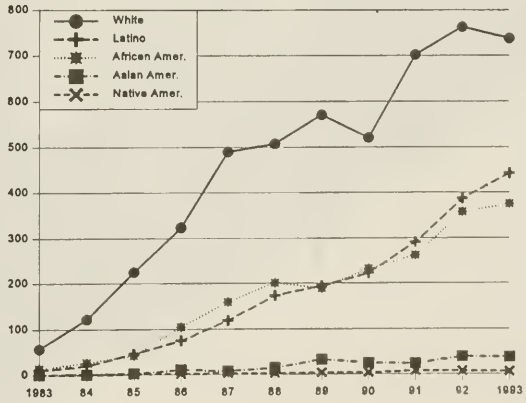
The majority of AIDS cases among homosexual men were diagnosed and reported in urban areas of California. Of 48,062 homosexual AIDS cases, 92.2% were diagnosed in urban areas, while 7.8% were diagnosed in non-urban/rural areas. Rural and non-urban

homosexual men with AIDS were more likely to be younger than urban men. Furthermore, white males accounted for an even higher proportion of non-urban AIDS cases in homosexual men (80%) than for the urban cases (73.8%). Accordingly, the proportion of AIDS cases in homosexual men of color in non-urban regions (19.5%) is lower than the urban region (26.3%).

New AIDS cases increased significantly in rural and non-urban regions through 1992 and declined slightly in 1993. Slightly over 55% of the AIDS cases in homosexual males in non-urban areas were diagnosed between 1991 and 1993, compared with 47% in urban areas of the state.

In non-urban regions the proportion of bisexual AIDS cases diagnosed is higher than the proportion of cases in exclusively homosexual men. Of 7,555 AIDS cases among bisexuals, 14.2% were diagnosed in the non-urban regions. The age distribution of cases among bisexual men is very similar for both urban and rural regions, with 65% of the cases in both regions diagnosed among men 30-49 years old. Bisexual men of color accounted for a higher proportion of AIDS cases in urban regions (48%) than in non-urban regions (35%). The trend in newly diagnosed cases among bisexual men increased substantially throughout the state in 1992, but in 1993 it continued to increase in the non-urban regions (by 20%), while there was a 9% decline in urban regions.

Exhibit 2.61
Trends in AIDS Incidence in California, Men Reporting Sex with Men and Women, by Race/Ethnicity



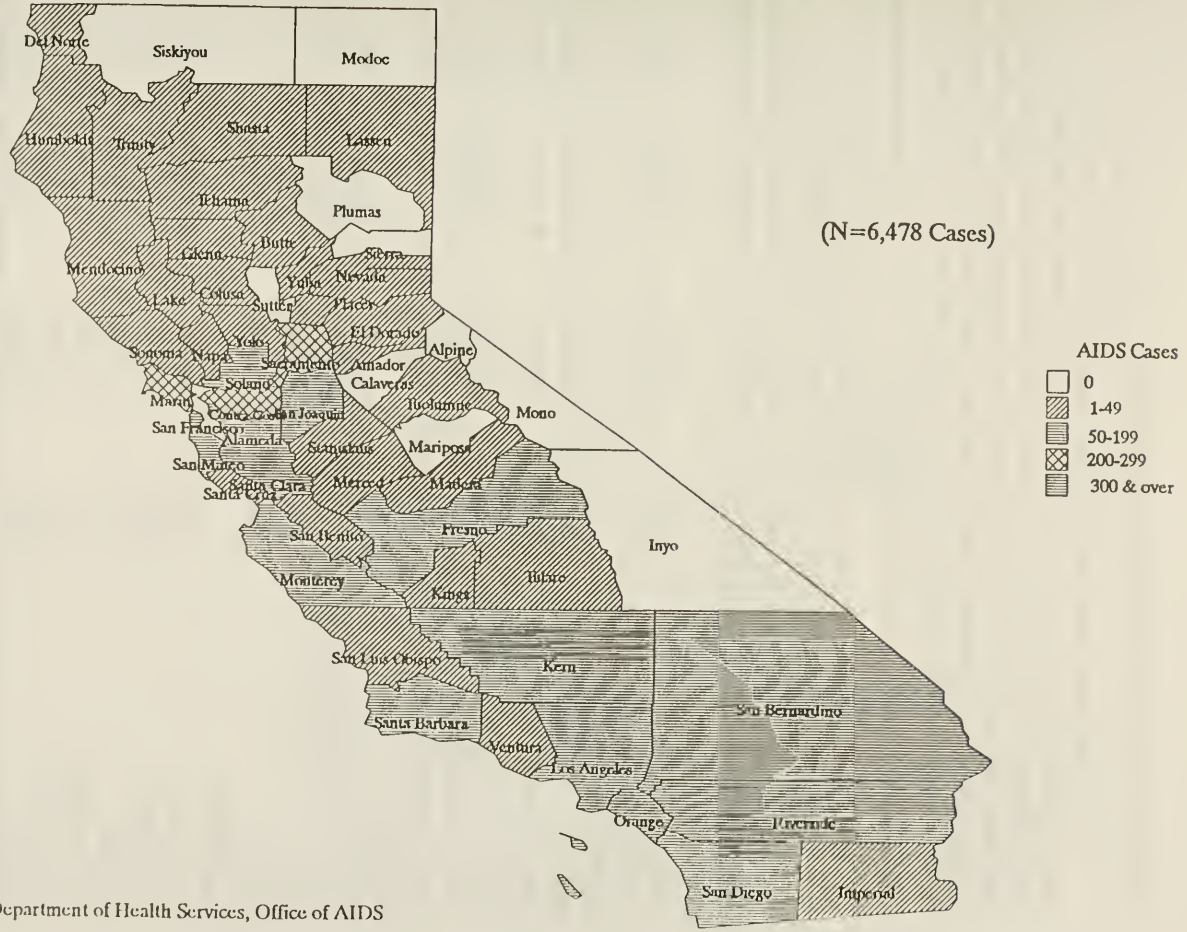
Source: California Dept. of Health Services, Office of AIDS
AIDS cases reported by 3/31/94
Adjusted for Reporting Delays

HETEROSEXUAL INJECTION DRUG USERS (IDU)

The estimated prevalence of HIV among women and heterosexual men who use injection drugs ranges from 17,000 to 23,000 cases. This figure represents 13% of the estimated statewide HIV cases. By the end of 1993, there were 6,478 female and heterosexual male IDU (hereafter referred to as heterosexual IDU) cases of AIDS, representing nearly 9% of the total AIDS cases statewide. (In addition, a total of 6,452 AIDS cases were diagnosed among homosexual IDUs and 1,681 cases among bisexual IDUs.)

Exhibit 2.62

Cumulative AIDS Cases Among Heterosexual Injection Drug Users 1980-1993



Source: California Department of Health Services, Office of AIDS

AIDS Cases Among Heterosexual Injection Drug Users

AIDS cases among heterosexual IDUs have been reported from most California counties (Exhibit 2.62) and from all racial/ethnic groups. However, the distribution of AIDS among heterosexual IDU varies across the state (Exhibit 2.63). Almost 23% of IDU cases are found in the Bay Area region and an additional 16% come from the Rest of California region. IDUs account for over 12% of all cases from regions outside of San Francisco, Los Angeles, and San Diego, and more than one-third of all cases among women.

Exhibit 2.63
Demographic and Regional Characteristics of AIDS Cases among Heterosexual Injection Drug Users (IDU): Data through December 31, 1993

Characteristic	No. of IDU AIDS Cases	% of IDU AIDS cases	Total AIDS Cases	IDU as a % of total cases
Gender				
Male	4,908	75.8%	71,097	6.9%
Female	1,570	24.2%	4,124	38.1%
Race/Ethnicity				
White	2,444	37.7%	49,392	4.9%
African American	2,670	41.2%	11,435	23.3%
Latino	1,285	19.8%	12,639	10.2%
Asian Pacific Islanders	31	0.5%	1,340	2.3%
Native American	31	0.5%	252	12.3%
Age Group				
13-24	212	3.3%	2,370	8.9%
25-29	837	12.9%	10,055	8.3%
30-49	4,928	76.1%	53,477	9.2%
50 & over	502	7.8%	8,920	5.6%
County/Region				
Los Angeles	1,697	26.2%	26,675	6.4%
San Francisco	1,032	15.9%	17,674	5.8%
San Diego	376	5.8%	5,628	6.7%
Bay Area Region	1,475	22.8%	11,246	13.1%
Southern Metro	862	13.3%	7,176	12.0%
Rest of CA	1,021	15.8%	6,778	15.1%

Source: California Department of Health Services, Office of AIDS

Nearly one-quarter of African Americans with AIDS are IDUs, and African Americans represent 41% of all heterosexual IDU cases. The age distribution of heterosexual IDU cases is similar to that of homosexual men, with fewer IDU diagnosed at age 50 or older.

The demographic and geographic data on homosexual IDUs and bisexual male IDUs with AIDS are similar to each other and tend to fall between the characteristics of homosexual men with AIDS and heterosexual IDUs with AIDS. The notable exception is that homosexual IDUs and bisexual male IDUs tend to be younger, with 23-24% diagnosed under age 30, compared to 15% of homosexual men and 16% of heterosexual IDUs.

Trends in Incident AIDS Cases in Heterosexual IDUs

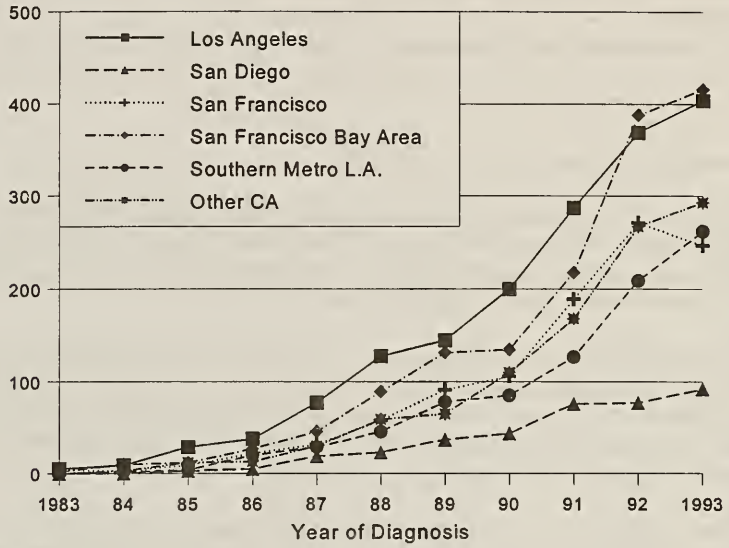
The number of newly diagnosed AIDS cases among heterosexual IDUs increased substantially from 69 in 1985 to 684 in 1992 and 1,716 in 1993. Women comprised about one-quarter of the annual AIDS incidence among heterosexual IDUs diagnosed through 1993. The epidemic does not seem to have peaked in heterosexual IDUs.

Newly diagnosed AIDS cases in heterosexual IDUs increased in all California regions from 1983 through 1992, except that San Francisco County showed a slight decline between 1992 and 1993 (Exhibit 2.64). Los Angeles County had the highest number of newly diagnosed cases in this risk category through 1991; however, between 1992 and 1993, the largest number of new cases came from the Bay Area region.

As shown in Exhibit 2.65, the number of new cases among heterosexual IDU's increased among all racial/ethnic groups through 1993. The highest number of new cases appeared among African Americans and the lowest among Asians and Pacific Islanders.

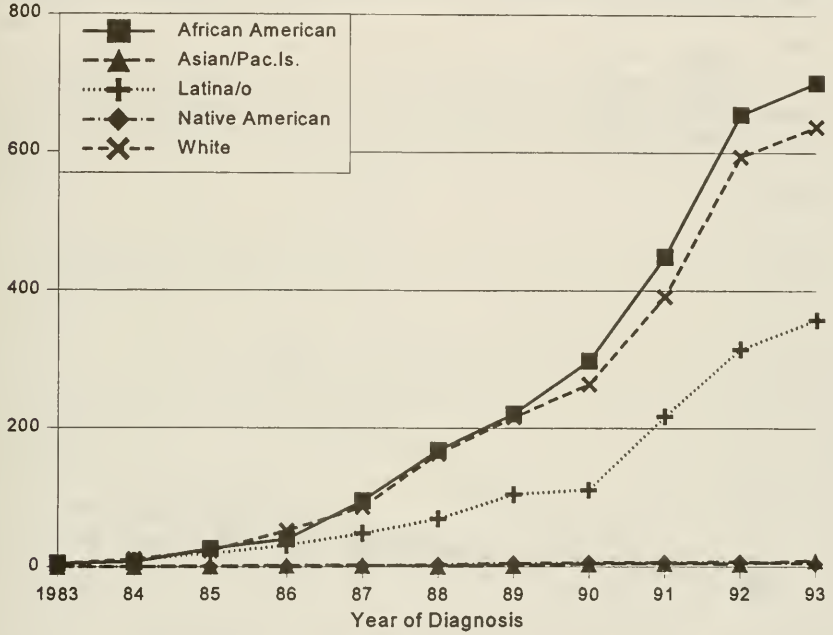
Similarly, new cases increased among all age groups, especially those age 30-49 years. (Exhibit 66) However, while the rate of increase in these cases declined somewhat between 1992 and 1993, both younger and older people experienced steady rates of increase.

Exhibit 2.64
Trends in AIDS Incidence in California
Injection Drug Use (Women and Heterosexual Men), by County/Region



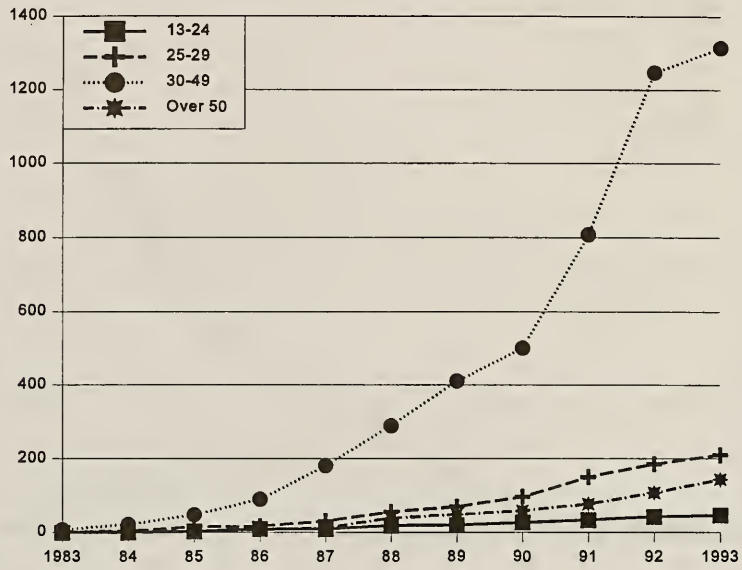
Source: California Department of Health Services, Office of AIDS - AIDS cases reported by 3/31/94
Adjusted for reporting delays

Exhibit 2.65
Trends in AIDS Incidence in California
Injection Drug Users (Women and Heterosexual Men), By Race/Ethnicity



Source: California Department of Health Services, Office of AIDS - AIDS cases reported by 3/31/94
Adjusted for reporting delays

Exhibit 2.66
Trends in AIDS Incidence in California
Injection Drug Users (Women & Heterosexual Men), by Age



Source: California Dept. of Health Services, Office of AIDS
AIDS cases reported by 3/31/94
Adjusted for Reporting Delays

Characteristics of Recently Diagnosed AIDS Cases in Heterosexual IDUs (1990-1993)

Exhibit 2.67 shows the distribution and trends of recent (1990-1993) AIDS cases among heterosexual IDUs. The average annual percentage of cases is shown on the left side of the chart, while the three year range percentage increase in annual incidence is displayed on the right of the chart.

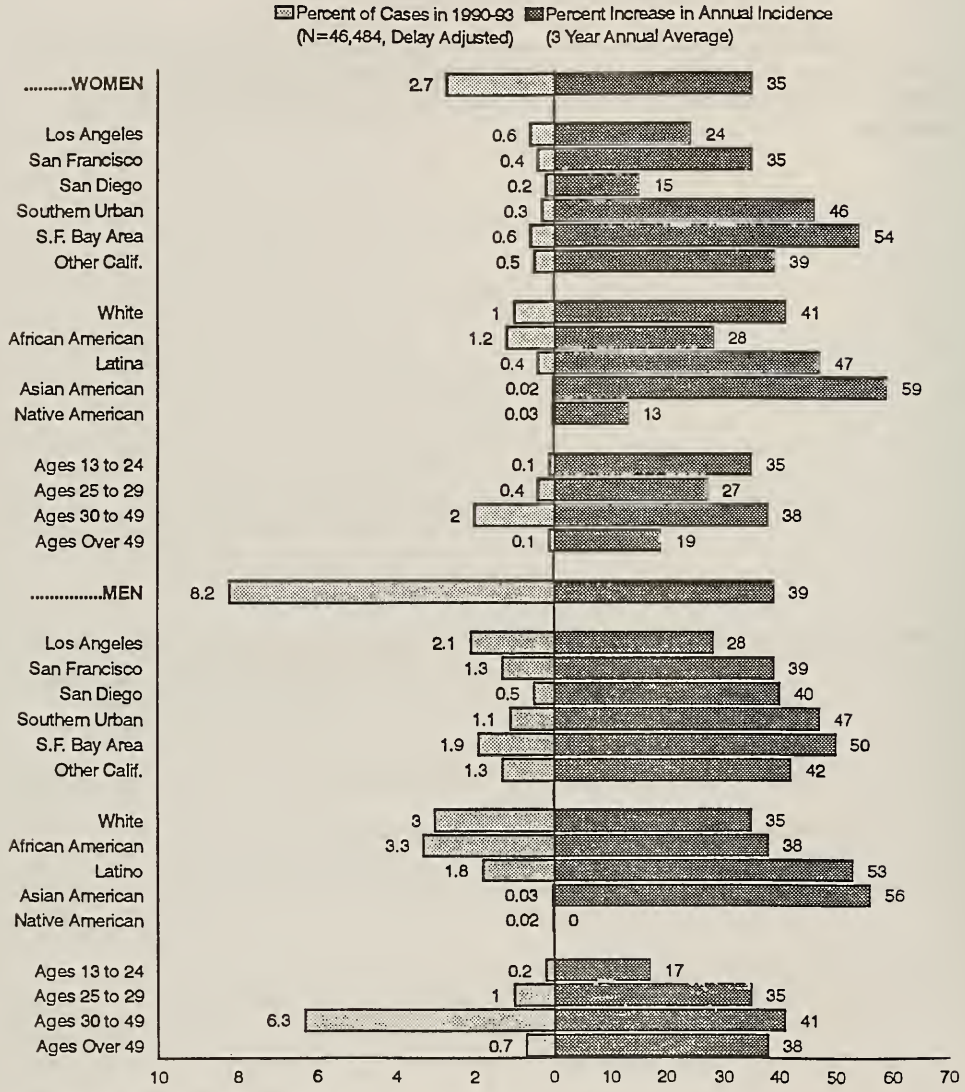
In 1988, heterosexual IDUs accounted for 6.2% of all diagnosed AIDS cases. Between 1992 and 1993, the proportion of new cases resulting from heterosexual IDU increased significantly, to 11%. The average annual percentage increase in heterosexual IDU annual incidence during 1990 to 1993 was 39% for men and 35% for women. These increases are

significantly higher than the 11% for homosexual men, indicating an increasing ratio of IDU to homosexual transmission in the past few years. It should be noted, though, that for the most part, the highest percentage increases were among those groups that comprise less than a half percent of total cases, i.e., it is easier to double small numbers than to double very large numbers.

By region, the largest percent increases in heterosexual IDUs occurred in the Bay Area region, Southern Metropolitan region and in the Rest of California region (non-urban counties). Percent increases by race/ethnicity were highest for Asian/Pacific Islanders and Latinos/as.

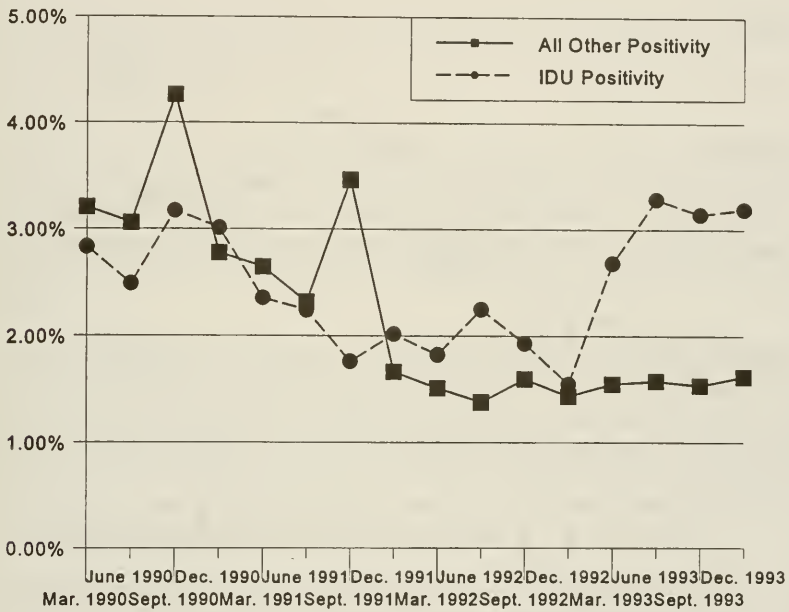
Exhibit 2.67

California AIDS Case Distribution and Trends
Injection Drug Users (Women & Heterosexual Men)



California Dept. of Health Svcs., Office of AIDS
AIDS Cases Reported by 3/31/94

Exhibit 2.68
Trends in HIV Positivity Rate - IDU's vs. All Other Groups



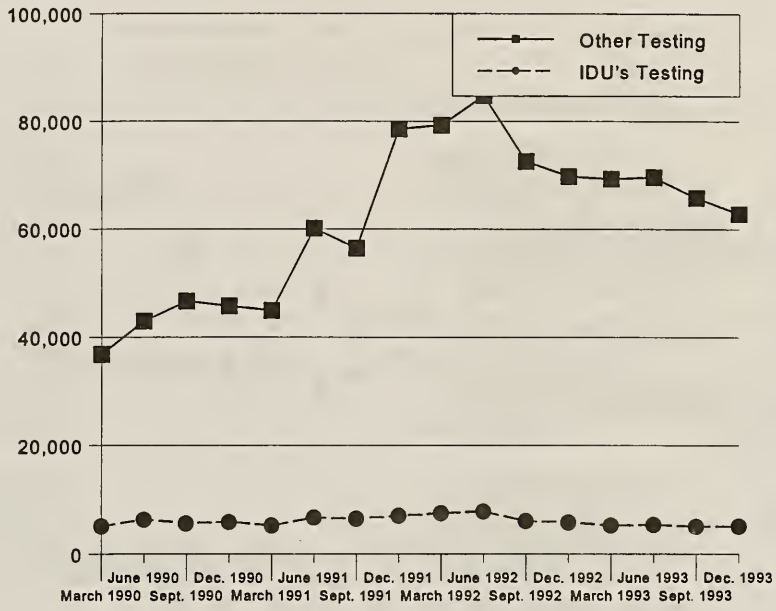
Source: California Department of Health Services, Office of AIDS

HIV Testing Among Heterosexual and Injection Drug Users

Each year between 1990 and 1993 approximately 30,000 heterosexual IDU's obtained an HIV test from California's publicly funded sites. An overall positivity rate of 2.4% has been observed among heterosexual IDUs who obtained an HIV antibody test at the State's publicly-funded sites between 1990 and 1993, as shown in Exhibit 2.68. HIV testing trends have remained fairly stable for this group during this period, in contrast to other risk categories where testing populations have declined recently (see Exhibit 2.69).

Of the 97,873 IDUs tested, whites make up 64.9%; Latinos, 22.1%; African-Americans, 9.4%; Native Americans, 1.6%; Asian/Pacific Islanders, 1%; and other groups, 1%. While male IDU clients consistently outnumber female IDU clients, the overall patterns of testing for IDUs are very similar. More persons tested from the 30 to 39 year age group than from any others; this contrasts with all testing clients where more persons from the 20 to 29 year old age group test.

Exhibit 2.69
Trends in Testing Volume - IDU's vs. All Other Groups



Source: California Department of Health Services, Office of AIDS

HIV Testing Data among Women IDUs

The 1991 in-depth analysis of the women tested shows that female IDUs represented 3.9% of all testing clients, and 9% of all female testing clients. One-third of the female IDUs were testing for the first time, 54% were repeat testers, and 12% had an unknown testing history. Of the repeat testers, 70% had a negative test after January 1, 1990. Of the female IDUs tested, 2.3% received positive results. Of the pregnant women tested, 1% were HIV positive.

Female IDUs reported a 14.4% STD rate, higher than any other risk group. Specifically, this rate was twice that of male IDUs. Female IDUs also reported the highest average number of sex partners of any high-risk group. HIV-negative women IDUs seeking repeat HIV testing had an average of 8.7 sex partners, twice as many as the 4.3 reported by

first-time testers. This shows an elevated risk of transmission of HIV in this group. STD rate was not associated with higher HIV positivity rates, even in clients with an HIV positive sex partner. In addition, the number of sex partners was not associated with HIV status. Collectively, these data show clear evidence of high levels of unsafe sex. The low positivity rate suggest that the prevalence of HIV among sexual and needle-sharing partners way below. Although heterosexual women with multiple partners have a much lower prevalence of HIV infection compared to IDUs, the level of HIV-related risk behaviors found in that group is similar to IDUs.

There were 4.3% women IDUs who knew they had an HIV positive sex partner; they had a positivity rate of 6.2% (more than three times the positivity rate of all female IDUs). Sixty-three percent of the women IDUs tested had an IDU sex partner. More than 26% reported exchanging sex for drugs or money, compared with 6.9% of IDU men. None of these secondary risks resulted in increased rates of positive test results within the group of women IDU's.

Of the first-time testers, 17% reported exchanging sex for drugs or money, whereas 32% of repeat testers reported such transactions. The positivity rate for all female IDUs who exchanged sex for considerations was 2.1% (3% for first-time testers and 1.2% for repeat testers). The increase in number of sex partners among repeat testers appears to be associated with the behavior of exchanging sex for drugs or money. Fifty-nine percent of all the sex partners reported in the analysis of IDU women were reported by the female IDU repeat testers who reported exchanging sex for drugs or money.

Repeat testers also showed a much higher STD rate than first time testers. The female IDU repeat testers who exchanged sex for drugs or money showed a 49% rate of recent STDs, compared with 29% of women IDU first-time testers who do so. Repeat testers who reported an HIV-positive sex partner were only half as likely to test positive as first time testers (3.6% versus 7.3%).

IDU women who test show a flat and moderate rate of HIV infection. They show a very high level of unsafe sex and consequently a very high potential for the rapid spread of HIV in this group, particularly repeat testers. Those who knew they had contacted an HIV-infected person were three times as likely to be HIV positive than those who did not know of such a contact.

HIV Testing Data Among Male IDUs

The HIV positivity data for IDU men is quite similar to that for IDU women. IDU men in San Francisco and the Bay Area region had higher HIV positivity rates than other areas of the state. In 1991 IDU men represented 5.4% of all testing clients; 41% of them were testing for the first time, 45% were repeat testers, and 13% did not provide prior testing

information. Among the retesters, 66% had received HIV negative results after January 1, 1990, and 23% had retested two or more times.

The overall positivity rate among male IDUs is 2.3%. The number of recent STDs is associated with the number of partners in first-time testers, but not in repeat testers. These men averaged 2.7 partners (compared with 7 partners per woman IDU). No association was found between recent STDs and HIV positivity.

In general, HIV-positive heterosexual male clients differed little from HIV-negative heterosexual male IDU clients overall, except that among first-time testers, HIV-positive clients were three years older than HIV-negative clients.

Two percent of IDU males knew they had an HIV positive sex partner, and 12% of that group were HIV positive. Within that subgroup, 19.7% of first time testers were HIV positive.

Of the 43% who reported an IDU sex partner and the 7% who reported exchanging sex for drugs or money, neither subgroup showed elevated HIV positivity over the entire group of IDU men receiving tests. Once again, more first-time testers than repeat testers received positive results (2.4% versus 1.3%).

Heterosexual IDU clients appear to have relatively high risk of transmission but low exposure to HIV. Clients who knew they had been exposed were much more likely to be infected than those who did not know. This group is far less impacted by HIV than the MSM testing population but shows a great potential for spread of the virus.

HIV Seroprevalence Studies

HIV Prevalence Among Clients of STD Clinics (1989-1992)

HIV seroprevalence surveys of heterosexual IDUs were conducted mainly in clinic settings (STD and drug treatment clinics) across the state. In 1992, a total of 1,479 blood specimens were collected and tested among heterosexual IDUs at 41 STD clinics in 22 California local health jurisdictions. Of these, 68 tested positive for HIV antibodies, a prevalence rate of 4.6% among heterosexual IDUs. The seroprevalence rates varied significantly by region of residence, race/ethnicity, and age group.

As shown in Exhibit 2.70, the highest prevalence rates were observed in San Francisco (6.8%) and the Rest of California region (5.6%); the lowest rate was 0% in San Diego County.

Exhibit 2.70 indicates that seroprevalence among African American heterosexual IDUs who attended STD clinics was about three times higher than whites who attended the same

clinics and over twice as high as Latinos/Latinas. Thirty-nine percent of the specimens tested were from Whites, of which 2.9% were seropositive; 36% of the specimens were from African Americans, of which 7.8% were seropositive; 22% were from Latinos/Latinas, of which 3.1% were seropositive; and 1.2% were from Asian/Pacific Islanders, of which none showed positive. Although the largest proportion of clients tested were between the ages of 30 and 44 (59%), seroprevalence rate was highest among people age 45 or older (6.2%).

The gender data in Exhibit 2.70 reveals that the overall seroprevalence among men was similar to that among women. Of the 900 specimens taken from men, 4.9% were positive; among women, 4.2% of 579 specimens tested positive. Regionally, rates among men were similar to those among women, except that in Los Angeles County the rate among heterosexual IDU men who attended STD clinics was 5.2%, compared to 3.2% among women. The highest seroprevalence rate among women (5.6%) was observed in the 30-44 age range, while among men it was among those 45 or older (7.0%). White (3.1%) and Latina (3.9%) heterosexual IDU women attending STD clinics showed a higher seroprevalence than men of the same racial/ethnic groups (2.8% and 2.7%, respectively). Among African Americans, male IDUs showed a higher rate (8.6%) than females (6.2%).

Exhibits 2.71 through 2.73 provide further information about seroprevalence among heterosexual IDUs attending STD clinics.

Exhibit 2.70
Hiv-1 Seroprevalence among Heterosexual IDUs Attending Sexually Transmitted Diseases Clinics in California, by Gender: 1992

	Males		Females		Total	
Regions	**No. tested**	**% Pos**	**No. tested**	**% Pos**	**No. tested**	**% Pos**
Los Angeles	231	5.2	187	3.2	418	4.3
San Francisco	104	6.7	43	7.0	147	6.8
San Diego	5	0.0	3	0.0	8	0.0
Other Bay Area	130	2.3	56	1.8	186	2.2
Southern Metropolitan	96	3.1	69	2.9	165	3.0
Rest of CA	334	5.7	221	5.4	555	5.6
Age Group						
Under 24	113	0.9	90	0.0	203	0.5
25-29	137	3.6	95	3.2	232	3.4
30-44	511	5.7	359	5.6	870	5.6
45+	129	7.0	32	3.1	161	6.2
Unknown	10	0.0	3	0.0	13	0.0
Ethnicity						
White	319	2.8	260	3.1	579	2.9
African American	336	8.6	193	6.2	529	7.8
Latino/a	221	2.7	103	3.9	324	3.1
Asian/Pacific Islander.	12	0.0	6	0.0	18	0.0
Native American	4	0.0	9	0.0	13	0.0
Other/Unknown	8	0.0	8	0.0	16	0.0
Total	**900**	**4.9**	**579**	**4.2**	**1479**	**4.6**

Source: California Department of Health Services, Office of AIDS

Exhibit 2.71

HIV-1 Seroprevalence among Heterosexual IDUs Attending Sexually Transmitted Diseases Clinics in California, By Gender, Race, and Age: 1992

		Males		Females		Total	
Ethnicity	Age	No. Tested	% Pos	No. Tested	% Pos	No. Tested	% Pos
White	< 24	58	0.0	56	0.0	114	0.0
	25-29	64	4.7	48	4.2	112	4.5
	30-44	168	3.6	145	4.1	313	3.8
	45+	23	0.0	8	0.0	31	0.0
	Unk.	6	0.0	3	0.0	9	0.0
Total		**319**	**2.8**	**260**	**3.1**	**579**	**2.9**
Afr.Amer..	< 24	19	5.3	10	0.0	29	3.4
	25-29	23	0.0	20	0.0	43	0.0
	30-44	212	9.0	147	7.5	359	8.4
	45+	82	11.0	16	6.3	98	10.2
	Unk.	--	--	--	--	--	--
Total		**336**	**8.6**	**193**	**6.2**	**529**	**7.8**
Latino/a	< 24	35	0.0	22	0.0	57	0.0
	25-29	43	4.7	24	4.2	67	4.5
	30-44	117	3.4	50	6.0	167	4.2
	45+	22	0.0	7	0.0	29	0.0
	Unk.	4	0.0	--	--	4	0.0
Total		**221**	**2.7**	**103**	**3.9**	**324**	**3.1**
Asian/PI	< 24	1	0.0	--	--	1	0.0
	25-29	3	0.0	2	0.0	5	0.0
	30-44	7	0.0	4	0.0	11	0.0
	45+	1	0.0	--	--	1	0.0
	Unk.	--	--	--	--	--	--
Total		**12**	**0.0**	**6**	**0.0**	**18**	**0.0**
Native	< 24	--	--	1	0.0	1	0.0
Amer.	25-29	--	--	--	--	--	--
	30-44	4	0.0	7	0.0	11	0.0
	45+	--	--	1	0.0	1	0.0
	Unk.	--	--	--	--	--	--
Total		**4**	**0.0**	**9**	**0.0**	**13**	**0.0**
Unk.	< 24	--	--	1	0.0	1	0.0
	25-29	4	0.0	1	0.0	5	0.0
	30-44	3	0.0	6	0.0	9	0.0
	45+	1	0.0	--	--	1	0.0
Total	Unk.	--	--	--	--	--	--
		8	**0.0**	**8**	**0.0**	**16**	**0.0**

Source: California Department of Health Services, Office of AIDS

Exhibit 2.72

HIV-1 Seroprevalence among Heterosexual IDUs Attending Sexually Transmitted Diseases Clinics in California, by Race/Ethnicity, Geography, and Gender: 1992

Ethnicity	Regions	Males		Females		Total	
		No. Tested	% Pos	No. Tested	% Pos	No. Tested	% Pos
White	Los Angeles	39	7.7	66	3.0	105	4.8
	San Francisco	41	4.9	16	6.3	57	5.3
	San Diego	5	0.0	1	0.0	6	0.0
	Other Bay Area	62	1.6	33	3.0	95	2.1
	South. Metro.	46	2.2	45	0.0	91	1.1
	Rest of CA.	126	1.6	99	4.0	225	2.7
	Total	**319**	**2.8**	**260**	**3.1**	**579**	**2.9**
Afr.Amer.	Los Angeles	114	6.1	84	4.8	198	5.6
	San Francisco	37	10.8	10	0.0	47	8.5
	San Diego	--	--	--	--	--	--
	Other Bay Area	31	6.5	13	0.0	44	4.5
	South. Metro.	8	12.5	2	0.0	10	10.0
	Rest of CA.	146	10.3	84	9.5	230	10.0
	Total	**336**	**8.6**	**193**	**6.2**	**529**	**7.8**
Latino/a	Los Angeles	78	2.6	33	0.0	111	1.8
	San Francisco	20	5.0	10	20.0	30	10.0
	San Diego	--	--	2	0.0	2	0.0
	Other Bay Area	33	0.0	8	0.0	41	0.0
	South. Metro.	40	2.5	21	9.5	61	4.9
	Rest of CA.	50	4.0	29	0.0	79	2.5
	Total	**221**	**2.7**	**103**	**3.9**	**324**	**3.1**
Asian/PI	Los Angeles	--	--	--	--	--	--
	San Francisco	6	0.0	4	0.0	10	0.0
	San Diego	--	--	--	--	--	--
	Other Bay Area	2	0.0	--	--	2	0.0
	South. Metro.	--	--	1	0.0	1	0.0
	Rest of CA.	4	0.0	1	0.0	5	0.0
	Total	**12**	**0.0**	**6**	**0.0**	**18**	**0.0**
Native Amer.	Los Angeles	--	--	3	0.0	3	0.0
	San Francisco	--	--	3	0.0	3	0.0
	San Diego	--	--	--	--	--	--
	Other Bay Area	--	--	--	--	--	--
	South. Metro.	--	--	--	--	--	--
	Rest of CA.	4	0.0	3	0.0	7	0.0
	Total	**4**	**0.0**	**9**	**0.0**	**13**	**0.0**
Oth/unk	Los Angeles	--	--	1	0.0	1	0.0
	San Francisco	--	--	--	--	--	--
	San Diego	--	--	--	--	--	--
	Other Bay Area	2	0.0	2	0.0	4	0.0
	South. Metro.	2	0.0	--	--	2	0.0
	Rest of CA.	4	0.0	5	0.0	9	0.0
	Total	**8**	**0.0**	**8**	**0.0**	**16**	**0.0**

Source: California Department of Health Services, Office of AIDS

Exhibit 2.73

HIV-1 Seroprevalence among Heterosexual IDUs Attending Sexually Transmitted Diseases Clinics in California, by Age, Geography, and Gender: 1992

Regions		Males		Females		Total	
		No. Tested	% Pos	No. Tested	% Pos	No. Tested	% Pos
Los Angeles	Under 24	27	0.0	29	0.0	56	0.0
	25-29	36	5.6	30	3.3	66	4.5
	30-44	141	7.1	119	3.4	260	5.4
	45+	27	0.0	9	11.1	36	2.8
	Unknown	--	--	--	--	--	--
	Total	**231**	**5.2**	**187**	**3.2**	**418**	**4.3**
San Francisco	Under 24	21	0.0	16	0.0	37	0.0
	25-29	16	12.5	6	16.7	22	13.6
	30-44	55	7.3	19	10.5	74	8.1
	45+	11	9.1	2	0.0	13	7.7
	Unknown	1	0.0	--	--	1	0.0
	Total	**104**	**6.7**	**43**	**7.0**	**147**	**6.8**
San Diego	Under 24	1	0.0	1	0.0	2	0.0
	25-29	1	0.0	1	0.0	2	0.0
	30-44	3	0.0	1	0.0	4	0.0
	45+	--	--	--	--	--	--
	Unknown	--	--	--	--	--	--
	Total	**5**	**0.0**	**3**	**0.0**	**8**	**0.0**
Other Bay Area	Under 24	20	0.0	12	0.0	32	0.0
	25-29	24	0.0	12	0.0	36	0.0
	30-44	70	2.9	29	3.4	99	3.0
	45+	11	9.1	2	0.0	13	7.7
	Unknown	5	0.0	1	0.0	6	0.0
	Total	**130**	**2.3**	**56**	**1.8**	**186**	**2.2**
Southern Metro	Under 24	19	0.0	17	0.0	36	0.0
	25-29	21	0.0	10	10.0	31	3.2
	30-44	47	6.4	40	2.5	87	4.6
	45+	6	0.0	2	0.0	8	0.0
	Unknown	3	0.0	--	--	3	0.0
	Total	**96**	**3.1**	**69**	**2.9**	**165**	**3.0**
Rest of CA	Under 24	25	4.0	15	0.0	40	2.5
	25-29	39	2.6	36	0.0	75	1.3
	30-44	195	5.1	151	7.9	346	6.4
	45+	74	9.5	17	0.0	91	7.7
	Unknown	1	0.0	2	0.0	3	0.0
	Total	**334**	**5.7**	**221**	**5.4**	**555**	**5.6**

Source: California Department of Health Services, Office of AIDS

HIV Prevalence in Drug Treatment Centers

Among 5,610 blood specimens collected and tested from heterosexual IDUs entering drug treatment centers (DTC) in 1992, 5.2% were seropositive (Exhibit 2.74). Rates by region ranged from a high of 7.9% positivity in the Bay Area region, and 7.1% in San Francisco, to a low of 2.0% in San Diego and 1.9% in the Rest of California region.

Nearly 50% of the specimens tested were from whites, of which 2.7% were HIV seropositive; 18% were from African Americans (17.9% seropositive) and 30% were from Latinos/Latinas, of which 2.0% were seropositive. Finally, 2.0% were from Asian/Pacific Islanders, of which none tested positive.

Blood taken from men constituted 66% of the specimens tested, of which 5.2% were seropositive. Of the 34% of blood specimens from women, 5.1% were seropositive. The largest number of specimens came from people aged 30-44 (67%), of which 5.8% were seropositive. The lowest seroprevalence rate was in the under-24 age group, which represented .04% of the specimens with a 1.0% seropositivity.

HIV Prevalence Among Out-of-Treatment Substance Users

An intervention research program targeting out-of-treatment substance users is currently being conducted in the City of Long Beach by the California State University, Long Beach. A total of 1,100 out-of-treatment substance users were recruited from May 1992 through mid-April 1994.

Between May 1992 and January 1994, 694 participants were recruited into this study. Of these, 62% were active drug injectors and 38% used crack/cocaine without a recent history of injection drug use. All drug injectors reported injecting either heroin alone or a mixture of heroin and cocaine, 24% injected cocaine and another 23% injected amphetamines in the 30 days prior to recruitment. In addition, 32% had used crack within this period.

Of the substance users recruited through January 1994, the majority (66%) were men; the mean age was 37.6 years (range: 18-69 years); 20% were currently married and 43% were never married. The majority (52%) of the participants live below poverty level earning less than $6,000 per year; 66% were unemployed.

Of 1,100 recruited through mid-April 1994, 46 were HIV-antibody positive, a positivity rate of 4.2%. This rate is slightly lower than an earlier rate of 5.5% among out-of-treatment IDUs observed between 1988 and 1991 in Long Beach. The racial/ethnic breakdown of HIV-positivity rates is as follow: African American 6.5% (31/476); Native American 5.4% (2/35); and Latino/a 2.7% (7/258); White 1.9% (6/316). HIV-positivity rate among men (4.4%; 34/767) is higher than that in women (3.6%; 12/333). HIV positivity rate was higher among substance users who reported ever using heroin or speedballs (5.1%;

16/311) than those who have never used these substances (3.8%; 30/789). Crack/cocaine users had a moderately higher seropositivity rate (4.3%) than drug injectors (4.1%).

Exhibit 2.74

HIV-1 Seroprevalence among Heterosexual Idus Entering Drug Treatment Centers in California, by Gender: 1992

	Males		Females		Total	
Regions	**No. tested**	**% Pos**	**No. tested**	**% Pos**	**No. tested**	**%Pos**
San Francisco	851	7.7	428	6.1	1279	7.1
San Diego	889	2.2	498	1.6	1387	2.0
Other Bay Area*	1236	7.8	712	8.0	1948	7.9
Southern Metro	--	--	--	--	--	--
Rest of CA**	743	1.7	253	2.4	996	1.9
Los Angeles***	--	--	--	--	--	--
Age Group						
Under 24	104	1.9	102	0.0	206	1.0
25-29	368	1.4	249	2.4	617	1.8
30-44	2458	5.6	1319	6.2	3777	5.8
45+	773	6.6	214	4.2	987	6.1
Unknown	16	0.0	7	0.0	23	0.0
Race						
White	1657	2.6	1072	2.8	2729	2.7
African American.	653	18.4	362	17.1	1015	17.9
Latino/a	1276	2.3	389	1.3	1665	2.0
Asian/Pacific Islander	68	0.0	27	0.0	95	0.0
Native American	21	0.0	23	0.0	44	0.0
Other/Unknown	44	6.8	18	0.0	62	4.8
Total	**3719**	**5.2**	**1891**	**5.1**	**5610**	**5.2**

Source: California Department of Health Services, Office of AIDS

* Rest of California = Fresno, and San Joaquin.

** Other Bay Area = Alameda, Contra Costa, Santa Clara, and San Mateo.

*** Los Angeles is not included because they could not break down sexual orientation by race and age group.

HETEROSEXUAL CONTACT

In California HIV prevalence among women and men infected with HIV through heterosexual contact is estimated to range from 7,500 to 10,200, or about 6% of the estimated statewide HIV prevalence. More than twice as many women as men are infected through heterosexual contact. By the end of 1993 nearly 3% of the cumulative AIDS cases in the state were attributed to the probable mode of heterosexual contact. The contrast between the estimated prevalence figure (6%) and the cumulative AIDS cases figure (3%) reflects a higher rate of increase in heterosexual transmission than in homosexual males or IDU transmission.

AIDS Cases: Among Heterosexual Contact

AIDS cases attributed to heterosexual contact have been reported from most California counties and all racial/ethnic groups. However, the distribution of AIDS among heterosexual contacts varies across the state (Exhibit 2.75). More than one third of cases in women are attributed to heterosexual contact, and this number is probably low since many women classified as having no identified risk were probably infected through heterosexual contact. In 1993, 13% of women with AIDS were in the no identified risk category. As shown in Exhibit 2.75, African-Americans account for 28% of heterosexual contact AIDS cases, and Latina/os account for 25%, and whites for 43%. A larger proportion of people contracting AIDS through heterosexual contact were younger than age 30 at diagnosis (26%) than of men who have sex with men or IDU cases. These cases represent HIV infections that occurred among teenagers and young adults. More than half of heterosexual contact cases were from Los Angeles County (34%) and the Bay Area region (21%).

Among male heterosexual contact cases, 52% reported sex with a women who injected drugs, 4% reported sex with an HIV-infected woman who had received blood or blood products, and 44% reported sex with an HIV-infected women without knowledge of her IDU or transfusion history. Among females, 41% reported sex with a man who injected drugs, 20% reported sex with a bisexual man, 5% reported sex with a hemophiliac or HIV-infected man who had received blood or blood products, and 34% reported sex with an HIV-infected man without knowledge of his IDU or transfusion history. This latter category in both men and women represents persons whose known HIV-infected partner was also infected through heterosexual contact, or was infected through IDU or other means. Thus, at least half of all heterosexual contact cases are associated with injection drug use.

Exhibit 2.75
Demographic and Regional Characteristics of AIDS Cases
Among Heterosexual Men and Women - Data Through December 31, 1993

Characteristics	No. of Heterosexual AIDS Cases	% of Hetero AIDS Cases	Total AIDS Cases	Hetero as a % of Total Cases
Gender				
Male	659	31.0%	71,097	0.9%
Female	1,466	69.0%	4,124	35.6%
Race/Ethnicity				
White	911	42.9%	49,392	1.8%
African American	600	28.2%	11,435	5.3%
Latino/a	537	25.3%	12,639	4.3%
Asian/Pacific Islander	69	3.3%	1,340	5.2%
Native American	5	0.3%	252	2.0%
Age Group				
13-24	162	7.6%	2,370	6.8%
25-29	394	18.5%	10,055	3.9%
30-49	1,251	58.9%	53,477	2.3%
50 & Over	318	15.0%	8,920	3.6%
County/Region				
Los Angeles	731	34.4%	26,675	2.7%
San Francisco	150	7.0%	17,674	0.9%
San Diego	180	8.5%	5,628	3.2%
Bay Area Region	439	20.6%	11,246	3.9%
Southern Metro	293	13.8%	7,176	4.1%
Rest of CA.	331	15.6%	6,778	4.9%

Source: California Department of Health Services, Office of AIDS

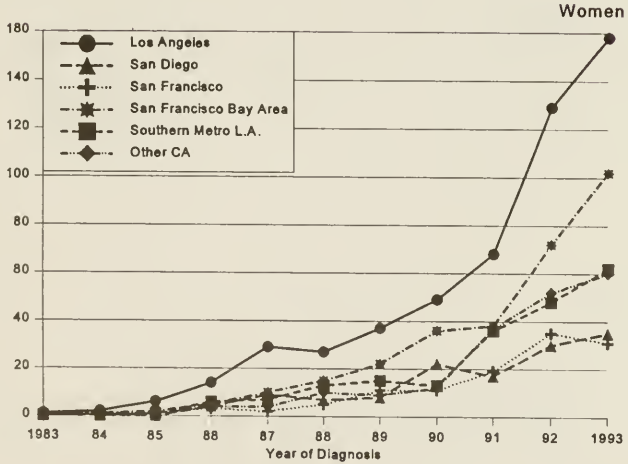
Trends in Incident Heterosexual Contact AIDS Cases

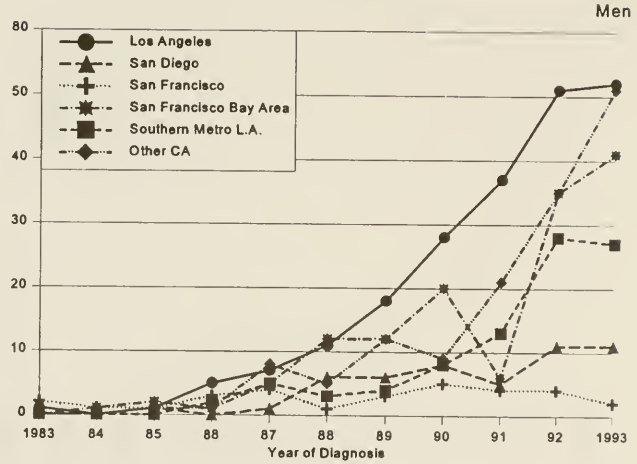
Annual AIDS incidence among heterosexual contact cases increased rapidly statewide, from 17 in 1985, to 221 in 1990 and 632 in 1993. The increase in newly diagnosed cases through 1993 indicates an increase in HIV transmission at least through 1983.

Through the end of 1993, new cases of AIDS attributed to heterosexual contact continued to increase more rapidly among women than men. Cases among women continued to increase in every region of the state, except possibly in San Francisco (Exhibit 2.76). Among men, cases continued to increase in all regions except the Southern Metropolitan region and San Francisco. Heterosexual contact AIDS incidence was highest in Los Angeles through 1993, followed closely by Bay Area counties (excluding San Francisco).

Exhibit 2.77 shows trends in AIDS incidence in cases of heterosexual contact by ethnicity. Incidence among women increased through 1993 among all racial/ethnic groups, except whites, where incidence may have reached a plateau in 1993. Among men, incidence slowed or decreased except among Latinos. Exhibit 2.78 shows that heterosexual contact cases increased steadily among all age groups through 1993, except among 13-24 year old women and men age 30 or older,

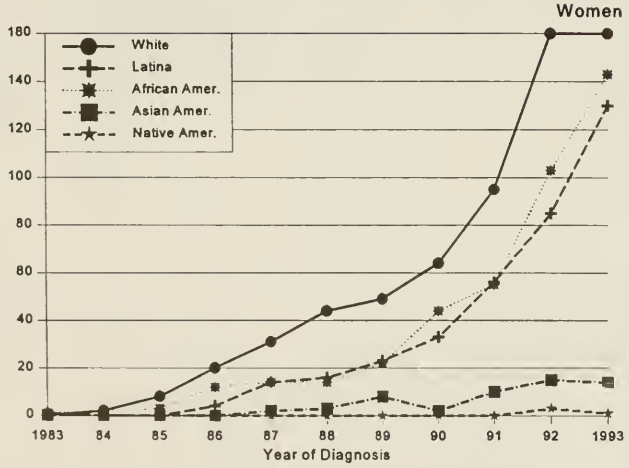
Exhibit 2.76
Trends in AIDS Incidence in California
Heterosexual Contact, by Sex and County/Region

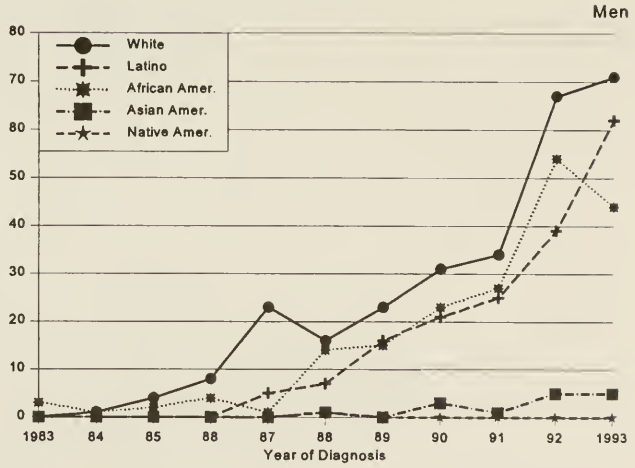




Source: California Dept. of Health Services, Office of AIDS
AIDS cases reported by 3/31/94 - Adjusted for Reporting Delays

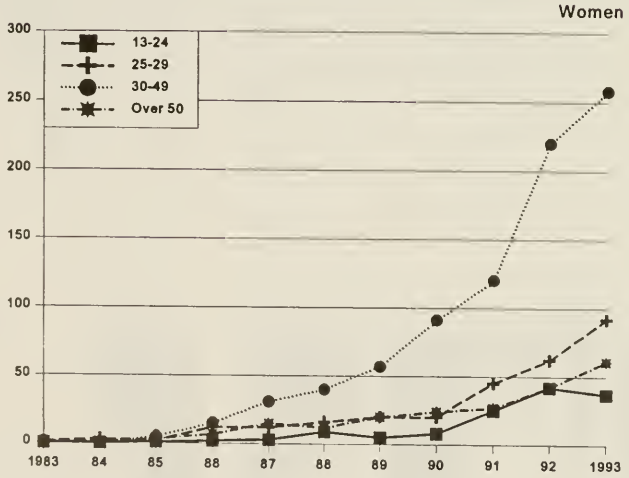
Exhibit 2.77
Trends in AIDS Incidence in California
Heterosexual Contact
by Sex and Race/Ethnicity

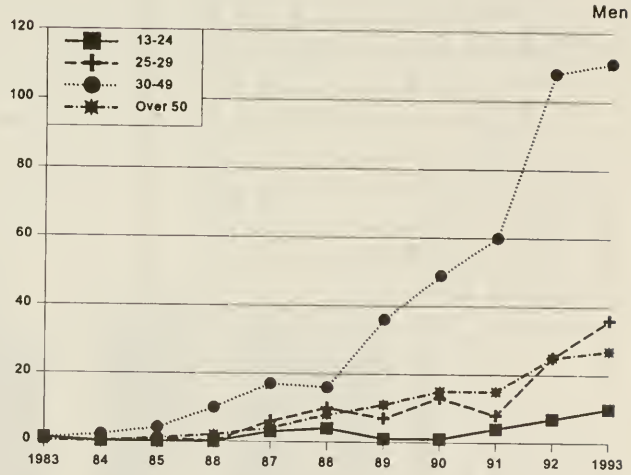




Source: California Dept. of Health Services, Office of AIDS
AIDS cases reported by 3/31/94 - Adjusted for Reporting Delays

Exhibit 2.78
Trends in AIDS Incidence in California
Heterosexual Contact, by Sex and Age





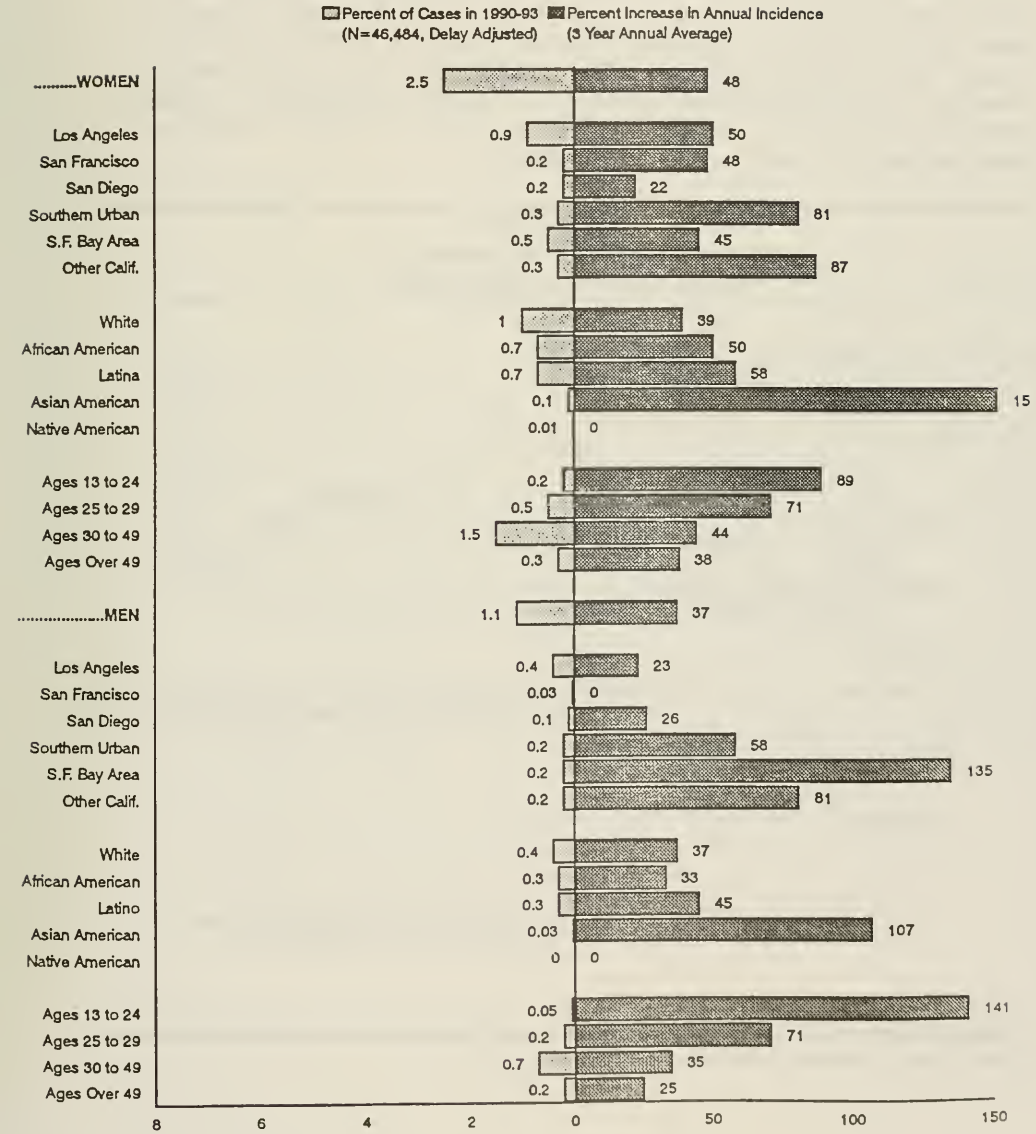
Source: California Dept. of Health Services, Office of AIDS
AIDS cases reported by 3/31/94 - Adjusted for Reporting Delays

Characteristics of Recently Diagnosed (1990-1993) Heterosexual Contact AIDS Cases

Exhibit 2.79 shows the distribution and trends of recent (1990-1993) AIDS cases attributed to heterosexual contact. The percentage of cases is shown on the left side of the chart, while the three year annual average percent increase in incidence is displayed on the right side of the chart. The proportion of AIDS cases attributed to heterosexual contact has increased over time to nearly 4% among cases diagnosed 1990-1993. The average annual percent increase in annual incidence during 1990-1993 was 48% for women and 37% for men. The increase for women is sharper than for female IDUs (35%), indicating an increasing ratio of female heterosexual contact to female IDU HIV infections in past years. Among men, the recent percent increase was similar to that for heterosexual IDUs. Note that most subgroups listed in Exhibit 2.79 represent less than 0.5% of all cases (or about 50 to 60 cases diagnosed per year). Among female heterosexual contact cases, increases were higher for women of color than for white women. Among the age groups, the largest increases in heterosexual contact cases were observed in the group aged 13-24, and declined with increasing age.

Percent increases for these subgroups are subject to artificial fluctuations due to small numbers and should be interpreted with caution.

Exhibit 2.79
California AIDS Case Distribution and Trends
Heterosexuals

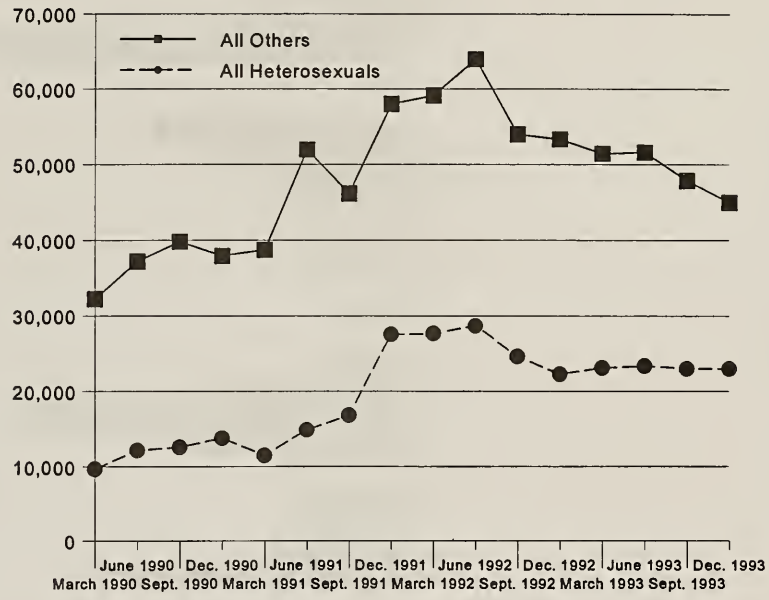


California Dept. of Health Svcs., Office of AIDS
AIDS Cases Reported by 3/31/94

HIV Testing among Heterosexuals

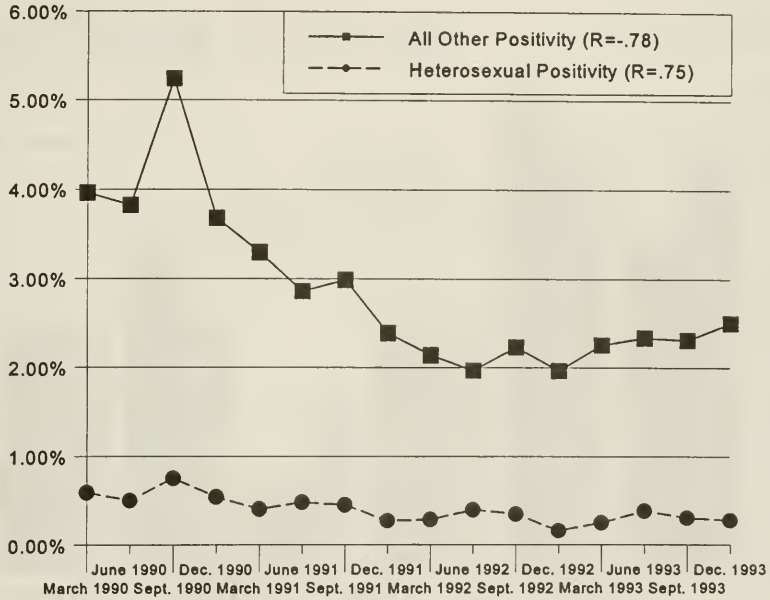
Exhibits 2.80 and 2.81 show that trends in HIV testing volume and positivity rates of heterosexual contact cases conformed with all testers since they represented the majority of those testing. Exhibit 2.82 summarizes the HIV positivity rates for heterosexual men tested at public sites in California who report having had multiple partners within the year prior to testing. The overall rates are very low, with a peak of 0.6% among first time testers in San Francisco, and a 0.5% rate among all testers in Los Angeles and San Francisco. Extracting first-time testers, which had such a pronouced effect on higher risk groups, did not result in much increase in the positivity rate of heterosexual men.

Exhibit 2.80
Trends in Testing Volume
Heterosexuals vs. All Other Groups



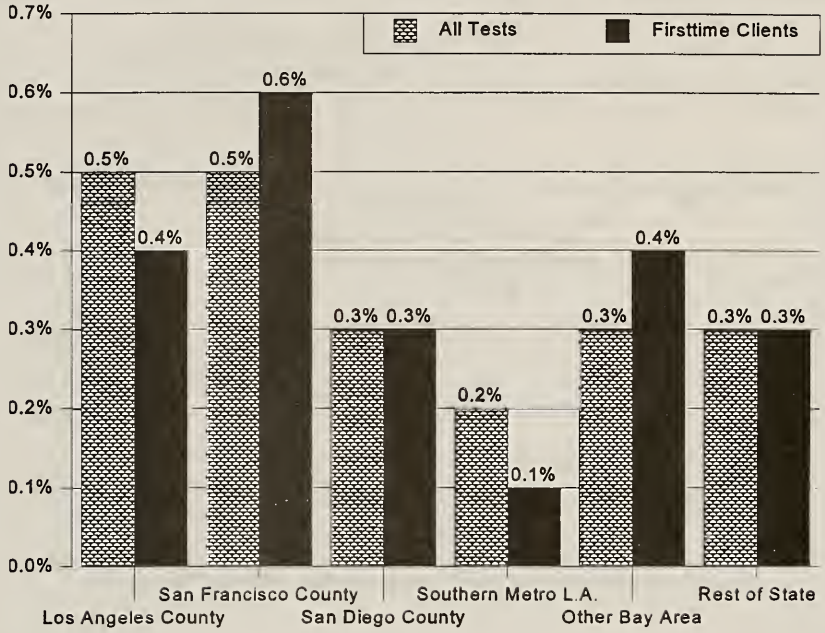
Source: California Department of Health Services, Office of AIDS

Exhibit 2.81
Trends in HIV Positivity Rate
Heterosexuals vs. All Other Groups



Source: California Department of Health Services, Office of AIDS

Exhibit 2.82
HIV Testing Results in 1993
Percent HIV Positive: All Tests and First-time Clients
Heterosexual Men with Multiple Partners

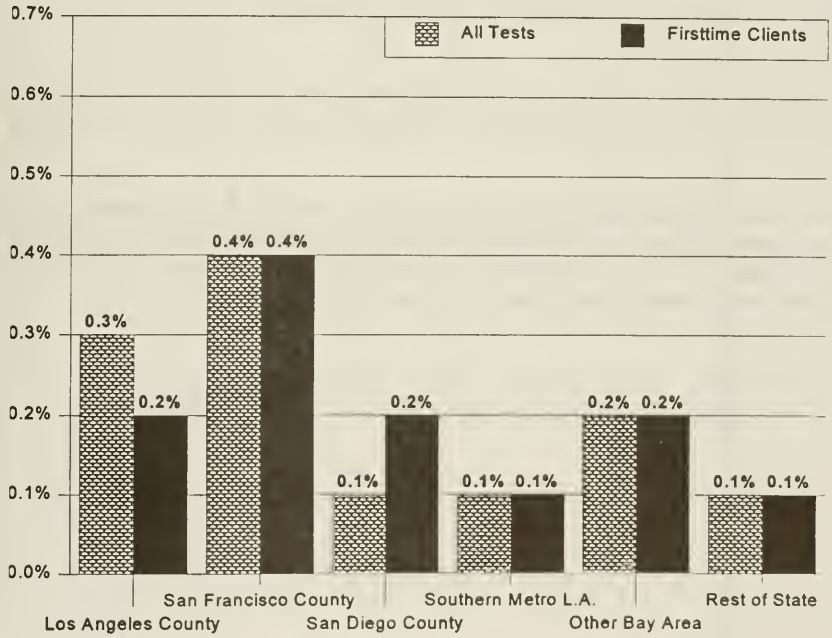


Source: California Department of Health Services, Office of AIDS

Exhibit 2.83 shows that positivity rates among heterosexual women with multiple partners were even lower. San Francisco had the highest rates but none exceeded 0.4%. First time clients differed little from all testers both because the rates are so low and because there is so little retesting in this group.

While heterosexual represented the largest group testing, they had extremely low seroprevalence. The termporal trends in HIV positivity rate among heterosexual clients do not suggest a significant increase in HIV infection in this group.

Exhibit 2.83
HIV Testing Results in 1993
Percent HIV Positive: All Tests and First-time Clients
Heterosexual Women with Multiple Partners



Source: California Department of Health Services, Office of AIDS

HIV Seroprevalence/Testing

HIV Prevalence Surveys in STD Clinics

Data from unlinked (blinded) surveys among 42,827 attendees of 41 STD clinics in 22 California local health jurisdictions in 1992 showed a 0.8% seropositive rate among heterosexual contact cases.

Overall region-specific seroprevalence rates are shown in Exhibit 2.84. San Francisco showed the highest rate of seroprevalance (1.8%), while the Southern Metropolitan region showed the lowest rate (0.4%).

Exhibit 2.84 also shows that 25% of the specimens tested among heterosexuals were from whites, of which 0.6% were HIV seropositive; 40% were from African Americans, of which 1.2% were HIV seropositive; 31% were from Latino/as, of which 0.6% were HIV seropositive; and 3% (1168) were from Asian/Pacific Islanders, of which 0.6% were HIV seropositive.

Sixty-three percent of the specimens tested among heterosexuals were from men of which 1.0% were HIV seropositive; and 37% were from women of which 0.5% were HIV seropositive.

The largest single age group of heterosexuals were under 24 years, representing 42% of the blood samples. This was followed by the 30-44 age group, then the 25-29 age group, and the 45 or older age group. The highest seroprevalence rate (1.4%) was in the 30-44 age group and the lowest seroprevalence rate (0.3%) was in the less than 24 age group.

Exhibit 2.84
HIV-1 Seroprevalence Among Heterosexuals Attending Sexually Transmitted Diseases Clinics in California, by Gender: 1992

	Males		Females		Total	
Regions	**No. Tested**	**% Positive**	**No. Tested**	**% Positive**	**No. Tested**	**% Positive**
Los Angeles	9,421	1.1%	5,994	0.6%	15,415	0.9%
San Francisco	1,575	2.3%	688	0.6%	2,263	1.8%
San Diego	1,099	2.0%	568	0.5%	1,667	1.5%
Other Bay Area	5,161	1.0%	2,999	0.5%	8,160	0.8%
Southern Metro	3,119	0.5%	1,845	0.2%	4,964	0.4%
Rest of CA.	6,767	0.7%	3,590	0.4%	10,357	0.6%
Age Group						
Under 24	10,818	0.4%	7,208	0.3%	18,026	0.3%
25-29	6,153	1.1%	3,117	0.6%	9,270	0.9%
30-44	8,268	1.8%	4,477	0.8%	12,745	1.4%
45+	1,696	1.2%	777	0.3%	2,473	0.9%
Unknown	207	1.4%	106	0.9%	313	1.3%
Race						
White	6,668	0.8%	4,073	0.2%	10,741	0.6%
African American	11,081	1.3%	6,017	0.9%	17,098	1.2%
Latino	8,357	0.8%	4,755	0.3%	13,112	0.6%
Asian/P.I.	627	1.0%	541	0.2%	1,168	0.6%
Am. Ind.	61	0.0%	56	0.0%	117	0.0%
Other/Unknown	348	0.3%	243	0.0%	591	0.2%
Total	27,142	1.0%	15,685	0.5%	42,827	0.8%

Source: California Department of Health Services, Office of AIDS

INFANTS AND CHILDREN

Incident Infections

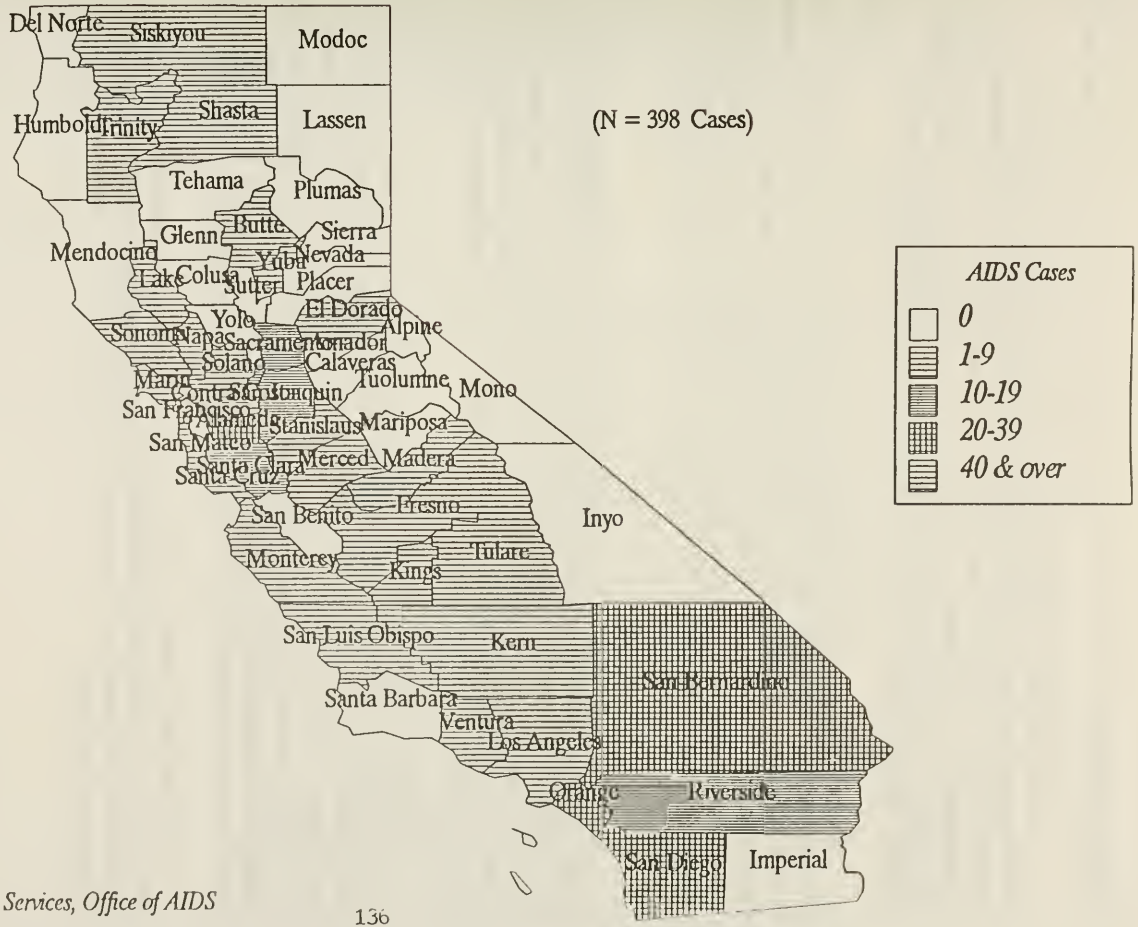
An estimated 100 to 150 HIV-infected infants were born in California each year since 1988. This estimate is based on the HIV survey of childbearing women and assumes a 25% transmission rate from mother to child. Further perinatal infections could be prevented by administering drugs such as Zidovudine to HIV positive women during pregnancy and labor and to the neonate. This has been shown to significantly reduce transmission (from 25% to 8%)***: however, the effects of exposure to Zidovudine on children are still being evaluated.

Exhibit 2.85 indicates that of the estimated 101 HIV-infected infants born in 1992, about one-third were from the San Francisco and the Bay Area region, one-third from Los Angeles County, and one-third from the rest of California. Nearly half of the infants had African-American mothers and a third Latina mothers. Almost one-quarter had African-American mothers from the San Francisco Bay Area, and 14% had Latina mothers from Los Angeles (data not shown). The majority were born to mothers in their twenties, but 9% had teenaged mothers. The sexual and drug use behaviors of the HIV-infected mothers is unknown at this time.

***Centers for Disease Control and Prevention. "Zidovudine for the prevention of HIV transmission from mother to infant". MMWR 1994;43:285-287.

Exhibit 2.85

Cumulative Pediatric AIDS Cases by California Counties



Source: CA Dept. of Health Services, Office of AIDS

Pediatric AIDS Cases

Pediatric AIDS cases reflect the extent of severe HIV disease among infants and children and provide clues about the profile of HIV infection in women of childbearing age. Mothers of pediatric AIDS cases were likely to have been infected with HIV further back in the past compared to HIV-infected women giving birth, and therefore provide weaker data about patterns of recent HIV infection. However, behavioral information available from pediatric AIDS surveillance provides data on mothers of pediatric AIDS cases.

Exhibit 2.86 describes the characteristics of pediatric AIDS cases. By the end of 1993, 399 pediatric AIDS cases were reported in California. Of these, 274 were infected perinatally, 88 were recipients of blood products, 27 were hemophiliacs, and 10 had other or undetermined exposure to HIV. The ethnicities of the mothers are not necessarily the same as the ethnicities of the babies. Exhibit 2.86 shows that of the babies, 28.5% were African-American, 35% were Latina, 32.3% were white, 0.5% were Native American, and 3.1% were Asian/Pacific Islanders.

Exhibit 2.87 shows that the most common route of HIV transmission reported among perinatal cases is injection drug use of the mother or sexual contact of the mother with an IDU man. Among these cases, 38% of the mothers reported injection drug use, 20% had sex with an IDU, 5% had sex with a bisexual man, 10% had sex with a person with AIDS or HIV, 5% received blood products, and 22% were infected with HIV with an undetermined method of exposure to HIV.

Exhibit 2.88 reveals that the profile of mothers differs notably by race ethnicity: 53% of African-Americans and 45% of whites reported injection drug use, compared to 28% of Latinas; conversely, sex with an IDU was more prevalent among Latinas (28%) than among whites (19%) or African-Americans (13%). A much larger proportion of Latinas had sex with an HIV infected partner (19%) than of whites (6%) or African-Americans (3%). (Women categorized as having sex with an HIV-infected person would include women having sex with a partner whose only exposure to HIV was through heterosexual contact.)

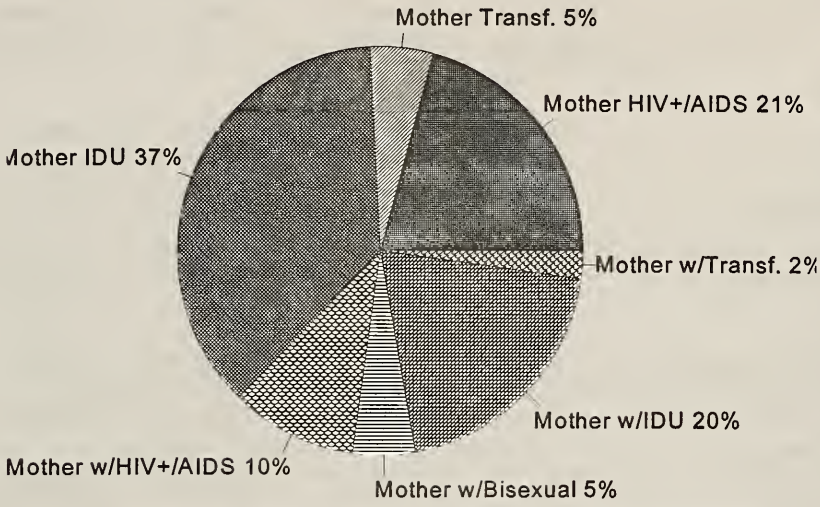
Given the stable number of perinatal infections, and assuming a consistent surveillance system, stable AIDS incidence can be expected, unless there are improvements in diagnosis of HIV infection or increased use of treatments that delay progression to the pediatric AIDS surveillance case definition.

Exhibit 2.86
Demographic and Regional Characteristics of Pediatric AIDS Cases:
Data Through December 31, 1993

Characteristics	No. of Pediatric AIDS Cases	% of Pediatric AIDS Cases	Total AIDS Cases	Pediatric as a % of Total Cases
Gender				
Male	218	54.7%	71,097	0.31%
Female	181	45.3%	4,124	4.39%
Race/Ethnicity				
White	129	32.3%	49,392	0.26%
African American	114	28.5%	11,435	1.00%
Latino/a	141	35.3%	12,639	1.12%
Asian/Pacific Islander	12	3.1%	1,340	0.90%
Native American	2	0.5%	252	0.79%
County/Region				
Los Angeles	151	37.9%	26,675	0.57%
San Francisco	23	5.9%	17,674	0.13%
San Diego	35	8.7%	5,628	0.62%
Bay Area Region	63	15.7%	11,246	0.56%
Southern Metro	59	14.8%	7,176	0.82%
Rest of CA.	67	16.8%	6,778	0.99%

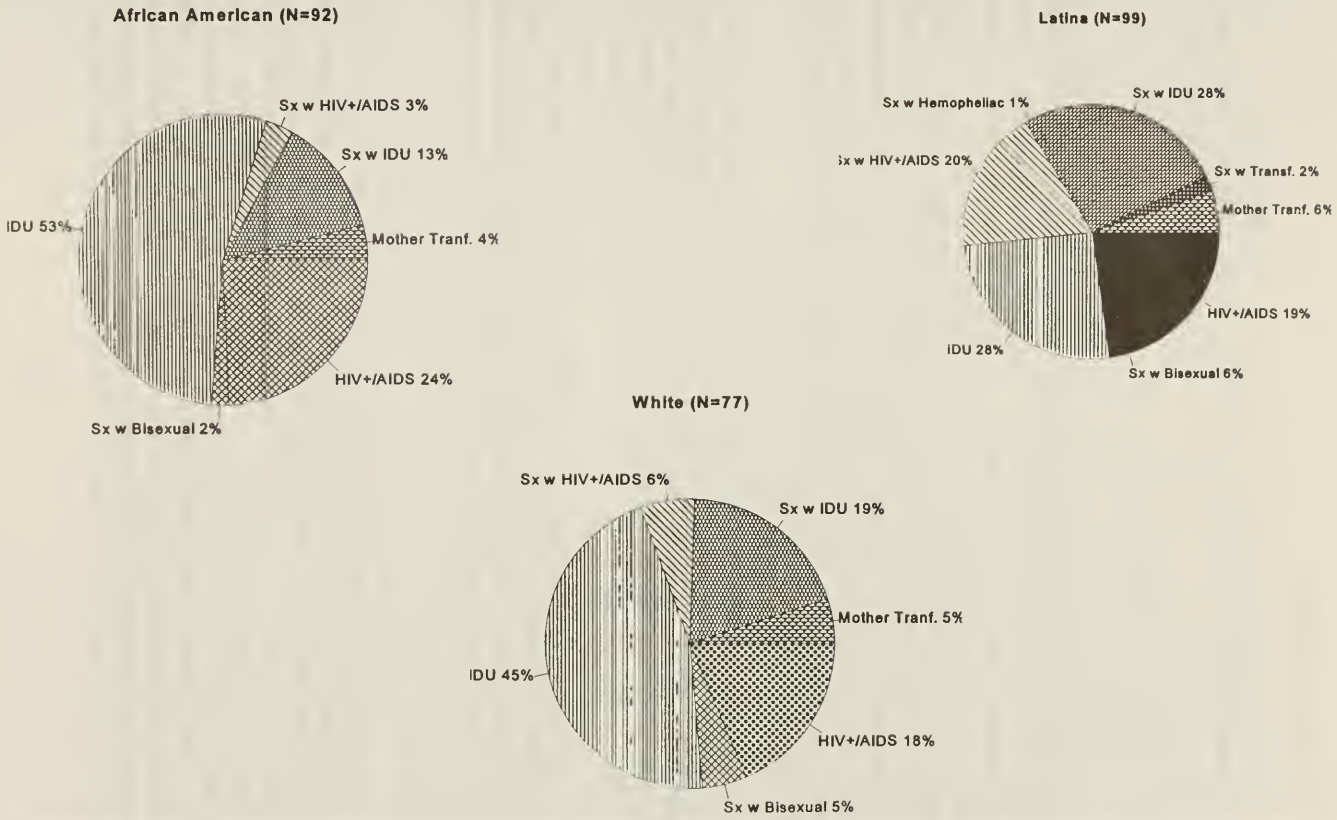
Source: California Department of Health Services, Office of AIDS

Exhibit 2.87
Perinatally Acquired Pediatric AIDS Cases (1980-1993)
Modes of HIV Transmission



Source: California Department of Health Services - Office of AIDS

Exhibit 2.88
Perinatally-Acquired Pediatric AIDS Cases (1980-1993)
Mother's Risk Factor by Race/ethnicity



Source: California Department of Health Services, Office of AIDS

HIV Infection Surveillance

Confidential surveillance of the spectrum of disease among HIV-infected infants is conducted in Los Angeles, San Diego, and in the San Francisco and Bay Area regions. This surveillance covers HIV infected infants and infants who have known perinatal exposure to HIV. A total of 729 infants in San Francisco, the Bay Area region and San Diego County were enrolled in this program through May 1994.

Perinatal infection accounted for 626 of the 729 infants enrolled. Of the infants enrolled, 51% were African-American, 23% were white, 21% were Latina/o, 3% were Asian/Pacific Islander, and 0.5% were Native Americans. This distribution is quite similar to the distribution of incident perinatal infections, except that a higher proportion of Latinas appears in the perinatal infection data because Los Angeles County was not included in this survey. Among perinatal cases, 43% of the mothers reported injection drug use, 13% reported sex with an IDU, 15% were presumably infected by sexual contact with a known HIV-infected or other high risk male. One quarter of the mothers were HIV-infected with no reported injection drug use or highest-risk sexual contact, and 3% reported transfusion of blood or blood products. A significantly higher proportion of African-American (56%) than white (23%) or Latina (17%) mothers reported injection drug use.

Other maternal behaviors associated with increased exposure to HIV included: crack cocaine use (19%), other street drugs (29%), and exchanging sex for drugs or money (8%). Some women may have reported more than one of these behaviors. Crack cocaine use was much more prevalent among mothers of African-American children (30%) than white (13%) or Latina/o children (7%).

The analyses of recent perinatal HIV infections, pediatric AIDS cases, and HIV infection surveillance cases suggest that the majority of HIV infections among childbearing women are IDU-related. In addition, the majority of HIV-infected mothers are women of color, with the highest rates of infection occurring in African-American women.

SUMMARY

In this chapter, every effort was made to present a comprehensive profile of the HIV-AIDS epidemic in California. A sound knowledge of the demographic, geographic, and risk behavior profile of all new or recent infections benefits planning for HIV prevention programs. Since there is not a reporting system for HIV incidence as there is for AIDS surveillance, HIV incidence can only be obtained by conducting special studies in defined populations repeatedly over a period of time to observe new infections. Although this is a very expensive approach, it is currently being used in multi-site federally-funded studies of homosexual men in the United States. For populations in which no incidence studies occur, an alternative is to supplement the AIDS surveillance data with a series of HIV seroprevalence studies in defined sentinel populations and with available data on markers of HIV-Orelated risk

behaviors. The strongest limitation of this approach is that it is extremely difficult to ascertain when HIV infection occurred. The State Office of AIDS is now conducting special studies in some of the populations that were either unrepresented or under-represented in the epidemiologic profile. It is anticipated that a subsequent epidemiologic profile would provide even more complete information for HIV prevention planning.

The epidemiologic profile presented here suggest that although HIV and AIDS in California were first reported among homosexual men in Los Angeles in the early 1980's, there are currently multiple sub-epidemics in which young homosexual men, heterosexuals, bisexuals, substance users, women, urban and non-urban areas of California are affected. The following briefly summarize the significant points referenced in the HIV/AIDS epidemiologic profile.

HIV disease is now the leading cause of death among men 25-44 years of age and the fourth leading cause of death among women of the same age group. As a group homosexual men are more severely impacted by the HIV epidemic than any other group. This group accounted for the highest proportions of reported AIDS cases and HIV antibody positive individuals who obtained HIV antibody tests at publicly-funded sites. On the average, the number of recently (between 1990 and 1993) diagnosed AIDS cases among homosexual men increased by 11% annually. Recent Hiv seroprevalence studies, HIV antibody test results and AIDS surveillance reports among homosexual men have shown that men of color and young gay men (both white and non-white) are disproportionately affected. Furthermore, although a substantial proportion (92%) of AIDS cases in homosexual men were diagnosed in the urban counties, increasing number of cases are being diagnosed in non-urban/rural counties. Moreover, homosexual male AIDS cases in non-urban/rural counties are more likely to be white and younger than in urban counties.

Results from a relatively small number of studies have suggested that men who have sex with men and women (bisexual men), especially men of color, may play significant roles in HIV transmission to women in some communities. Overall, there has been an annual average increase of 15% in bisexual AIDS cases diagnosed between 1990 and 1993 compared to the 11% reported among homosexual men. The rate of growth in AIDS cases among bisexual men of color is much higher than that observed among white bisexual males. In addition, surveillance reports suggest that the geographic distribution of HIV disease among bisexual men may be more evenly spread than among homosexual men. Non-urban counties accounted for a higher proportion of the total bisexual AIDS cases (14.2%) diagnosed in the state than for exclusively homosexual cases (7.8%)

Estimates of injection drug/substance users vary by the substance in question. An estimated 300,000-500,000 Californians reported ever injecting drugs. In general, it is estimated that there are more substance users out-of-treatment than those in-treatment. Moreover, several studies have shown that the prevalence of HIV infection among out-of-treatment substance users is several folds higher than in-treatment substance users. The

number of AIDS cases diagnosed among heterosexual IDUs between 1990 and 1993 increased annually by an average of 39% in men and 35% in women. These increases are at least three times higher than the increase seen among homosexual men. HIV seroprevalence rates among heterosexual IDU males are similar to those among heterosexual IDU females. From HIV serosurveys in STD clinics and HIV test sites, heterosexual men and women IDUs have comparable prevalence in infection. However, in many cases, women who are HIV antibody positive tend to have higher STD rates than men. Several studies have also shown that homosexual and bisexual men who also inject drugs have substantially elevated HIV prevalence compared to homosexual men who do not inject drugs. African Americans are disproportionately represented among the substance-using populations in California. A cross-sectional survey of perinatal substance exposure showed higher rates of illicit drug exposure among African American, English-speaking women and those who did not receive prenatal care. In general, a higher proportion of the substance-using populations reside in inner cities and urban areas of the state, however statewide substance use data have shown that non-urban areas have a fairly large population of substance users.

Statewide estimate of HIV among pregnant women indicate a stable prevalence of infection. It is uncertain, however, if HIV prevalence among pregnant women is the same as or lower than in non-pregnant women. Anecdotal reports from outreach workers and community advocates indicate that in some regions of the state, HIV prevalence among all women of reproductive age may be higher than the prevalence among women who recently gave birth in the same region. Nevertheless, an increasing number of women and infants are testing HIV positive and being subsequently diagnosed with AIDS. Substance use, sexual contact with multiple partners and sexual contact with an IDU partner or an HIV-infected partner are the predominant risk factors identified among California women. It is estimated that more than twice as many women as men became HIV-infected through heterosexual contact. This fact is also reflected in the AIDS surveillance statistics where 69% of all heterosexual AIDS cases were reported among reproductive-age women.

Finally, recent studies are showing elevated risk of HIV infection and sometimes higher HIV infection rates among young men and women. HIV serosurveys among young MSM in the San Francisco Bay Area region and Los Angeles County have reported unusually high seroprevalence rates in this group. A detailed birth cohort analysis of the AIDS surveillance data showed than an increasing proportion of HIV infection occurred among men in their teens and early twenties. Furthermore, STD rates (markers of HIV-related risks) in this population are disproportionately higher than in adults. In women, HIV prevalence rates among young childbearing women are comparable, and in some cases higher than those of adult women. While currently available data suggest that this pattern is seen mostly in urban area, anecdotal reports indicate similar or slightly lower levels of risk behaviors among the youth in non-urban/rural areas of California.

CHAPTER 3: OTHER NEEDS ASSESSMENTS OF TARGET POPULATIONS

INTRODUCTION TO TARGET POPULATIONS

This chapter describes in detail the specific demographic and HIV risk-related characteristics of the 16 target populations living in California that have been identified by the statewide planning group as being most in need of HIV-related prevention and education services at the present time. Each target group description includes:

1. A summary of the general demographic characteristics of the population described, such as the number of individuals in the target group, the age range of the population, and poverty status;

2. A description of the most significant HIV-related risk factors that place each target group at high risk for HIV infection; and

3. A listing of the key barriers that have prevented or will continue to prevent members of those groups from receiving appropriate and effective HIV prevention outreach and education.

Because people have multiple identities, they may fit into several of these categories, such as adolescent and homeless, or women and substance users.

These target population summaries are presented in the following order:

1. Substance Users and Their Sex Partners
2. Gay and Bisexual Men of All Ethnicities
3. Sex Industry Workers (Male, Female, Transgender)
4. Youth/Adolescents (ages 12-24)
5. People of Color Communities
6. Transgender/Transvestite Individuals
7. People in the Criminal Justice System
8. Homeless/Transient Individuals
9. Immigrants and Undocumented Persons
10. Women and Their Sex Partners
11. Seasonal/Migrant Farm Workers/Agriculture-Related Workers
12. Persons Engaging in Heterosexual Sex
13. People in Group Living Situations
14. The Disabled Community
15. People Who Pierce or Tattoo
16. Children (ages 0-11)

SUBSTANCE USERS AND THEIR SEX PARTNERS

A) Introduction to the Population

Substance abuse as an agent of HIV transmission encompasses a range of behaviors, including both addictive and casual use of alcohol and other drugs. Clearly, injection drug use with unsterilized needles has been and remains the primary risk factor placing substance users at risk for HIV infection. However, the role of alcohol and other drugs in influencing engagement in unsafe sexual behaviors must be considered one of the most significant co-factors exacerbating HIV transmission risk among all California populations. Because substance use and abuse transcends race, age, and gender, it is a factor influencing HIV infection throughout the state.

John Newmeyer of the Haight Ashbury Free Medical Clinic in San Francisco - a leading expert on California substance abusing populations - has estimated that there are approximately 15,000 injection drug users (IDUs) currently living in San Francisco. Eighty-five percent of these IDUs (approximately 12,750) are estimated to be heroin users, with the remainder (approximately 2,250) comprised mostly of methamphetamine users. Most of these methamphetamine users are considered to be addicts; the remainder are more infrequent or "weekend" users whose injection drug habits may or may not lead to more serious long-term addictions.

Dr. Newmeyer has used an anchor point method with key indicators to estimate the number of IDUs in California to be approximately **200,000**, with 70,000 of these drug users residing in Los Angeles County. These totals mean that over 42% of the state's IDUs live in either Los Angeles or San Francisco, while the two counties account for only 32% of the state's total population. Dr. Newmeyer's estimates indicate that there are approximately 115,000 IDUs in California living outside of San Francisco and Los Angeles, representing approximately 0.52% of the total population of California outside of these two major metropolitan areas.

These numbers increase even further, however, when one considers the population of Californians who state that they have ever injected drugs in their lives - a retrospective analysis which may be helpful in estimating future numbers of Californians who will inject drugs for the first time over the next several years. A major population-based survey of California adults over the age of 18 (Communication Technologies, 1988) found that 1.7% stated that they had ever injected drugs personally, and that 0.27% percent had injected drugs over the previous year. **Projected to the entire population of California over the age of 18, this would mean that between 300,000 and 500,000 Californians have injected drugs at one time or another.** In addition, in one survey of out-of-school youth (California Department of Health Services, December, 1993), 15.4% of respondents reported ever having used injection drugs; 8.9% reported that they had used heroin within the past six months; and 5.7% stated that they use heroin every few months or more.

By contrast, the population of Californians who can be considered to fit into the category of so-called "high-risk recreational drug users" is much larger than the IDU population. This population's willingness to experiment with a variety of illegal substances may indicate higher risk levels for HIV exposure than other components of the population. The 1988 Communications Technologies study noted above - prepared for the State of California Department of Health Services Office of AIDS - defined recreational drug users as,

> Those who had used sedatives, painkillers, tranquilizers, stimulants, or hallucinogens at least twice within the past year; those who had used marijuana at least once a month during the last year; and/or those who had ever used intravenous drugs or heroin at any point in their lives.

The 1988 Communications Technologies study found that 11% of respondents statewide qualified under this category, a finding which could be extrapolated to include between 2.8 and 3.1 million Californians. Furthermore, an additional 6% of the statewide study population had used cocaine at least twice within the past year, and 4% had used stimulants at least twice within the past year. The same study found that the statewide percentage of individuals abstaining from alcohol use was less than 10% across all demographic groups within the population.

From a 1991 KABB telephone survey conducted among African Americans and Latinos, an estimated 77,000 African Americans and 99,000 Latinos reported ever using "crack cocaine", "rock", or "ice". About 1% of African Americans (12,500) and 0.5% of Latinos (25,000) claimed they had used needles to inject drugs for non-medical purposes in the past 10 years. Conceivable, the true estimates of injection drug users or substance users are several folds higher than those provided here. These estimates are deemed low because they were derived from self-report of behaviors that are illegal or perceived as socially unacceptable.

The geographic and demographic distribution of injection drug user populations, as well as the prevalence of HIV among IDU communities, varies widely, and the causes of this phenomenon are not yet clear. According to Lurie & Reingold (1993), while studies consistently show an HIV prevalence rate as high as 50% to 60% among IDUs in major cities on the eastern seaboard such as New York and Northern New Jersey the HIV seroprevalence rate among IDUs in San Francisco appears to have levelled off at about 15% as of 1988. Such differences in seroprevalence suggest the need for a more complete understanding of both geographic and cultural differences in the behavior of different injection drug user groups before effective HIV prevention outreach can be tailored to the needs of specific drug using groups.

B) Risk Behaviors of the Population

As summarized by Lurie & Reingold (1993), the major mechanism for the spread of HIV infection among IDUs is, "inoculation of an HIV-negative IDU with traces of blood from contaminated needles and other paraphernalia previously used by an HIV-infected individual." Shared needles have been proven as the HIV transmission agent in numerous studies of HIV transmission around IDUs. Frequency of injection is another important factor in the transmission of HIV infection. **Because cocaine users inject drugs more frequently than users of other injection drugs such as heroin, injecting cocaine is particularly risky as an HIV transmissive behavior** (Chaisson, et. al, 1987; Anthony, et. al., 1991).

Again in the words of Lurie & Reingold (1993), after injecting the needle into the skin, but before depressing the plunger to inject drugs, it is usual for IDUs to "boot", or to withdraw a small amount of blood back into the syringe in order to verify by the appearance of blood that a vein has been entered. Even when booting does not take place, the tip of a needle is continually in contact with the blood of the injector. When the same syringe is used by another IDU, a small amount of blood from the first user may be injected, along with the drug, into the vein of the next user. If the first user if HIV-infected, this becomes an efficient method of transmitting HIV to the second needle sharer. Because needle sharing is common among IDUs, HIV prevention research and prevention strategies have naturally tended to focus on the prevention of needle sharing and on needle cleaning as methods for preventing IDU HIV infection.

IDUs, however, engage in a wide range of other significant risk behaviors that are lesser known, but that also contribute to high levels of HIV infection among these communities. The sharing of "cookers", for example, which are used to dissolve drugs into liquid form before drawing them into the syringe, is cited by Lurie & Reingold (1993) as a significant means through which bodily fluids can become mixed and HIV can be passed on. The sharing of cotton used to filter drugs to remove impurities, and the sharing of water used to rinse syringes and avoid clogging are additional transmissive agents. Risk of HIV infection is generally higher among injection drug users who inject in shooting galleries, where the sharing of needles, cookers, cotton, and rinse water is common.

Intravenous drug users also often engage in an activity known as subcutaneous injecting, or "skin popping", either when they are first beginning to drugs, or later in their drug-using careers when all other injection sites have been exhausted. IDUs sometimes also use one syringe to measure out a larger amount of drugs for use by multiple users, a procedure known by many names, including "backloading". This practice, in the words of Lurie & Reingold (1993) is, "convenient, because syringes are marked on the outside with a numerical scale. Drugs can be drawn into one syringe, then expressed into one or more syringes in measured amounts."

According to the American Public Health Association (1991), injection drug users predominately use heroin, although users of intravenous cocaine and amphetamines are also at risk if they share "works". Methamphetamine injection may be more prevalent in non-urban areas of the California in which heroin is not yet commonly used, or is not the drug of first choice. **Studies of needle sharing behavior in various U.S. cities (e.g., Haverkos, 1988) indicate that between 50% and 99% of injection drug users share needles.** A study of Latino and African-American women in methadone maintenance programs conducted in 1993, for example, (Marin & Gomez, 1993) found that 60% reported sharing needles frequently. Needles may be shared between sexual partners or in friendship groups, or anonymously in "shooting galleries", where injection drug users can rent or borrow used equipment. In some urban areas, surveys have linked shared needle use to the regulation of syringes that has made needle posession a crime, and the subsequently short of supply of needles which frequently necessitates sharing (e.g., Feldman & Biernacki, 1988).

One study conducted of nearly 350 injection drug users in Long Beach, California, located just south of the city of Los Angeles, (Rhodes, et. al., 1990), brought the point home even more dramatically, finding that fully 87.9% of all respondents reported sharing needles at least once, with only 40.3% reporting making an effort to regularly sterilize their needles and syringes. Within this group, lower rates of needle sharing were reported among cocaine users than among heroin and speedball users. There was also little or no awareness of the risk of HIV infection from sharing other injection-related paraphernalia such as cookers and cottons, while risk of infection from one's partner was often denied or minimized with regard to both drug usage and sexual risk.

The HIV-related effects of injection drug use disproportionately impact ethnic communities in California. Twenty-nine percent of all AIDS cases attributed to injection drug-based infection are among Latinos, for example, a population that constitutes only 21% of the general California population. Latino IDUs appear to become infected with HIV at a higher rate than non-Hispanic whites. One reason for this is the fact that Latinos appear more likely to use shooting galleries where needle sharing is common (Marin, Gomez, 1993). Among AIDS cases in Latina women, 48% are attributable to injection drug use, and another 30% are attributable to sex with an IDU. Therefore, 78% of all AIDS cases in Latina women, as compared to 58% in white women, can be linked to injection drug use. Latina women who inject drugs will likely continue to be one of the fastest growing populations infected with HIV.

Lurie & Reingold (1993) note that the role of the injection drug using community in promoting and maintaining injection and needle sharing behavior is complicated by the fact that there exists not one, but many, individual subcultures within the overall IDU population. This means that prevention outreach must address IDUs on a community-by-community basis if true behavior change outcomes are the objective of prevention. Feldman & Biernacki (1988), Wiebel (1988), Christie (1990), and others advocate application of an ethnographic approach to more fully learn about the social and cultural dynamics within drug user

communities that motivate specific behaviors and responses. In addition, because IDUs are marginalized by society, community behaviors such as the sharing of the scarce resources of food, housing, drugs, and injection equipment promotes social bonding and group cohesion, traits necessary for survival in a hostile environment, but those characteristics complicate attempts to change needle sharing behavior. Lex (1990) has provided evidence that IDU subcultures also tend to be heavily male-dominated, with a male-to-female ratio of approximately 5:1.

Unsafe sexual activity by injection drug users appears to take slightly different forms within different communities of color in California, a fact which complicates outreach and education, and may necessitate IDU prevention approaches which are simultaneously both ethnically and socioeconomically based. According to a major study of heterosexual IDUs in San Francisco (Lewis & Watters, 1991), in which 623 IDUs were interviewed (40% of them white, 41% of them African American/Black, and 12% of them Hispanic) having 10 or more sexual partners was reported more often by whites than blacks, and by women more than men, while African American/Black IDUs reported more sex-for-money exchanges than whites, and women reported more of these than men. White respondents were also more likely than black respondents to have a consistently stable partner who injected drugs.

In the same study, **over two-thirds of all respondents reported never using condoms**, with African Americans and whites virtually identical in this high-risk behavior. Respondents with more than 10 sexual partners, men with male sexual partners, and those who engaged in prostitution were all more likely to use condoms. White ethnicity was also significantly and independently associated with each of the following practices: having 10 or more sexual partners; anal sex; having an IDU as a steady sexual partner; and oral sex. The study also found that - at least in San Francisco - its own outcomes correlated with recent research suggesting that **HIV transmission among IDUs is increasingly as much the result of sexual as of needle-sharing activity.**

> "These people are not worrying about using condoms. Essentially, a man who takes a crack hit is not going to go get a condom and then have sex. People are having sex in bathrooms, in vacant buildings, in the bushes. It is not just a joke.
> --member of the public, Fresno meeting

The potentially lethal outcomes of injection drug use, of course, range far beyond the individual to include those persons with whom the individual has unprotected sexual intercourse. Having unprotected sex with an injection drug user is a key means through which substance abuse helps proliferate HIV within the general community, particularly to poorer women of all ethnicities who often exchange sex for drugs or engage in prostitution with injection drug users. In a study of Latino and African-American women in methadone treatment (Marin & Gomez, 1993), 84% of respondents reported having sex with an IDU, and only 12% reported consisted condom use. In the study of IDUs in Long Beach (Rhodes, et.

al., 1990), 61% of sexually active females and 21% of sexually active males reported exchanging sex for money or drugs. And in a survey of male IDUs with steady female partners, 83% of 70 white male and 79 black male IDU respondents had multiple sex partners; 15% reported male sexual contact; and 38% reported heterosexual anal intercourse, but 73% of all study respondents never used condoms.

A more focused study of female partners of IDUs (Corby, Thronton-Johnson, & Tanner, 1991) also found that although levels of knowledge regarding HIV transmission were high among the women surveyed (with an average of 82% of HIV-related questions correct on a 16-item test) fully 88% believed that there was a chance they would become HIV infected. Despite relatively high knowledge levels, almost all respondents had engaged in unprotected vaginal intercourse during the previous six months, with the most frequent reasons given for inconsistent condom use being dislike of condoms by male partners (27%), and/or a "personal dislike" of condoms (23%). (In the same study, black interviewees were more likely than whites or Latinas to have contracted syphilis, have multiple sex partners, engage in prostitution, use crack, and drink alcohol on a daily basis.)

It is also important to note, as Rhodes, et. al. (1990) also point out, that **the reduction in sexual pleasure attributed to condoms is especially significant to heroin users** because of the attenuating effect of heroin on sexual functioning in general, and on penile sensitivity in particular.

Crack cocaine use and other drug use closely correlates with risky behavior in regard to HIV exposure. Having sex while intoxicated with crack or any other drug - including alcohol, or drugs used in combination - increases the likelihood of unsafe sexual activity. Among a population of African American/Black teenagers living in Oakland and San Francisco who were self-identified crack users (Fullilove, Thompson-Fullilove, Bowser, & Gross, 1990) a history of sexually transmitted diseases was much more prevalent among those who combined crack with sex (52%) than with those who did not (31%). Daily users of both crack and marijuana were significantly more likely to report an STD than those who used only one of these drugs on a daily basis, or than those who used neither drug on a daily basis.

C) Barriers to HIV Prevention Within the Population

Although the point may seem self-evident, it is important to recall that most drug use in American society is illegal, and that drug users -- mistrusting of AIDS educators, wary of law enforcement, and protective of non-drug-using family and friends -- may not self-identify as drug users, and thus may not seek out the education and support they need to effect long-term behavior change to reduce HIV risk. By the same token, AIDS educators may have difficulty in contacting and identifying drug using populations because of community norms which prohibit outreach that could be viewed as tacit approval or encouragement of substance abusing behaviors, with prohibitions on needle exchange programs being the most obvious historical example.

Drug and alcohol use is also frequently a symptom of other major problems ranging from lack of economic opportunity, to depression and mental illness, to lack of self-esteem or social self-efficacy. Approaches to changing HIV-related risk behavior among IDUs and other substance abusers must therefore be tied to a spectrum of outreach and treatment services, ranging from drug treatment, to job placement, to mental health care, to supportive human services. As mainstream drug treatment providers have known for some time, no one issue in the life of the substance abuser can be truly removed from another, and the risk of HIV exposure may justifiably be a lower priority issue to a heroin user who is unable to hold down a job and is struggling to maintain a family. At the same time, the extent to which local treatment programs can provide access to systems of care and support is extremely limited, and HIV prevention funding is too often restricted to HIV prevention costs only, and not to the costs of linking HIV prevention efforts to a more comprehensive range of treatment and service mechanisms to support the long-term transition to sobriety and low-risk behavior for the illegal drug user.

In terms of the injection drug using community as a whole, many researchers agree that the key means for preventing the widespread use of unsterilized works and needles by IDUs will depend on a shift in norms within the drug using community itself that makes it socially acceptable to not share needles within a group shooting situation. While the relative unavailability of clean needles in most California urban areas increases the likelihood of sharing needles, Rhodes, et. al. (1990), for example, found that IDUs who had been able to significantly reduce their potential for exposure were either less likely to inject in settings where there were likely to be strangers (such as in shooting galleries), or were more likely to have a circle of acquaintances of no more than five people with whom they shared needles, suggesting that it is the condition of anonymous group shooting-up which continues to sanction and even require needle-sharing as a social mechanism. According to Rhodes, et. al. (1990), the perception that bleach will ruin one's equipment can negatively impact adoption of bleach cleaning practices in both individual and group shooting settings.

In the case of crack users, a San Francisco/Oakland study of crack-using teens found that passivity, as a personal style, may be a highly significant factor for risk for sexually transmitted diseases (Fullilove, Thompson-Fullilove, Bowser, & Gross, 1990). Teaching passive individuals to take more positive and active responsibility for their behavior, however, is a difficult task, and is one that is much easier to recommend than to accomplish.

Significant barriers exist for HIV prevention when HIV outreach workers are not sensitive to the particular cultural and social milieus of the particular substance abuse community with which they are working, or when they do not understand that HIV and AIDS risk is only one factor in a complex range of problems facing IDUs. As Lurie & Reingold (1993) point out, AIDS has most severely impacted disadvantaged segments of American society, and lack of education and lack of financial resources make it more difficult to "build the skills and self-confidence that IDUs need to avoid HIV infection." Lack of employment, education, housing, and other social necessities are most often at the root of drug addiction,

with many substance abusers respond to the traumatic hopelessness of their environments through the release provided by drug use. Within this perspective, HIV/AIDS becomes only one of many consequence of injection drug use within this community, one that must be addressed within a global perspective of this community's needs and conditions in order for HIV education to be both appropriate and successful.

GAY AND BISEXUAL MEN OF ALL ETHNICITIES

A) Introduction to the Population

Standard psychological and sociological estimates of the prevalence of individuals within the general population whose sexual behavior is exclusively homosexual have varied widely over the past forty years, from the estimate of as high as 10% originally proposed by the Kinseys in their landmark 1950's studies, to the 3% figure proposed by more recent researchers. In terms of the male population of the state of California, application of the 10% estimate to 1990 census figures would mean that approximately 1.2 million men over the age of 18 in the state are exclusively gay, while use of the 3% formula results in **an estimate of 360,000 exclusively gay men over the age of 18**. These estimated populations include openly gay men, gay men who are closeted, gay transgender men, and men who have sex exclusively with other men, but who do not self-identify themselves - or even think of themselves - as being gay. The category also includes self-identified gay men who have sex with women, although no statitstics are available to accurately estimate the size of this population.

It is important to realize, however, that even though we do not know the prevalence of homosexuality within the general population, **application of even the most conservative estimate of 3% results in a statewide gay population that is well over a quarter of a million individuals.** And if we apply a slightly larger estimate of 5.5% to acknowledge the large number of gay men who are known to migrate to population centers such as Los Angeles, San Francisco, and San Diego from outside the state, we find a total of over 660,000 gay men living in California.

An even larger number of California men are bisexuals, or men who have had sex with both other men and with women. Uncertainty about the number of gay men living in California are exceeded by the lack of knowledge about the number of non-gay bisexual men within the state, because it is difficult to collect data about what is often a hidden or secret population. Many men have sex with men but do not have sex with men exclusively, and many of these are individuals whose behavior is kept a secret from friends and family. Therefore, no accurate estimates are available to permit an extrapolation of the number of bisexual California men, whose same-sex behavior is known to vary widely from individual to individual. But even if one assumes that there is only the same number of bisexual men as there are exclusively homosexual men (to most researchers, a low estimate) there are 660,000 bisexual men at risk in California, resulting in a total of at least 1.32 million gay and bisexual

men statewide. It is important to note that an estimated 10% of all heterosexually transmitted AIDS cases among women have been through bisexual male partners.

Gay and bisexual men in California encompass all age groups, all ethnic and language backgrounds, all socioeconomic levels, and every variety of familial group. Because young people, including gay and bisexual young people, are encompassed by the youth category elsewhere in this document, the reader is referred to both this section and the section on youth. It may be more practical to make assumptions about the socioeconomic status of gay men based upon their ethnicity and education, rather than upon their sexual orientation per se because gay and bisexual populations are diverse, and because less is known about gay men living outside of major metropolitan areas.

It is known, of course, that there are high concentrations of gay men in some specific California cities, especially Los Angeles, San Francisco, and San Diego. In addition, some smaller gay resort areas - especially the Palm Springs/Palm Desert region east of Los Angeles, Laguna Beach south of Los Angeles, and the Guerneville/Russian River area north of San Francisco - have high concentrations of permanent gay residents, as well as large transient populations of vacationing gay men from both inside and outside the state. All three of the state's largest metropolitan areas have gay populations that live both within the center of these cities, and in outlying areas surrounding these cities, such as the San Francisco Bay area as a whole, and Orange County near Los Angeles.

> "When I hear people talk about dying from HIV, I become ballistic. Because I'm living with this. I'm not dying from it."
> --member of the public, San Diego meeting

B) Risk Behaviors of the Population

Apart from injection drug use with an unsterilized needle, the risk behavior thought to place gay and bisexual men at highest risk for HIV transmission is unprotected anal intercourse, and in particular, unprotected receptive anal intercourse. One study of urban gay men in three medium-sized California cities (Hays, Kegeles, & Coates, 1990) found that 43% of respondents reported having engaged in unprotected anal intercourse during the previous six months. A recent survey of gay and bisexual men conducted in Fresno (Central Valley AIDS Team, 1994) found that 25% of gay and bisexual men surveyed indicated that they felt unprotected insertive anal sex was relatively safe. A 1993 survey and gay/bisexual men in Santa Clara County (Gans, 1993) found that 33% of respondents reported engaging in some instances of unprotected anal sex in the prior six months, and that 11% reported engaging in receptive anal sex without a condom and with ejaculation.

Other risk behaviors that place gay and bisexual men at risk include unprotected oral sex, contacts with open sores or cuts or abrasion of the mucous membranes (e.g., fisting), and

sharing of sexual toys (e.g., dildos). However, a myriad of secondary influences that motivate these behaviors must also be regarded as risk factors, particularly in the case of alcohol and other drug use which leads to unprotected sex. Other common secondary influences include the lack of supportive services for initiating and maintaining safer behavior; so-called 'survival guilt'; and conditions of inequality within sexual contact, such as in the case of sex between young and older men where a younger partner is seen as less likely to be HIV infected, and/or one of the partners may be more vulnerable to control by the other. There is continued debate as to whether re-exposure to HIV when one is already infected with the AIDS virus further compromises one's immune status, or makes one more vulnerable to HIV-related conditions.

Because gay men have been more consistently exposed to focused preventive HIV education over the course of the epidemic than any other group, it is commonly reported by researchers that gay men have higher levels of knowledge than other groups, and that white gay men and older gay men have higher levels of knowledge than gay men of color and young gay men. These educational efforts are generally agreed to have led to a significant decline in unsafe sexual behavior among openly gay men during the period of approximately 1984 to 1989, the period at the beginning of the epidemic when the greatest concentration of information was being disseminated, along with extensive media 'horror stories" about the growing killer.

In one large-scale study of sexually active gay men (Stall, Ekstrand, Pollack, McKusick, & Coates, 1990), for example, participants reported a 76% decline in high-risk sexual behavior from 1984 to 1988, from a high risk median in 1984 to a low risk median by 1985, and remaining at that level through the time of publication. The ongoing San Francisco Men's Health Study reported (Ekstrand & Coates, 1990) that drastic reduction in insertive and receptive unprotective anal intercourse had taken place within the population of San Francisco gay men between 1984 and 1988, with only 12% admitting relapsing to unprotected receptive anal intercourse following initial behavior change.

Several newer studies, however are beginning to indicate that longer-term abstinence from unsafe sexual activity is proving to be much more difficult for gay and bisexual men to sustain over the long term, and that new approaches may be needed to sustain safer behaviors over the crisis' second decade. Stall, Eckstrand, Pollack, McKusick, & Coates (1990) report that **69% of the high-risk sex that occurred during a 1988 San Francisco measurement could be characterized as a relapse from a safer behavior pattern.** A number of factors seem to contribute to relapse to unsafe behavior over the long term, although research findings raise as many questions as answers about what contributes to relapse behavior among those who have previously adopted safer behaviors. In one Fresno survey (Central Valley AIDS Team, 1994) those with friends or relatives with HIV or who had died of AIDS were no more likely to have safer sex than those who did not know someone with HIV, although other surveys have found a positive association between the number of AIDS funerals attended and a commitment to safer sex.

Part of what is difficult about preventing HIV transmission among gay and bisexual men is the complex patterns of attitudes and individual responses which lead to engagement in unprotected anal intercourse. Respondents to the California urban study (Hays, Kegeles, & Coates, 1990) who reported having unprotected anal intercourse, for example, reported greater enjoyment of unprotected anal intercourse and perceived less risk from unprotected anal intercourse, yet labeled themselves as more at risk for AIDS, reported poorer communications skills with sexual partners, and at the same time were more likely to have boyfriends/lovers than men who have not engaged in high-risk sex. These same respondents also perceived the likelihood of acquiring HIV from unprotected anal intercourse with young gay men to be significantly lower than with older gay men. In a larger study (Stall, Ekstrand, Pollack, McKusick, & Coates, 1990) men in monogamous relationships most often reported having unprotected intercourse because they were "in love", while men without primary sexual relationships reported having unprotected sex because they "became sexually aroused", used drugs and alcohol in conduction with sex, or did not have condoms available at the time of the encounter.

There is also strong evidence to suggest that knowledge and behavior patterns among gay men differ widely across racial and ethnic lines, indicating the inadequacy or inconsistency of the success of HIV prevention messages delivered to people of color communities, as well as cultural differences affecting sexual behaviors among different ethnic groups. More accurate surveillance information is needed, however, which breaks down API communities by specific cultural groupings and national origins, in order to allow prevention programs to effectively develop outreach strategies that address the needs of affected populations. In a KABB survey comparing American Indian, Filipino, and Latino gay/bisexual communities in San Francisco (Fairbank, Bregman, & Maulin, 1991), the percentages of those who engaged in either risky or possibly risky sexual behavior ranged from 25% of American Indians to 70% and 71% among Filipinos and Latinos, respectively. At the same time, the level of unprotected anal intercourse among Filipinos and Latinos was approximately two times that of the number reported in surveys focusing on whites, in spite of the fact that most respondents were very knowledgeable about AIDS and said they had changed their sexual behavior as a result of HIV. Forty-two percent of the combined respondents also reported engaging in sexual activity while under the influence of drugs or alcohol. One study of Asian/Pacific Islander men in San Francisco (Choi, Cortes, Lew, & Coates, 1993) reported that one out of four API men reported that he had engaged in unprotected anal intercourse within the previous three months.

Amyl nitrate, colloquially called "poppers" has been implicated in the epidemic among gay men. Poppers, which belong to a class of vasodilatory drugs called alkyl nitrates, were common accessories to the gay male social scene of the 1980's when the epidemic began. Numerous studies have demonstrated the risks for HIV infection that the use of poppers presents. While under the influence of poppers, people often are more inclined to initiate unsafe sexual behaviors, specifically receptive anal intercourse without a condom (de Wit et al., 1994 and Ostrow, et al., 1994). The physiological effect of poppers prompt a desire for

vigorous friction in the act of intercourse, and the dilatory effect increases the probability of small ruptures in the anal lining, creating more avenues for HIV to gain access into the blood stream (van Griensven et al., 1994). Additionally, poppers have been shown to be immunosuppressive, even with moderate use. Regular use of amyl nitrates by persons with compromised immune systems may hasten the onset of HIV-related symptoms (Dax et al., 1994). Poppers, even more than alcohol and marijuana, have been associated with unsafe sexual behavior (Ostrow et al., 1994).

Considerable evidence indicates an alarming second was of HIV-infection in young gay and bisexual men. Youth, in general, are at increasing risk for HIV-infection. The number of AIDS cases among adolescents and youth is currently doubling every 18 months. Seventy-one percent of these cases in San Francisco are among gay and bisexual men (San Francisco Department of Public Health, 1993). Two studies (Hays et al., 1990, and Stall et al., 1989) found that young gay men report higher levels of risk behavior than gay men over 30. Forty-three percent of the gay men between the ages of 18 and 25 surveyed in the Hays study reported having engaged in unprotected anal intercourse in the previous six months. These same respondents also perceived lower risk from unprotected anal intercourse, suggesting that HIV-prevention messages had not effectively reached this group. The San Francisco Department of Public Health estimates that 12% of non-drug using gay and bisexual men between the ages of 12 and 25 are already infected with HIV. Among drug-using gay and bisexual youth and adolescents, 14% are HIV positive. A State Office of AIDS study indicates that this may be a pattern in many other areas of the State. As more and more infections occur in men in their teens and early twenties, there is an urgent need for HIV-prevention programs designed with a clear understanding of the issues facing this population.

C) Barriers to HIV Prevention Within the Population

Apart from the difficulty in preventing long-term relapse from safer behaviors, significant barriers exist in reaching and affecting the behavior of gay and bisexual men of color, and in reaching closeted gay men and bisexual men of all types. Many AIDS programs are designed for a 'standardized' model of self-identified gay men - usually white gay men - and are not culturally appropriate or effective for men of color. At the same time, they do not encompass a wide enough range of ancillary services to support the special needs of ethnic communities. African-American men from Alameda and Contra Costa Counties who have sex with men (Gil Gerald & Associates, 1993) agreed strongly in a focus group about the need for substance abuse, vocational, and mental health services, while expressing a critical need for culturally competent services. Many Latino and African-American gay male communities are also economically distressed, and express a great deal of distrust in the public health system, as well as dissatisfaction which how they are treated by many AIDS service providers (Ibid.).

While all gay and bisexual men of color communities receive inadequate prevention services, the U.S. Conference of Mayors reports that Asian/Pacific Islander and Native American communities generally receive the least prevention service of all. The needs of

Native Americans are frequently relegated to the Indian Health Service (IHS), for example, with totally inadequate results since the IHS has no HIV prevention program specifically directed to gay and bisexual men. Primary HIV prevention programs for non-English speaking gays are frequently not available, particularly for people who speak Asian and Pacific Islander languages. At the same time, an inadequate number of services are provided directly within neighborhoods where gay and bisexual men of color live. In both smaller and larger cities, however, services may need to be based in 'safe' locations that individuals feel comfortable entering and exiting, in order to avoid the stigma of others learning about either their HIV status or sexual orientation.

Generally, gay and bisexual men of color interviewed through our research believed that the most effective HIV prevention programs for members of their risk group were prevention programs run specifically by and for men of color. This could include programs which are freestanding, community-based ventures, or programs which are semi-autonomous units of non-profit agencies or county health departments. In general, gay/bisexual men of color believed that their own understanding of the needs and backgrounds of their own cultural group was most effective in overcoming barriers to accessing men of color who are having sex with men.

It is of course also extremely difficult to reach men who have sex with men but who do not self-identify as gay. These men may avoid education targeted to gay men out of fear of being identified as homosexual, or may ignore or dismiss such messages because of a need or desire to deny that they are in any way similar to gays or at risk. Barriers to reaching closeted and bisexual men include the lack of developed networks and information-sharing among members of these groups; the fact that they may or may not access traditional routes of information common to self-identified gay men; and the fact that adopting new, safer behaviors with a significant other, such as a spouse, might reveal the individual's hidden same-sex behavior patterns. Strategies for overcoming such barriers must take into account the need for closeted gay men to access information and support safely and confidentially, and must evolve creative strategies for reaching bisexual men at risk who are often completely out of the mainstream of HIV prevention and education messages for men having sex with men.

> "We must take a look at our youth — the ones that weren't around to get the message in the beginning."
> --member of the public, San Diego meeting

There are several areas in the state that are resort areas known to gay men all over the world. These include Palm Springs/Palm Desert and the Guernville/Russian River areas. Visitors to these resort areas may neglect to practice safer sexual behaviors while on vacation and contract and transmit HIV before they return to their city homes. Moreover, HIV-positive gay men often relocate to these areas from the urban cities because of the lower cost of living

and higher quality of life and a resident support system. With the mix of transient and resident persons, these areas present challenges for HIV prevention programs.

Prevention efforts that target youth, particularly school-based programs, too often assume the heterosexuality of their audience. These programs are unlikely to address the complex psychological and developmental issues facing young men who have sex with men. These issues include self-esteem, social isolation, relationship skills, and internalized homophobia. While these problems are not unique to young men who have sex with men, the stigma attached to same-gender sex adds complex dimensions to these issues. Because of the already controversial nature of AIDS, education in the public schools, inclusion of the concerns of gay and bisexual adolescents is a volatile issue in some jurisdictions. Additionally, there are few prevention programs that have the ability to reach young gay and bisexual men who are not in school. Younger gay men may feel that they have little in common with older gay man and may feel alienated from the general gay community. Prevention efforts that target older gay men may not appropriately address the special concern of younger men.

There is, emerging evidence to suggest that both levels and correlates of sexual risk are different between younger and older gay men. One cross-sectional survey (Stall, et. al., 1992) found that gay men under the age of 30 report higher risk behavior for HIV than men over 30, and that correlates for high-risk behavior among younger gay men included reporting a lower attributed risk for HIV infection to unprotected anal intercourse, and higher concern about AIDS risk. It may be that younger generations of gay men, who have not experienced the firsthand effects of HIV and AIDS on friends and loved ones to the extent that older gay men have, may need to receive large-scale, "first wave"-type educational information and support which may need to be repeated every five to eight years to account for newer populations of emerging self-identified gay and bisexual men in California.

SEX INDUSTRY WORKERS (MALE, FEMALE, TRANSGENDER)

A) Introduction to the Population

Due to the illicit nature of sex industry work, it is not possible to provide accurate estimates of the total number of individuals involved in the sex industry in California. Police department estimates are based on arrest records, and tend to count only prostitutes who work the streets. According to representatives of Coyote, a respected San Francisco Bay area-based prostitute education and advocacy organization, **street prostitutes account for only 10% to 30% of all individuals working in the sex industry** at any one time. The majority of sex industry workers are 'call girls', working through hotels, massage parlors, erotic theaters, and other venues. A smaller percentage are gay and straight men, including gay youth who earn money as hustlers and call boys, and individuals who earn money through pornography.

A further factor impeding the production of an accurate sex industry count is the large number of intermittent sex workers within the industry. This category includes men and women who only engage in sex work when they have an emergency need for money or in exchange for drugs, as opposed to people whose sex work is their primary source of income. Many individuals make the transition in and out of the sex industry throughout their lives, and do not consider it to be a primary factor in their lives.

According to Coyote, in urban areas approximately 70% to 75% of sex workers are women. The remaining 25% to 30% of sex workers are men and transgenders, although percentages in this second category are likely to be lower in non-urban areas. It is extremely difficult to obtain estimates of the number of transgender sex industry workers because police categorize individuals only as either male or female, without noting previous or transitional genders.

Again, according to a representative of Coyote, the ethnic breakdown of sex industry workers is likely to be reflective of the ethnic breakdown of the poor taken as an entire class. There is evidence to support the assertion that police arrest a disproportionate number of women of color as a result of racism. There is also some evidence of institutionalized prostitution using young Asian illegal immigrant women.

In terms of sex industry worker age, Cal-PEP (the California Prostitute Education Program, an HIV-specific outreach and advocacy project) estimates that the majority of prostitutes fall between the ages of 18 and 37, with many sex industry workers being in their early and mid-teens, as well as many individuals working even up to the age of 50. According to Coyote, street prostitutes tend to be younger, with many starting out in their teens. "Off-street" prostitutes tend to be slightly older with more experience in the industry, many of whome entered the arena while in their twenties.

Finally, sex industry workers as a whole are disproportionately poor, although a small minority do have medium to high incomes. Again according to Coyote, prostitution arrests tend to take dramatic jumps when the economy is slow, reinforcing the idea that many prostitutes engage in sex industry work on an occasional basis, either to help make ends meet financially, or to compensate for lost work or other livelihood.

B) Risk Behaviors of the Population

As mentioned in the section on Women, rates of HIV transmission among prostitutes and sex industry workers suggest that rates within this population are highest for those who report a history of injection drug use (National Research Council, 1990). However, the prostitute advocacy group Coyote believes that recent immigrants who work in massage parlors are the sex industry group at greatest risk of HIV infection, because they have the least information and because many fear deportation and are therefore less empowered to assert their own wishes with regard to safer sex precautions.

An evaluation of AIDS prevention efforts among women in the sex industry (Dorfman, 1992) found that 72% of a cohort study of sex workers in San Francisco stated that they felt at risk for HIV infection, and that 80% of sex workers who inject drugs felt at risk. Simultaneously, there was a prevalent attitude among respondents that it was less important to be safe with one's steady partner, boyfriend, or husband, with ninety-four percent of respondents stating that they used condoms always or sometimes with customers, while only 25% did so with steady partners. This behavioral dichotomy possibly relates to the distinction that sex workers must often draw between their 'tricks' and those sexual partners with whom they share an emotional connection. The study also found that women sometimes feel that they have very little power when it comes to negotiating safe sex with their customers or partners.

A representative from Coyote stated that on-call sex workers are generally very safe, but that street prostitutes are not. High rates of sexually transmittted diseases occur among these groups, although reliable data is not available, and the clients of street prostitutes often are insistent on not using condoms, and will pay more for unsafe sex. This same informant also noted that many clients specifically "look for girls with track marks on their arms so that they can get away without using a condom."

While safe sex and condom use issues are key to projecting the relative risk of sex industry workers, drug and alcohol abuse may actually play an equally significant risk role in the case of sex industry workers. According to Cal-PEP, 50% of street prostitutes are addicted to drugs, with this number rising to as high as 75% to 98% in some drug-infested neighborhoods. Street prostitutes are perhaps most vulnerable to the hazards of drug use. A significant risk factor for sex workers involves the smoking of crack, a practice that can leave burns in and around the mouth, making oral sex a much higher risk behavior. In terms of injection drug use, the only statistics available are from a study conducted in Tel Aviv, Israel, in which 128 of the females who claimed they did not use injection drugs were found to be HIV negative, while only two of the 52 prostitutes who admitted to injection drug use were found to be HIV negative.

C) Barriers to HIV Prevention Within the Population

Economics and legality are perhaps the two most significant barriers to HIV prevention among the population of sex industry workers in California. Because virtually all sex industry workers are involved in the profession not by choice, but because of economic necessity, it is extremely difficult to identify alternative behaviors that do not involve leaving the industry altogether. At the same time, because prostitution is illegal, many sex workers are unwilling to identify themselves as prostitutes to health workers, and supportive systems are looking to encourage maintenance of safe sexual behavior with partners, or to encourage and support drug treatment. It is the ironic consequence of society's condemnation of prostitution and its unwillingness to regulate the industry that the ones most vulnerable within the industry - the prostitutes themselves - are those most often sacrificed by the system.

"Although you may have to resort to things like sex working in order to get your rent paid, in order to get your fix, that does not mean that you don't have to protect yourself."
--member of the public, Long Beach meeting

Informants to the research conducted as a part of this planning process noted that because police confiscate condoms as evidence of prostitution in the event of arrest, prostitutes may often be reluctant to encourage the use of condoms on the grounds that it can serve as a means to incriminate them later. The San Francisco Board of Supervisors has gone on record as condemning the practice of police confiscation of condoms, but the practice continues in many areas in the absence of other means of producing evidence of sexually bartered behavior.

Outreach workers striving to reach sex industry workers have a challenge both in locating members of this population, and in convincing prostitutes to give them the time to present HIV prevention messages, because of the loss of income that can result from taking time to listen to a street-based presentation. Many sex workers also understand the value of condoms, but state that their clients are not willing to use them, thus presenting the argument that condom use actually leads to severe economic hardship in the case of sex industry workers. These arguments are extremely difficult to overcome, requiring as they do either viable economic alternatives to present to prostitutes, or requiring the inculcation of strong self-protective and self-assertive communication techniques, often the very skills that sex industry workers lack in their own lives.

Dorfman (1992) reports that he frequently heard the comment, "All my friends have AIDS," as he conducted his research on San Francisco sex industry workers. In the final analysis, the phenomenon of fatalism, which affects so many economically and socially oppressed communities, may be the most difficult barrier of all for outreach workers to overcome. For those who have lost much hope for their own futures, and who have little to look forward to in terms of financial and personal opportunity, a confrontation with a life-threatening illness such as AIDS can easily come to resemble simply one more hurdle in a struggle against a lifetime of impossible odds.

YOUTH/ADOLESCENTS

A) Introduction to the Population

The Youth and Adolescents category refers specifically to two groups of young people, both of whom are at extremely vulnerable periods of their lives in terms of exposure to potential HIV transmission risk. Adolescents, for purposes of this category, refers to young people between the ages of 12 and 16, and the term 'youths' refers to young people between the ages of 17 and 24. Together, these two groups of at-risk young people constitute nearly 19% of the total population of California, or nearly one in every five state residents. There is

a total of 1,912,683 adolescents between 12 and 16 living in California according to the 1990 Census, and 3,714,659 more youths between 17 and 24, for a total of 5,627,342 adolescents and youths across the State.

Approximately evenly divided between male and female, adolescents and youths tend to be more hard-hit by poverty than other residents of California, with 17% of adolescents and 19% of youths in California living below the poverty line, compared to 13% of all Californians. Youths and adolescents cross all ethnic, economic, and social boundaries and reside in communities across the state. They also encompass all sexual orientation and sexual behavior categories. The following table documents the ethnic composition of adolescents and youth in California.

Exhibit 3.1
Ethnicity of Youth and Adolescents in California
1990

ETHNIC GROUP	ADOLESCENTS	YOUTH
African American/Black	9%	8%
Asian/Pacific Islander	12%	10%
Latino/Hispanic	29%	29%
American Indian/Alaskan		
White	61%	62%
Other	19%	19%

Source: 1990 U.S. Census

B) Risk Behaviors of the Population

Within the U.S., AIDS is the seventh leading cause of death among 15 to 24 year olds, and the number of AIDS cases is now doubling among adolescents and youth roughly every 18 months. Within California, there is a total of 2,080 young people aged 20 to 24 who have been diagnosed with AIDS, a number that increased by 12% between March, 1993 and March, 1994.

Adolescence and youth are times of exploration of self and of risk-taking, and sexual behavior is a natural part of this exploratory pattern. This makes it difficult to estimate, for example, how many adolescents and young adults are gay or bisexual, or how great a degree of risk is faced by different aspects of the youth and adolescent population. We do know that high teenage pregnancy and STD transmission rates point to high levels of risky behavior

among virtually all youth and adolescent groups throughout the state. More than one in ten adolescent females in California becomes pregnant each year, and adolescents who initiate sexual intercourse before age 16 are nearly twice as likely to become pregnant within the first six months of beginning sexual activity as those who wait until they are 18 or 19 to have intercourse for the first time. Nationally, the highest rates of sexually transmitted diseases occur among adolescents, with rates of STD infection declining exponentially past the age of 19.

In addition, in the city of San Francisco (San Francisco Department of Public Health, 1993), the majority of the city's HIV-positive youth and adolescents are young men have sex with men or young gay/bisexual men (71%), while gay and bisexual men becoming infected with HIV are increasingly young men 25 years of age and under. Ninety percent of youth with AIDS in the City are men having sex with men. In addition, the San Francisco Department of Public Health currently estimates that among the City's approximately 5,000 non-drug using gay/bisexual youth aged 12 to 25, fully 12% (600) are already HIV positive, while gay/bisexual drug using 12-25-year-olds have an HIV prevalence rate of 13%. Early indications from a State Office of AIDS study suggest that these patterns may exist in many other counties in California.

According to the Select Committee on Children, Youth, and Families of the U.S. House of Representatives (1992), by age 20, 68% of adolescent females and 86% of adolescent males are sexually active. Among sexually experienced teens age 18-19, nearly 25% of females report having had six or more partners, and nearly 20% of males report having six to ten partners, with less than half reporting use of condoms at first intercourse. Three million teens are infected with an STD each year, and in 1990, nearly two-thirds of the more than 12 million STD cases reported were among persons under age 25. The same risky behavior that transmits HIV transmits STDs, and lesions from other STDs increase the risk of HIV infection.

In California, a state YRBS study (California Department of Education, 1994) found that just under 40% of 10th graders surveyed were found to be sexually active. In a survey of rural Lake County young people (County of Lake Health Services Department, 1990), 63% of adolescents surveyed had taken part in some type of sexual activity, and 35% had had sex with more than one partner during the past year. In a multi-ethnic survey of white, Chinese, and Filipino-American 10th and 11th graders, only 13% of the Chinese students were sexually active, compared with 32% of the Filipino sample, and 37% of the white sample. Among sexually active students, no ethnic differences were identified for the total sexual behavior risk index.

In terms of adopting safe sexual behavior, studies have demonstrated that young people are not significantly more likely to carry out AIDS-preventive behaviors based on their knowledge levels alone, and that, in general, adolescents and young people have not changed their sexual practices nor their methods of contraception as a result of the AIDS epidemic

(DiClemente, 1990). One statewide study (Zimit, et. al., 1993) found that, although knowledge of HIV/AIDS transmission and prevention had risen considerably between 1988 and 1991, the students surveyed in 1991 demonstrated no reduction in irrational anxiety about interacting with a PWA, and, more importantly, no increase in perceived personal vulnerability to HIV/AIDS. Fear and anxiety of HIV, attitudes about risks other than HIV, and other safe behavioral intentions have also not been shown to be significantly related to consistent condom use among youth or adolescents.

However, an increased perception of susceptibility to HIV risk (DiClemente, 1990) has been strongly associated with a reduction in high-risk HIV-related behavior, and one study of sexually active inner city junior high school students found that respondents who believe in the effectiveness of condom use in preventing HIV transmission were 2.2 times more likely to report using condoms consistently than those who did not believe this. The same study also found that those who perceived the cost of condoms to be low were 1.9 more likely to be consistent condom users than those who did not, and that those with a history of three or more sex partners were half as likely to use condoms consistently.

Of a large group of sexually active adolescents surveyed in one statewide study (DiClemente, 1990) only 47% of females and 25% of males report using condoms as their primary contraceptive, with between one-quarter and one-third of all sexually active adolescents never using any form of contraception at all. Among respondents to another study of adolescents with a mean age of 16.2 years (Brown, DiClemente, & Park, 1992) only 29% of those who had recently become sexually active reported using condoms consistently. While condom use was on the increase among one group of students surveyed (California Department of Education, 1994), **only 60% of 9th graders and approximately 50% of 10th graders reported using condoms during their last sexual intercourse, figures which are even lower among 11th and 12th graders with approximately 40% reporting condom use.** In the rural Lake County survey, among youths engaging in vaginal intercourse during the past six months, only 28% of respondents reported consistent condom use.

In many cases, knowledge levels concerning basic HIV transmission facts among youth and adolescents appears to be inadequate. One large-scale study (Brown, DiClemente, & Beausoleil, 1992) found that sexually active boys, as compared to their non-sexually active peers, were less knowledgeable about HIV, less fearful of HIV, less tolerant of PWAs, riskier in non-HIV-related attitudes, and had a more extensive history of engaging in other risky behaviors unrelated to HIV/AIDS. In a survey conducted in Lake County, while 73% had been taught about HIV/AIDS infection in school, 13% weren't sure. Only half of the young people reported that they knew where to get factual information about HIV/AIDS, and only 53% knew where to get tested to see if they were infected with HIV. In the same survey, 96% of respondents knew that sharing needles could cause infection, and 94% knew that holding hands was not a mode of transmission, but 62% either believed that or were not sure if mosquito bites were a mode of transmission, and 35% believed that one could be infected

with HIV by donating blood. Although general knowledge of transmission modes was high, many misconceptions remained.

There is some evidence to support the contention that white youth and adolescents are receiving more effective or absorbing more general HIV education than their ethnic minority counterparts. White adolescents in San Francisco high schools (DiClemente, Boyer, & Morales, 1988) were more knowledgeable than African American/Black adolescents about the cause, transmission, and prevention of AIDS, while African American/Black adolescents were more knowledgeable about HIV/AIDS than their Latino/Latina peers. In the same study, African American/Black and Latino adolescents were approximately twice as likely as white adolescents to have been runaway and homeless youth (California Department of Health Services, December, 1993). Further, over 50% of respondents knew someone living with HIV, and 30% had known a person who had died from AIDS. Less than 10% of the study's juvenile justice or child welfare youths knew anyone living with HIV, living or dead, and over 75% of the out-of-school youths felt their friends put themselves at high risk of contracting HIV, but less than one-third believed they themselves were at high risk.

In the city of San Francisco alone, an estimated 1,000 to 1,500 runaway and homeless youth spend the night on the city's streets every night, according to the San Francisco Police Department. Between June 1 and November 30, 1990, a random survey of 214 of these homeless youth revealed that 60% were female; 56% were non-white (mostly African-American and Latino); 22% were born outside the U.S.; and the mean age was 16.7 years (range 11-21). The survey also revealed that 75% of the young people had multiple family problems; 71% had significant life change/stressors within the last year; 42% had experienced the death of a family member or friend; 37% had been physically abused; 11% had been sexually abused; 40% had an STD; 8% of females and 22% of males had engaged in anal intercourse; 69% had used alcohol or drugs within the last 2 months; 15% used intravenous drugs; 12% had intravenous drug-using partners; and 9% stated that drugs were "a problem" for them.

In terms of youth and adolescent drug use, the 1988 National Household Survey of drug abuse estimated that 45% of Californians 12-17 years old used alcohol at least once in the past year; that 16.5% drank more than monthly and 6% used more than weekly; and that 30% of youth in California had used illicit drugs, including 21% in the last year and 9% in the last month (cited in San Francisco Juvenile Probation Department, 1993). Slightly over 20% of adolescents in another study (California Department of Health Services, December, 1993) had used alcohol or other drugs prior to the their last sexual intercourse. Furthermore, a drug and alcohol survey conducted at Humboldt State University in northern California found that 77% of students had used alcohol within the past 30 days, and that 38% of students binge (i.e., had five or more drinks at a sitting within the previous two weeks). Thirty-two percent of these students reported they had also used some kind of illegal drug other than marijuana at least once during the past year, and 12% had used some kind of illegal drug other than marijuana within the past thirty days. Injection drug users (IDUs) and female partners of men injecting

drugs or bisexual men are estimated to already represent fully 25% of HIV-infected youth in San Francisco (Katz, Givertz, Shalwitz, 1993).

Finally, it is crucial to also bear in mind that, in addition to HIV-related risk behaviors, it is nationally estimated by the Society for Adolescent Medicine (1992) that one in every five adolescents suffers at least one serious health problem, and that as many as one in four are at high risk for school failure, delinquency, early unprotected sexual intercourse, and/or substance abuse. Such statistics highlight the fact that adolescence and young adulthood are times of complex change and development, in which no single issue such as HIV risk can be addressed singly or in a vacuum. As the Carnegie Corporation of New York (1992) notes, "With the exception of infancy, no time of life compresses more physical, intellectual, social, emotional, and more development into so brief a span [than adolescence]."

Proper attention to the complex range of developmental conditions and health and social needs of young people requires an integrated, multi-disciplinary focus on health maintenance which encompasses all risk factors and behaviors which affect adolescent health preservation. In order to be effective, this approach must be integrated with an understanding of the special complexities of adolescent health issues, of which HIV infection and AIDS are often only one component in a larger complex of issues and risk behaviors to which young people -- and in particular young people from low income backgrounds, ethnic cultural groups, and dysfunctional family situations -- are particularly susceptible. The emerging new field of adolescent health exists specifically to address adolescent health and care needs within an integrated context which pays specific attention to the developmental phases in which the young person finds him or herself, and to the fact that, according to Pentz (1992), adolescent risks tend to be "co-morbid", that is, "interrelated, clustered, and not capable of being addressed in isolation." Proper attention to HIV treatment and care for young people must encompass both a thorough understanding of youth development needs in regard to care, and a more integrated approach to youth wellness within which HIV/AIDS is a key, but not necessarily exclusive factor.

C) Barriers to HIV Prevention Within the Population

Early prevention education should begin for young people well before they reach an age at which they begin experimenting with risky behaviors. However, the provision of HIV/AIDS education to young people remains controversial in many areas of the state, and the degree to which HIV/AIDS education may encourage or even exacerbate youth risk behaviors remains a subject of contention.

Perhaps primary among the many barriers to successful HIV prevention faced by in-school youth and adolescents is the fact that HIV/AIDS education in schools remains controversial. This is unfortunate, since the in-school youth population in California is large, and represents a major opportunity to provide education to both youth/adolescents and to children. There are currently 1,002 separate school districts operating 7,731 schools within

the State of California, employing 223,932 teachers to instruct a daily total of over 5.5 million students, 58% of whom are members of ethnic minorities who speak more than 46 languages. While in-school HIV/AIDS prevention education is mandated by legislation, the fact remains that the specific form that education must take is not explicitly defined, nor is the length of school-based HIV prevention intervention sessions thought by many to be sufficient to both inculcate and reinforce effective behavior-related messages. In addition, no special requirements exist regarding the education and training of teachers to administer HIV/AIDS-related prevention messages in schools. Topics often stressed in school-based HIV education programs, such as factual knowledge about HIV, the avoidance of drugs, and the use of condoms do not necessarily help adolescents make choices about, their number of sexual partners, the acceptance of individuals with HIV/AIDS, or, for that matter, individual sexual preference.

In 1992-93, just over 80% of high school students participating in the YRBS study (California Department of Education, 1994) had received HIV education, and over 60% had had discussions about HIV/AIDS with their parents. At the same time, however, roughly 70% of the schools requested to participate in the survey chose not to participate because of the commitment of time required, and the controversial nature of the sexual behavior questions.

> "We receive our HIV education from the same funds that provide supplies for female hygiene and the art department. I did learn about AIDS in Health, but I learned more about the dangerous effects of not wearing a seat belt."
> --member of the public, Long Beach meeting

Out-of-school youth and adolescents are extremely difficult to reach with prevention and education messages, and must generally be accessed within the context of specific health or social service interventions, such as street outreach programs related to substance use or general health. The juvenile justice system can serve as a key access point for HIV-related education, if that education is adequately integrated into reinforceable components. Ongoing support for young people to maintain behavior change is also essential, particularly for young people in high-risk situations such as street youth, substance abusers, and gang members. **However, for all young people, HIV prevention education must stress the fact that young people <u>can</u> develop a clear sense of personal control over the conditions and decisions within their lives, and must teach communication and assertiveness skills that give young people experience and confidence in maintaining self-directed behavior choices.**

As noted by the National Institute of Mental Health (1994), service delivery and research for youth are subject to special legal and societal constraints. Examples include the need to protect youth confidentiality, and the need to direct programs in terms of the difference between youth legal status as either minors or emancipated minors (for those under 18). The locus of responsibility for each young person should also be considered, such as

whether the young person is under the supervision of a parent, the court system, a foster parent, or a legal guardian, or has been granted emancipated status.

Another frequent barrier to successful HIV/AIDS education is the fact that young people are often not directly involved in either the creation of education materials nor as educators and role models in the process of disseminating information and support. It is essential to involve young people in the development of programs and materials in order to assure products that are successful, sensitive, and relevant. In addition, many materials and programs developed to serve young people are too often either not responsive to the specific developmental needs of the young people, or not knowledgeable or respectful of the specific language of young people, and of the ethnic, cultural, language, economic, sexual, and gender background of specific youth audiences.

Positive peer role models, as well as caring adults, have been extremely successful in helping to bring about risk-reducing changes in individual and group behavioral norms, and in serving as influential models to help change young people's attitudes toward themselves and their health. Peer-based education can also be effective in helping the young person to understand his or her level of personal risk, and to translate the significance of this realization into his or her own life and behaviors. This personalization should, however, take place only in a safe setting where self-disclosure is met with acceptance, support, and confidentiality. A young person who admits to his peers that he or she is gay or living with HIV within a support group, for example, should be protected from responses of judgment, derision, or abuse by other peer members; groups should at all times assure both the confidentiality and safety of participants.

It is of particular importance in the case of youth and adolescents that HIV antibody testing be always available in a context in which pre- and post-test counseling and referral for support is provided by trained professionals, both so that young people can understand the implications of an HIV test result, and so they can receive adequate ongoing support following a positive test result. In the case of young people and adolescents, for example, a personal sense of invulnerability to HIV can be reinforced if one or two negative test results are received. Conversely, a full gamut of supportive services, including housing, food, medical and psychosocial care, and drug treatment must be available in conjunction with HIV antibody testing if a positive test result is not to exacerbate the crisis situations that already exist in the young person's life.

PEOPLE OF COLOR COMMUNITIES

A) General Introduction to the Population

California is rapidly becoming one of the first states in the nation in which communities of color will soon constitute a majority of the overall population. **At least 43% of California's residents are members of either African American/Black, Asian/Pacific**

Islander, Latino, or Native American communities, a figure which is expected to pass 50% well before the year 2000. And even these existing totals fail to take into account the hundreds of thousands of illegal and/or undocumented individuals who are currently living in California, and who continue to arrive annually to the state from both the south and the west.

California can be proud of the many strengths that its diverse cultural groups bring in enriching the cultural and social life of the state. However, it must be acknowledged that meeting the HIV prevention needs of people of color communities from a culturally appropriate and community-sensitive standpoint has been inadequate. Already, **more than 34% of the state's AIDS cases occur within ethnic communities**, a caseload which is expanding much more quickly than the white AIDS caseload. Women of color are particularly hard-hit by HIV and AIDS in the state; 53% of all women diagnosed with AIDS in California are women of color. These state problems mirror a national crisis in which African American/Black and Latino populations alone, while constituting only 21% of the total U.S. population, represent about 43% of all adult AIDS cases in the nation.

The State of California Office of AIDS' Multicultural Liaison Board has worked extensively to document the needs of communities of color in regard to HIV/AIDS education and prevention services. The Board has performed an outstanding service to the residents of California, by clearly outlining significant strategies which can help overcome the lack of adequate HIV/AIDS education currently reaching the state's ethnic communities. Throughout the following section on the status of HIV/AIDS prevention within California's communities of color, we have drawn extensively on the Working Draft of the Multicultural Liaison Board's seminal 1994 publication, *Frameworks for Change*. We are indebted to the Multicultural Liaison Board (MLB) for its efforts in bringing so much detailed information concerning California ethnic communities so clearly to the fore, and in creating a framework for this Plan's recommendations concerning people of color.

One of the most useful frameworks suggested by the Multicultural Liaison Board is one that could in general apply to most target populations described in this document, but which is most appropriate in the case of people of color communities because of the barriers most education planners have had in conceiving of people of color as living in either rural or urban areas. The MLB proposes adoption of an extremely useful new third category of California regions - **meso-urban** - to describe those many areas of the state that are not entirely rural in nature (*e.g.*, in terms of their "having little contact with urban centers and in areas with a primarily agricultural economy"), nor entirely urban, either (*e.g.*, inner city areas situated within large urban centers).

Many of California's communities of color, for example, live in moderately sized cities such as Fresno, Riverside, or Bakersfield, which are distant from major urban centers, but could hardly be characterized as small towns. In the same way, many groups of smaller cities are situated in the general vicinity of urban areas, but are far enough away to have their own identities and cultural patterns; the MLB cites portions of Alameda, Contra Costa, San Mateo,

Santa Clara, Santa Barbara, Marin, Riverside, and Ventura Counties as being typical of this type of region, which is also sometimes referred to as "emerging urban-suburban" regions. Finally, the MLB notes that many areas which are commonly referred to as urban are actually so spread out that they can only more accurately be called 'meso-urban'. The MLB cites the greater Los Angeles area as the prime example of this type of sprawling semi-urban region.

The MLB notes that communities of color are often widely dispersed within meso-urban areas, and that individual cultural groups may not live in compact neighborhoods or communities that can be easily identified by researchers and demographers. Similarly, the MLB notes that dispersion of populations and of resources within meso-urban areas can result in a parallel dispersion of funding to support effective HIV-related ethnic outreach within these areas. The fact of meso-urban areas also often means that communities of color cross city or county boundaries, and cannot be adequately served by funding which is specific to municipalities alone. The category of meso-urban provides an ideal new context for considering the unique realities of California from the perspective of both the cultural and geographic realities of a complex and growing state.

The MLB also points out that for all communities of color in California, a significant barrier to effective HIV prevention materials and outreach has been the continued misperception that linguistic translation of written materials and curricula can be equated with cultural translation of materials. Frequent word-for-word translation of materials originally intended for a middle class, white audience produces prevention materials that have no cultural meaning within communities of color, which must instead be directly given the resources to develop their own materials based upon their own familiarity and expertise in working with the specific cultural groups they represent. Such an approach demands a new concept of "cultural translation" of materials which respects the differences in ethnic communities, and the fact that the difficult issues which are often raised through discussions of HIV can be confronted in a manner that overcome barriers such as denial, resistance, prejudice, and fear.

The MLB also notes the importance of presenting HIV/AIDS issues within the context of people's lives and cultural realities; of inviting 'ownership' and personal involvement in local HIV prevention efforts and campaigns as a way to help eradicate cultures of denial within communities of color; and of encouraging a community-based approach to services in which local residents design programs to serve local residents, versus programs which take a so-called 'multicultural' approach - a term which too often stands for an intervention that is simply trying too hard to be all things to all people. For all communities of color in California, addressing barriers such as these will be crucial to assuring focused, appropriate, and effective HIV prevention education that truly begins to address the root attitudes and behaviors within communities of color, and begins to eradicate the epidemic which is threatening not only California's diverse cultural communities, but the heart and soul of what makes California the vibrant and challenging state that it is.

B) **Descriptions of California's People of Color Communities**

1) African-American Communities

A) Population Demographics and Characteristics

According to the 1990 U.S. Census, **there are a total of 2,110,700 African American/Blacks living in California, constituting 7% of the state's overall population**. These communities, while varying widely in terms of both income level and family structure, tend to have a much higher rate of poverty than the overall population; fully 21% of all African American/Blacks have incomes below the poverty line according to the 1990 Census, compared to 13% of all Californians. African American/Black populations tend to be concentrated in several key urban and meso-urban counties with the state, particularly Los Angeles, San Francisco, Alameda, and Riverside Counties, but are found in both urban and rural communities throughout California.

African American/Blacks are extremely over represented among persons with AIDS in the state, with fully 16.1% of male AIDS cases and 36% of female AIDS cases originating from within African American/Black communities as of March 31, 1994. While 8 out of every 100,000 females and 184 out of every 100,000 males were living with AIDS in California as of March 31, 1994, the rate among African American/Blacks was 62 out of every 100,000 females and 386 out of every 100,000 males. In particularly hard-hit areas of the state, such as Alameda County, African American men make up 17% of the population, but make of 39% of the local AIDS caseload. The CDC has demonstrated that as of late 1992, one out of every 60 women of childbearing age in California was already HIV positive.

> "African Americans make up the largest percentage of people who are diagnosed at later stages of HIV infection. We die at five time the rate of the dominant ethnic population. We have become the last ones diagnosed, at first ones to die."
> --member of the public, San Diego meeting

B) Risk Behaviors of the Population

According to a San Francisco survey of Bay Area African American/Black communities (Day, Houston-Hamilton, Taylor, Jang, & Crowe, 1989) fully **31% of all African Americans engage in at least one behavior which puts them at heightened risk for exposure to the AIDS virus**. Applying 1990 Census figures, this would translate to a total of 654,317 at-risk African American/Blacks living in the state of California. The same survey reports that the most at-risk of this population were likely to be men under the age of 40, particularly men between the ages of 18 and 29. These men are more likely to be bisexual, to be single or living with a lover, to have at least a high school education, and to have been in

jail for more than three days. They were also less likely to attend church, and had an overall better knowledge and awareness of AIDS than their less-exposed counterparts.

A slightly lower degree of risk was identified in a study conducted by the NSI Research Group for the California Department of Health Services (Araba-Owoyele & Littaua, 1992), which found that approximately 15% of California African American/Black heterosexuals over the age of 18, or approximately 200,000 California adults, can be considered at high risk for HIV transmission. The inclusion of heterosexuals only, however, eliminated both gay and bisexual populations, and also defined high risk individuals by a more demanding criteria than those applied in the study above.

The San Francisco study found further found that 84% of all respondents said they considered their own risk of HIV infection to be very low, and that although HIV knowledge had increased significantly between 1987 and 1988, there remained many misconceptions regarding the potential risk of sexual contact. This was borne out by the state study, which found, for example, that 24% of respondents believed the AIDS virus could be transmitted by mosquitos and other insects, and that 56% believe the AIDS virus can be transmitted during blood donation.

Only 27% of study respondents in the San Francisco study reported that they used condoms more often because of AIDS, although 40% reported that they select partners more carefully. However, a relatively large 10% of respondents reported unprotected anal sex within the previous month, despite that fact that only 2.6% reported homosexual or bisexual contact over the previous 12-month period. Respondents whose first sexual activity occurred before the age of 13 were nine times more likely to report three or more sexual partners as compared with those whose first sexual intercourse occurred after the age of 13.

The 1988 survey of San Francisco African American/Blacks found a high degree of substance abuse within local African American communities. In the year leading up to the last year of the study, 29% of respondents had used cocaine, 17% had used crack, 7% had used injection drugs, and another 4% had used injection drugs at some point prior to the previous year. **About 40% of the 7.4% who said they had injected drugs admitted sharing needles while doing so.** In addition, about one third of those who had shared needles stated that they had done so with either gay injection drug users, or with individuals who later developed AIDS or tested positive for HIV.

According to the statewide survey on HIV-related knowledge, attitudes, and beliefs among African American/Blacks and Latinos in California (Araba-Owoyele & Littaua, 1992) an estimated 77,000 African American/Blacks, or 5% of the total African American population in California, reported that they had used 'crack', 'rock', or 'ice' at some point in their lives, an estimate which the study authors say is low, due to the presumed under-reporting of these illegal activities. A significantly higher proportion of African American/Black women reported the use of at least one of the above drugs during the past 10 years. The use of

alcohol to enhance sexual enjoyment was reported by 28% of African Americans in the same study. This figure was echoed by respondents to the San Francisco study, in which 38% of respondents reported that they had been high on alcohol during sex; 23% had been high on marijuana during sex; 13% had been high on cocaine during sex; and 8% had used crack during sex.

C) Barriers to HIV Prevention Within the Population

The state's Multicultural Liaison Board, in its 1994 report to the California Office of AIDS entitled *Frameworks for Change*, identified several significant barriers to effective prevention education for African American/Black communities that can be addressed by appropriate and professionally-implemented strategies. The group agreed, for example, that targeting the African American/Black community as a set of fragmented risk groups, such as IDUs or out of school youths, was much less effective than targeting the community as a whole. As a speaker at one of the MLB hearings put it,

> The African American community is made up of more than substance abusers and youth out of school. I think a great deal of the [existing outreach] programs are too restricted for the populations we need to reach....I think it's important that we try and contract our efforts wholly dealing with the entire community as opposed to dealing with the smallest part of each of our communities.

The MLB also agreed that application of their new 'meso-urban' category for reaching African American/Blacks who do not live in strictly urban environments is essential to reaching the large number of African Americans who do not live either in inner cities or in rural areas, but who may have rural-type problems in accessing needed care, services, and information. At the same time, the MLB recognized the importance of reaching more isolated rural individuals and communities with outreach and education programs that appropriately help overcome barriers such as transportation, community acknowledgement of the problem of HIV, and the problems of isolation.

Lack of access to or information about available prevention services also remains a key community need, and one that is frequently unaddressed, either because of a lack of local resources, or to a lack of adequate community-wide education concerning resource availability. According to the California-wide KABB study, for example, over 25% of African Americans would not know where to go for HIV testing if they needed it (Araba-Owoyele & Littaua, 1992). Because there is often mistrust and enmity between primary white gay agencies and African American/Black agencies, and because so-called Eurocentric approaches to prevention are frequently not effective when applied to African Americans means that services must be specifically developed and publicized that are operated and delivered by African Americans to African Americans.

The lack of peer educators reaching African American/Black target groups was also stressed by the Multicultural Liaison Board in its report to the state of Office of AIDS (1994), which noted that so-called 'multi-cultural' approach to AIDS education - as opposed to more 'Afro-centric' strategies - most often results in an ineffective application of *de facto* tokenism by agencies that are trying to be all things to all communities. Furthermore, the MLB noted the need for adequate outreach that recognizes diverse sexualities within the African American/Black community, and focus on the special needs that both African American women and youth have for tailored outreach and support services. In regard to the former issue, the MLB particularly noted the fact that complex sexual identities may distance many African American/Black men and women who are not strictly gay-identified from messages and strategies that are specifically geared toward gay-identified African American men and women.

Finally, the lack of adequate participation and involvement by the church and by church leaders was stressed as a barrier to community awareness and visibility in regard to HIV/AIDS, which must be addressed by a of building linkages to African American/Black religious organizations throughout the state.

2) Asian/Pacific Islander Communities

A) Population Demographics and Characteristics

Asians and Pacific Islanders (Asian/Pacific Islanders or API) are the fastest-growing community of color in the United States, with an extraordinary diversity encompassing individuals of over 40 different nationalities, who collectively speak over one hundred languages and dialects. In California, **API communities are among the state's fastest growing populations, with roughly 9% of the state's total population - or approximately 2,747,780 persons.** The following table describes California's Asian/Pacific Islander populations in terms of their culture of origination, expressed as a percentage of the state's total Asian/Pacific Islander population.

Exhibit 3.2
Asian and Pacific Islander Ethnic Populations in California as a Percentage of California's Total Asian/Pacific Islander Population

Filipino	25.7%	Laotian	2.0%
Chinese	24.7%	Hmong	1.7%
Japanese	11.0%	Hawaiian	1.2%
Vietnamese	9.8%	Thai	1.1%
Korean	9.1%	Samoan	1.1%
Asian Indian	5.6%	Guamanian	0.9%
Cambodian	2.4%	Other	3.6%

Source: 1990 U.S. Census

In the city of San Francisco, Asians and Pacific Islanders make up 30% of the total city and county population, including 39 distinct cultural and linguistic groups, including Chinese, Filipinos, Japanese, Vietnamese, Koreans, Asian Indians, and Samoans - a dazzling mix of cultures which mirrors the complexity and depth of API populations statewide. Asians/Pacific Islanders are the largest ethnic group within the city of San Francisco. The city is important as an example of how Asian/Pacific Islander communities may be beginning to be impacted in California, in part because 341 of the 1,161 AIDS cases among APIs reported throughout the U.S. as of early 1994 occurred within the city of San Francisco itself. This means that, although only 3% of all Asian/Pacific Islanders in the United States live in San Francisco, the city accounts for fully 21% of the total API AIDS cases throughout the United States. Asian/Pacific Islander AIDS cases increased by 224% between 1986 and 1988 in San Francisco; and between 1992 and 1993, API AIDS cases had the highest percentage increase among all racial groups in the city, with a total one-year increase of 30%. San Francisco may well be a window into the future of the AIDS epidemic among API communities throughout the United States.

In terms of female populations, Asian/Pacific Islander women comprised over 10% of all California API AIDS cases in 1991. Annual AIDS incidence among Asian/Pacific Islander women increased at a much higher rate among women (51%) than among men (20%). In Alameda County just across the Bay from San Francisco, 2% of all females living with HIV are Asians/Pacific Islanders.

(B) Risk Behaviors of the Population

According to the State of California Multicultural Liaison Board in its seminal document, *Frameworks for Change* (1994) API communities experience high rates of communicable diseases, which in themselves serve as major surrogate markers for HIV infection incidence. Asians and Pacific Islanders, for example, have a rate of 36.4 per 100,000 population for gonorrhea, and 3.3 per 100,000 for syphilis. In the city of San Francisco, again according to the Multicultural Liaison Board, APIs have maintained a mean of 51% of all tuberculosis cases that have been diagnosed within the city over the past five years.

Although little actual evidence is available, the problem of underreporting of API AIDS cases may be greater than of other groups because of several cultural factors. As noted by Choi, Cortes, Lew, & Coates (1993), in many Asian and Pacific Islander communities in which a high value is placed on family honor, AIDS may be considered a disease that brings dishonor to the family. Illness itself is frequently a taboo subject, and HIV infection may be perceived as denoting a lack of moral integrity on the part of the individual or family affected. Furthermore, the association of HIV/AIDS with homosexuality brings stigmatization that is "automatic and uncompromising." (Ibid.) A sense of shame and a need to protect the family name, as well as generalized denial and avoidance, may prevent many APIs from seeking early testing and treatment, as well as from seeking support for the ongoing maintenance of lower-risk behaviors.

As a general framework for discussing the prevalence of unsafe sex within API communities, the MLB notes that the widespread power imbalance between heterosexual Asian/Pacific Islander men and women can lead to nonconsentual unsafe sex, and observes that negotiation of condom use or birth control can often become an arena for API men to exert control and dominance. These imbalances also carry over into the gay and lesbian API community.

Projections by the San Francisco Department of Public Health AIDS Office estimate the total number of Asian/Pacific Islander men who have sex with men in the city at over 16,000. HIV prevalence projections by the city AIDS Office indicate that 35% of these men are estimated to be HIV infected, and that nearly 85% of all API AIDS cases in the city are among men who have sex with men. According to Choi, Cortes, Lew, & Coates (1993), among 59 of 150 subjects in the ongoing Gay Asian and Pacific Islander Men's Study who had anal intercourse with their main partner in the previous three months, 30% reported never using condoms, 28% used condoms only sometimes, and only 42% reported using condoms consistently. A majority of the men practicing anal intercourse within the previous three months (57%) had used alcohol, and 15% had smoked marijuana prior to engaging in anal intercourse.

Substance abuse rates are harder to generalize across API communities, although a statewide study of 1,000 Asian/Pacific Islanders in California correctional facilities showed that roughly 90% were there for drug-related crimes (National Institute on Drug Abuse, 1991).

According to the Multicultural Liaison Board, risk factors for HIV among Asian/Pacific Islander youth engaging in high risk behaviors are numerous. In one seroprevalence survey of youth people attending San Francisco's sexually transmitted disease clinic, for example, HIV seroprevalence for API young people was 2.3%. Additionally, the Chinese American Youth Drug Study (1983) documented widespread use of alcohol and drugs among Chinese youth, with more than 60% of the Chinese young people interviewed for the study reporting having used drugs besides alcohol, and 40% having used Quaaludes. And in a recently released seroprevalence survey by the San Francisco Department of Public Health AIDS Office of gay-identified youth ages 17-22 questioned in bars, clubs, recreation centers, and parks and at select street locations found that 4.2% of API youth surveyed were HIV infected, and that nearly 30% reported unprotected anal sex within the prior six months leading up to the survey.

The following sections describe findings of knowledge, attitude, and behavior surveys where they have been conducted for specific API populations within the state of California as a way to begin to draw distinctions among the specific Asian/Pacific Islander communities.

Chinese Community Behaviors and Attitudes:

Chinese Americans are the largest Asian/Pacific Islander population in the United States, and the second largest in California. Since becoming aware of AIDS, only 15% of respondents to a major San Francisco KABB study (Ja, Kitano, & Ebata, 1990) reported that they have changed their sexual behavior as a result of the disease, and only 2.7% reported having taken the HIV antibody test. Use of condoms and other safe sex practices also appears limited.

Over 77% of respondents to the San Francisco study reported that they had received some AIDS information, but most felt isolated from the effects of AIDS both in their own communities and in their personal and family lives, with 74% of individuals expressing the opinion that they could protect themselves from AIDS, and that it probably would not affect their lives. Although nearly all respondents correctly identified all known ways of HIV transmission, most also incorrectly identified more casual activities. For example, over three-quarters of respondents believed that kissing could transmit AIDS, and slightly less than three-quarters believed or were uncertain about whether drinking from the same glass or being bitten by a mosquito could transmit the virus. Twenty-one percent of all study respondents stated that they had received no information concerning AIDS.

Fully 90% of all study respondents were interviewed in Chinese, and three-quarters of all subjects preferred to have their HIV prevention information delivered in either Chinese or

in both Chinese and English. The study also elicited the finding that substantial cultural and linguistic barriers to receiving HIV education exist for this community. Particularly given the formidable cultural difficulties involved in discussing sensitive and taboo subjects such as sex, homosexuality, and death, it is perhaps not surprising that among those least informed regarding AIDS are persons with low incomes, less education, and who are principally Chinese speaking.

The study demonstrated as well that gay and bisexual Chinese are the subgroups most clearly at risk for AIDS. Findings indicated that specific programs must be developed for Chinese gay and bisexual men who do not clearly self-identify as gay/bisexual, but continue to maintain their lives within the general Chinese community, in which homosexuality itself is a forbidden subject. Even today, for example, the country of China continues to deny the indigenous existence of homosexuality, regarding it as a sign of "the decline and evil of Western civilization," and criminalizes homosexual activity (Choi, Cortes, Lew, & Coates, 1993).

Japanese Community Behaviors and Attitudes:

Approximately one-quarter of a KABB study's respondents conducted with Japanese men and women in San Francisco (Ja, Kibata, & Ebata, 1990) were found to be fairly misinformed concerning HIV and AIDS. One-fourth of respondents did not feel that AIDS was a problem for the Japanese community, and fully 40% of the respondents didn't know or believe that drinking from the same glass or being bitten by a mosquito could not transmit the virus. In addition, **although 86% of respondents felt AIDS to be the most important or one of the most important health issues in America, only 58% felt the same way about the importance of AIDS within the Japanese community.**

Slightly under two-thirds of study respondents stated that they were satisfied with the level of AIDS information they were receiving or had received. Almost the entire sample had heard of AIDS through newspapers and television, primarily in English, and almost all felt that they could be susceptible to AIDS and, at the same time, that they could protect themselves against it. Contrary to San Francisco Chinese communities, however, 65% of Japanese respondents stated that they preferred their information on AIDS to be delivered in English, with only one-fifth stating that they would prefer the information to be delivered in both English and Japanese. However, only one in ten study respondents stated that they always used condoms during sexual intercourse. Unsafe drug use with a needle, by contrast, was found in only one study respondent out of 224.

Filipino Community Behaviors and Attitudes:

The U.S. Filipino population has continued to double roughly every ten years since 1965, and Filipinos now constitute the second-largest Asian-Pacific population in America, according to the 1990 Census (1,406,770 persons), a close second only to Chinese-Americans

(1,645,472), and far exceeding the number of Japanese (847,562), Asian Indian (815,447), Korean (798,849) and Vietnamese (614,547) now living in the U.S. At current rates of increase, Filipinos will become the largest Asian-Pacific minority population in the U.S. within two to five years. **Filipinos are already the largest Asian-Pacific ethnic group in the state of California** (704,850 persons) accounting for over half of all Filipino-Americans living in the U.S., with over half of these in turn living within the three Southern California counties of Los Angeles, Ventura, and Orange (U.S. Bureau of the Census, 1992).

The cultural diversity of the Philippine islands contributes to a complex world view which makes specific health-related interactions complex and ramified. Filipinos who immigrated to the United States during the first two of the three waves of Filipino migration (roughly prior to 1965) are generally older, reside more frequently in rural communities and are more pervasively matriarchal in terms of family structure; third wave immigrants (post-1965) tend to be better educated that previous immigrants, and live more frequently in urban centers, especially within California. Filipinos tend to accept two concurrent sets of health beliefs with separate logical bases, one of which trusts modern western medicine and its interventions, while the other relies on supernatural and folk explanations for health conditions; the general life concept of balance (timbang) is key to the overall perception of illness origin within most Filipino subcultures.

Nationally, Filipinos living in San Francisco, New York, and Los Angeles currently have the highest AIDS incidence among all Asian/Pacific Islander AIDS cases. Of these cases, over 75% occur among men having sex with men, who do not generally reside in neighborhoods with high densities of Filipinos. In Santa Clara County, 90% of the total Asian/Pacific Islander AIDS cases are among Filipinos.

Of respondents to a San Francisco KABB study conducted within Filipino communities (Gorrez & Areneta, 1990) 80% acknowledged AIDS to be the most or one of the most important problems currently facing the Filipino community. At the same time, 39% believed that Filipinos were the least likely ethnic group to contract AIDS compared to other racial and ethnic groups. Even more startlingly, and reflecting perhaps the strong Catholic orientation of Filipino communities, 24% agreed or agreed strongly that AIDS is God's judgment against homosexuals and intravenous drug users. Overall HIV/AIDS knowledge scores within the Filipino study sample were low. The majority of study respondents were knowledgeable about established modes of transmission, but misconceptions about casual modes of transmission were evident. U.S.-born Filipinos tended to have higher knowledge scores than individuals born in the Philippines.

Ninety-two percent of respondents to the San Francisco KABB survey reported having heard AIDS information, but only 38% agreed that they were receiving adequate information, and only 32% believed that they were receiving enough bilingual information. Almost half considered English/Tagalog to be the most informative language for AIDS educational

materials aimed at their population, followed by preferences for English (23%), Tagalog (10%), and English/Tagalog/Ilocano (8%).

The same study also found that 78% of respondents had heard of the AIDS antibody test, but only 13% of the total had been tested. A small proportion said that they had changed their sexual behavior over the past five years as a result of AIDS, yet condom use remained low, with variance in usage correlated to type of sexual behavior. Only 9% reported increased condom use over the past five years due to AIDS. Anal intercourse without a condom was reported for 7% of study respondents, and with a condom by only 2%.

An additional survey comparing American Indian, Filipino, and Latino populations in San Francisco (Fairbank, Bregman, & Maulin, 1991) found that as many as 70% of Filipinos engaged in either risky sexual behavior or possibly risky sexual behavior, and that the level of unprotected anal intercourse among both Filipinos and Latinos were approximately two times the number reported in surveys of whites. In addition, 62% of Filipinos in the survey reported not always using condoms, and 68% of Filipinos reported having difficulty in talking about condoms with their sexual partners.

Southeast Asian Community Behaviors and Attitudes:

Southeast Asian communities primarily encompass individuals having Cambodian, Laotian, and Vietnamese heritage. In California, these three groups account for 14.3% of the state's total Asian/Pacific Islander population, larger than the total number of Japanese living in California. In a survey of AIDS-related knowledge, attitudes, and behaviors among these three demographic groups in San Francisco (Murase, Sung, & Vuong, 1991) over half of respondents in all categories stated that they had not changed their sexual behavior since becoming aware of HIV and AIDS. The Laotian sample, which had the highest volume of risk behavior, also indicated the largest percentage for changed sexual behavior. Unprotected anal sex was practiced by 2% of Laotians, 1% of Cambodians, and 6% of Vietnamese. Laotians, however, showed a much high percentage of unsafe drug use (11%) than their Vietnamese or Cambodian counterparts (0.0% and 1.1% respectively).

It has also been reported that higher rates of AIDS prevalence exist among Southeast Asian communities living and working in California's rural areas than among other ethnic communities within these rural settings (Rural AIDS Project Report, Unpublished).

> "These are the beliefs from our community. Number one: HIV is a gay disease. Number two: those who are infected are Vietnamese males who sleep with white gay males and bring the disease back into the community; therefore, it is an immoral act, and they deserve it."
> --member of the public, Long Beach meeting

The overall AIDS knowledge levels for all three cultural groups proved to be critically low, according to study findings -- much lower on average when compared to all other communities of color surveyed in San Francisco; over one-half of the respondents in each cultural group, for example, had not heard of the HIV antibody test. Study respondents with high HIV/AIDS knowledge scores seemed to be just as likely to engage in high-risk behaviors as those who scored lower on AIDS knowledge tests, suggesting that, as with many other populations, general HIV/AIDS knowledge is not a significant factor in influencing safer behavior practice. In fact, the study demonstrated that AIDS knowledge was not only not significantly related to high-risk sex behavior, but that it was also not correlated with either message recall or drug behavior. In every group, women tended to score significantly lower in AIDS knowledge than men.

Vietnamese individuals scored the highest mean in terms of HIV/AIDS knowledge, followed by Laotians and Cambodians. Sixty-nine percent of Vietnamese subjects and 61% of Laotians had received information about AIDS, but only 36% of Cambodians reported similarly. All three groups stated a preference for receiving HIV/AIDS education in their native language.

C) Barriers to HIV Prevention Within the Population

The greatest overall barrier to effective API HIV education may lie in the fact that what little funding exists for education tends to target Asians and Pacific Islanders as a whole, as if they were members of a single homogeneous group or linguistic family. This trend carries over into the ethnic categorizing of APIs as part of a single ethnic group in both state and national epidemiological reporting, rather than distinguishing between separate API communities such as Filipinos, Guamanians, Chinese, etc. Asians and Pacific Islanders generally identify themselves according to their particular ethnic group or nationality, rather than by the political label of API, and they do not always respond to messages that are not delivered in their native language.

The significant differences of culture and language between differing Asian/Pacific Islander ethnic groups must be considered by HIV/AIDS educators, because these differences will prevent successful HIV education efforts as long as they fail to address the Asian/Pacific Islander community from a perspective that reflects real API communities (Multicultural Liaison Board, 1994). HIV/AIDS prevention service providers and prevention program designers must also possess the cultural sensitivity, linguistic resources, and financial capabilities to address the needs of APIs, especially those in immigrant and migrant communities (Chang, 1993); this need carries over into the need for culturally sensitive and culturally competent service personnel in medical clinics and health institutions that serve API populations.

The Multicultural Liaison Board (1994) also notes that HIV prevention education can be particularly challenging in API communities because it brings to the fore several topics --

illness, death, sex, homosexuality -- that are difficult, if not taboo, to express in public. The phenomenon of 'losing face' can serve an additional obstacle to API prevention education, particularly to the extent that many gay and bisexual API men remain closeted in order to spare their families from losing face. Such men may have sex surreptitiously, in unsafe encounters which can put both these men and their families at risk.

At least one major national report (Chang, 1993) also notes that Asians and Pacific Islanders are less likely to have a regular source of primary health care than non-APIs, and that they consistently lack access to and under-utilize mental health care and substance abuse services due to a lack of culturally and linguistically sensitive programs. This will continue to serve as a major barrier, for example, to seeking HIV antibody testing and other services, because of a fear of being unable to access appropriate medical or support services in the event HIV-positivity is discovered.

The dearth of effective HIV prevention information directed to Asian/Pacific Islander communities has resulted in a severe state of HIV/AIDS denial among most API cultural groups. As stated earlier, the Multicultural Liaison Board (1994) noted that the acknowledgment of HIV within the API community often is equated with making a tacit acknowledgment that homosexuality, substance abuse, and premarital sex exist. This means, for example, that many API individuals may be reluctant or unwilling to accept HIV education because they believe that it will stigmatize them as homosexuals. Until an increase in prevention messages in a diverse range of community API sites exists, this epidemic of denial will continue to take a heavy toll on this diverse and growing California ethnic population.

4) Latino/Latina Communities

A) Population Demographics and Characteristics

Latino and Latina populations - also known as Hispanic populations - comprise 27% of the total population of the state of California, for a total of 7,557,550 individuals according to the 1990 Census. Fully 45% of this total population, or 3,402,756 individuals, live in the counties of Los Angeles and San Francisco, with the remainder distributed throughout California, encompassing urban communities, meso-urban communities, and rural and farm communities, particularly in California's Central Valley region. Latinos in California come from all countries in Latin America, but predominately from Mexico. Eighty percent of all California Latino men and women are of Mexican descent; another 5% are Salvadorean, 2% are Guatemalan, and 2% are Puerto Rican. Although a wide variety of other Latin American nationalities make up the state's Latino community, no other single group represents more than 1% of Latinos in California.

The diversity among different Latino cultures in California, however, is as much a product of differences in class and generation as it is of cultural heritage and nation of origin. Latinos who have been in California for many generations are a very different subgroup from

those who have been here less than fifteen years. Some Latinos are monolingual in Spanish, others monolingual in English, and others speak both languages, occasionally accompanied by a third Native language. Approximately 24% of all Latinos in California (1,782,167 persons) say they speak English either "not well" or "not at all", while 72% of all Latinos (or 5,478,712 total persons) speak Spanish as the principal language at home and within social groups.

As of March 31, 1994, 19% of men and 21% of women living with AIDS in California were Latino or Latina, making Latino men second only to whites in both number and percentage of AIDS diagnoses, and Latina women third behind whites and African American/Blacks. While the vast majority of AIDS cases among Latino men are attributable to homosexual or bisexual contact with or without injection drug use (81%), fully 40% of all Latina AIDS cases were attributable exclusively to heterosexual contact.

B) Risk Behaviors of the Population

Several knowledge, attitudes, and belief (KABB) surveys indicate generally good knowledge of the true modes of transmission of HIV within the Latino community, but also indicate many other erroneous beliefs regarding casual modes of HIV transmission (e.g., Marin & Marin, 1990). Degree of acculturation (including, in some cases, level of fluency in English) has been most strongly linked to level of personal knowledge regarding HIV risk factors, with less acculturated communities having many more erroneous beliefs, and being less aware that someone can be infected with HIV without actually appearing to þe ill. These acculturation differences persisted even after controlling for personal level of education.

One recent study of migrant farm workers in San Diego County, for example (Munos, Marks, Munos, & Lloyd, 1993), found that 12% of respondents had already taken an HIV test, and that 81% had thought about taking the test. At the same time, one California study (Araba-Owoyele & Littaua, 1992) found that 33% of Latinos believe the AIDS virus can be transmitted by mosquitos and other insects (versus 24% of African American/Blacks) and that 60% believe the virus can be transmitted during blood donation. Another study (Romero, Arguelles, & Rivero, 1993) found that 43% of a group of Latina women surveyed did not know of any symptomology associated with AIDS.

At least one statewide KABB study (Araba-Owoyele & Littaua, 1992) has determined that a higher proportion of Latinos (21%) than African American/Blacks (15%) aged 18 years and older can be considered as heterosexuals engaged in high-risk behaviors in relation to HIV. Extrapolated to the general population, this estimate suggests that at least 1 million Latino adults in California engage in activities which put them at risk of acquiring HIV via heterosexual transmission. However, a large San Francisco study (Fairbank, Bregman, & Maulin, Inc., 1991) found that 71% of gay and bisexual Latino men (versus, for example, 25% of Native Americans) engage in risky or possibly risky sexual behavior, and that the level of unprotected anal intercourse among gay/bisexual San Francisco Latinos was approximately

two times that of whites, with 47% of 100 respondents reporting unprotected anal intercourse within the last 12 months.

One survey of Latino and non-Latino white men and women aged 18-49 in California (Van Oss Marin, Gomez, & Hearst, 1993) found that 3% of all Latino married men and 6% of all Latino unmarried men reported at least one same-sex partner within the 12 months prior to the interview. Among married men in the study, twice as many Latinos (18%) as non-Latino whites (9%) also reported having two or more sexual partners. Less acculturated men and more highly acculturated women were more likely to report having multiple heterosexual partners. Among Latino men, 49% of study respondents used condoms with secondary partners, as compared to 20% who used them with primary partners. Among Latina women, these proportions were 46% and 13%, respectively.

A telephone survey of Latino men ages 18 to 49 in nine western states (Van Oss Marin, Gomez, & Tschann, 1993) found that 38% of respondents reported at least one secondary female sexual partner in the last 12 months prior to the interview, and that levels of condom use among Latino men with multiple sex partners appeared to be on the increase. Key predictors within the study of the subjects' condom use with secondary partners included carrying condoms; personal self-efficacy; positive attitude toward condom use; having friends who use condoms; and lack of symptoms of depression in the week prior to the interview. Significant predictors of condom carrying were likely to be: being comfortable in sexual situations; having a positive general attitude toward condom use; and personal self-efficacy. Interestingly, less acculturated men tended to have more positive attitudes toward condom use than acculturated men, and stated that they carried condoms more often than did their acculturated counterparts.

In terms of injection drug use, Latinos represent a total of 29% of all statewide AIDS cases attributable to injection drug usage. One study of IDUs (Marin & Gomez, 1992) found that Latinos had higher frequencies of injection drug use than other ethnic groups, and that Latinos were more likely to inject in shooting galleries where there is more needle sharing. Among AIDS cases in Latina women, 48% are attributable to injection drug use, and another 30% are attributable to sex with an IDU. Therefore, 78% of all AIDS cases in Latino women, as compared to 58% in white women, can be traced to injection drug use. Latina women who inject drugs will continue to be one of the fastest growing populations infected with HIV in California over the coming years of the epidemic.

> "Many Latinos are living and dying of AIDS without being reported to county epidemiology....Many are sick, but too frightened in this age of immigrant bashing to access care. Therefore, they turn to folk remedies, or return to their country of origin to die."
> --member of the public, Long Beach meeting

Finally, a further critical issue exists in terms of the importance of the family unit in Latino culture increasing the willingness of an HIV positive woman to conceive or to bring her pregnancy to term. According to Marin & Gomez (1992), pediatric AIDS cases in the Latino community will continue to increase as Latina women who inject drugs and elect to bear children continue to be one of the fastest growing populations infected with HIV in California.

C) Barriers to HIV Prevention Within the Population

As the Multicultural Liaison Board (1994) points out, the statewide AIDS case incidence figures are generally thought to be significantly smaller than the actual number of AIDS cases within Latino and Latina communities, since for many reasons a large number of Latinos either refuse or are unable to be tested for HIV or to seek medical care for HIV-related conditions. According to the a report by the U.S. Surgeon General's National Hispanic/Latino Health Initiative (1993), Latinos tend to be over-represented in secondary labor markets, and have inadequate insurance and Medicaid coverage. Fairbank, Bregman, & Maulin, Inc. (1991) found, for example, that 71% of the Latinos in their study did not have any form of medical insurance. Latinos also have poor or low access to the health or medical care settings wherein preventive services are likely to be offered, and are significantly under-utilizing existing community-based prevention and care resources. The lack of a sufficient number of Latino and culturally competent care providers partially explains this phenomenon, as does the prevalence of bureaucratic patient intake processes that can be barriers because of fear of deportation, or discomfort with mainstream institutional systems. As a general rule, in fact, barriers faced by Latinos in receiving preventive care tend to be magnified in nearly all cases due to their special linguistic and cultural differences.

The MLB also points out that the family plays a key role in the lives of most Latinos and Latinas, and that fear of being rejected by the family deters many individuals from learning about their HIV/AIDS status. Anti-immigrant hostility also plays a key role, with many farm workers and others fearing being reported if they test HIV positive, or deported because they will be picked up at a testing site. Finally, as the MLB notes, "a sense of fatalism is not unknown in the Latino/Latina community." As one Latino educator from Southern California testified to the MLB,

> I attended four presentations in two days, and it's amazing how misinformed the...population is. They have this really bad concept that they're already positive, so they don't want to know. They strongly believe they are all HIV positive [already], it just hasn't yet progressed to AIDS.

That AIDS may be even more widespread within the Latino community than official statistics indicate suggests the importance of cultural factors in both transmission of HIV/AIDS among Latinos, and in the reluctance of Latinos to seek HIV testing and counseling to deal with the threat of infection. The Multicultural Liaison Board notes that, for the most part, the

kinds of education and prevention issues raised and addressed by the gay white communities in the early 1980's are only now beginning to be addressed by the many facets of the Latino community. Internal prejudices within the community, such as homophobia and sexism, which tend to limit outreach to those Latinos and Latinas most affected by the disease, and external prejudices which limit outreach to Latinos by outside educators and agencies, create a culture both of underservice and of denial that has the potential to make the AIDS crisis among Latinos much worse. Women in Latina culture, for example, must often contend with sexism, with denial of homosexuality and bisexuality, and expectations that they will defer to their husbands or lovers on issues such as condom use (Marin & Gomez, 1992). The role of the Catholic Church as an influence in Latino culture which promotes care for persons with HIV/AIDS while it prohibits the use of condoms to prevent the spread of the disease, and condemns homosexual and bisexual activity, typifies the contradictory cultural messages that are difficult to resolve within the Latino community.

In terms of injection drug use, it has been noted that methadone treatment is often unattractive to Latinos because the individual remains addicted, and thereby is involved in a program that inherently contradicts the individual's need for a strong self-image based upon self-reliance and independence. According to Marin & Gomez (1992) Latinos tend to under-utilize traditional drug treatment programs because the programs are largely insensitive and inappropriate to Latino culture, and many Latinos prefer to seek treatment through family and community-based service options.

In the case of Latino populations, the Multicultural Liaison Board suggests that a prevention approach that recognizes the diversity of the Latino community, and that serves different Latino populations distinctly, will be more effective than a prevention strategy that treats the entire community as one homogeneous entity. Latino subgroups who have been living in California for over 50 years require a different approach from those who arrived five years ago, while Latino gay and bisexual males require a wholly different outreach strategy from that offered to families. Many Latino gay and bisexual males still live with their families, in a climate in which their sexual proclivities may be understood and tacitly accepted, but in which a discussion of those behaviors is not permitted. Separate outreach methods are required for different individuals, an approach which requires creativity, sensitivity, and a complex prevention approach framework. Finally, Marin & Gomez (1992) stress the significance and appropriateness of a continuous, culturally sensitive program of education that emphasizes safe sexual skill training for Latinos as a means to help increase the percentage of Latinos and Latinas who insist on condom use during every sexual encounter.

5) American Indian/Alaskan Native Communities (Native Americans)

A) Population Demographics and Characteristics

The state of California boasts the second highest population of Native Americans of any state in the United States.[****] According to the 1990 Census, there are a total of 196,889 Native Americans currently living in California, comprising .61% of the state's total population. As the Multicultural Liaison Board (1994) puts it, the size of the Native American community in California is reflected by its diversity. Some Native American groups have lived in the state for centuries, while others are more recent arrivals. Many live on reservations, and others live in urban or rural settings; still more Native Americans move back and forth between the reservation and other locales. The greatest concentrations of Native Americans within the state of California are in the San Francisco Bay Area and Los Angeles County.

Native American communities, however, have too often dwelled in the shadows of California life, remaining virtually invisible and unacknowledged by mainstream culture. Native American communities also suffer from intense poverty and disregard, with the Multicultural Liaison Board (1994) noting that, "The American Indian population is the...least educated and most neglected minority group in the state of California." According to the 1990 Census, 19% of Native Americans in California had incomes in 1989 that were below the poverty line, compared to 13% of all Californians.

> Native Americans are the poorest, least educated and most neglected minority groups in California. In one community, approximately 7 to 8 percent of the population, ages 3 to 28 are inhaling paint. In that same community, only two youths have graduated from high school in the last eight years."
> --member of the public, Fresno meeting"

Unfortunately, as the Multicultural Liaison Board notes, the invisibility of California's Native American communities "is deadly when combined with the AIDS epidemic." Although few statistics are available, we do know that in the city of San Francisco alone, the number of Native American AIDS cases recently jumped from seven to 52 cases in a twelve-month period - a more than 700% increase in the space of one year (Multicultural Liaison Board, 1994). At the same time, HIV prevention education has always been severely under-funded among the state's Native American peoples, while the community itself faces a crisis of denial which makes raising and confronting the issues of HIV prevention a daunting task at best. The

---

[****] For purposes of this summary, the term 'Native American' is used to refer to all native peoples of North America, including Canada and Alaska (though not of Central America) irrespective of formal recognition by the U.S. government or any other government (Multicultural Liaison Board, 1994).

equation of HIV/AIDS with taboo or undiscussed subjects, as with other communities of color, makes HIV a difficult subject both.

Added to this equation is the extreme diversity of Native American cultures in California. Many Native Americans, for example, have Spanish surnames, and mixed cultural identities. The federal government also still refuses to recognize many Native American tribes, such as the Chumash, while Native Americans from south of the border face a categorical dilemma in not knowing whether to identify themselves as Native Americans or Latinos/Latinas. Although the term 'Native American' encompasses indigenous populations from all over the state and the nation, different tribes have vastly different history and cultures. These differences must be addressed by education and prevention strategies which address the distinct needs of different Native American cultural groups with culturally competent interventions that permit the issue of HIV to be raised in an atmosphere of safety and sensitivity.

B) Risk Behaviors of the Population

Native Americans and Alaskan Natives have historically been hard hit by infectious diseases in this country. AIDS appears to be no different. While there is a glaring paucity of studies on HIV prevalence among AI/NA in California, the available data draw a disturbing picture. Between March 1988 and June 1990, the rate of HIV infection among AI/NA requesting Hiv testing at alternative test sites in California was 5.4%. This rate is higher than the rate for any other racial group except African-Americans (Conway, 1992). Preliminary results from an Indian Health Services survey of HIV prevalence are disheartening as well. Finding showed similar rates of infection among urban and rural AI/NA for female STD patients and prenatal patients. While rural locations for many AI/NA communities may have offered protection from widespread HIV infection in the recent past, the virus is clearly making in-roads into previously unaffected areas (Conway, 1992).

Data on STD rates also indicate a high level of risk for HIV infection among AI/NA. A study conducted from 1984 to 1988 in 13 states, found gonorrhea rates to be approximately twice the rate for AI/NA as for non-AI/NA. During that same period, average primary and secondary syphilis rates were more than two times higher for AI/NA. A study in King County, Seattle found AI/NA to have incidence rates of gonorrhea five times the rate for while (Toomey, Oberschelp, and Greenspan, 1989).

Perhaps exemplifying the fact that Native Americans have been consistently ignored in the development and delivery of HIV prevention programs, few studies exist to describe the risk behaviors of Native Americans in regard to HIV/AIDS. One study conducted in San Francisco (Fairbank, Bregman, & Maulin, 1991) indicates that 25% of American Indians engage in either risky sexual behavior or possibly risky sexual behavior. While this percentage is relatively low, it is also true that **73% of Native Americans interviewed in the**

study reported using condoms only sometimes, and that 68% of Native Americans report having difficulty in talking about condoms.

There have also been historically high levels of drug and alcohol abuse among Native Americans, a condition which is exacerbated by the poverty and the limited economic opportunity resulting from the long history of anti-Indian public policy in this country. According to Conway "epidemic intravenous methamphetamine use has been reported in one rural AI/NA community, and injection drug use has been implicated in hepatitis B outbreaks in two other western AI/NA communities. AI/NA youth, too, may be at increased risk for drug-related transmission of HIV, ans AI/NA high school seniors reported the highest race-specific prevalence rates for use of alcohol, cocaine, hallucinogens, and barbiturates for the period 1976-89".The Multicultural Liaison Board (1994) cites a statistic in one California community showing that between 5% and 8% of the population ages three to 28 are inhaling paint. In the same community, only two youths have graduated from high school within the last eight years.

Inadequate access to health and medical services undoubtedly worsens the rate at which Native Americans seek services and support related to HIV prevention and testing. Sixty-eight percent of Native Americans participating in the San Francisco study above reported that they have no private insurance, and 18% reported that if they became ill they would have nowhere to go to receive medical treatment.

C) Barriers to HIV Prevention Within the Population

The long history of abuse of Native Americans in the United States has left a community that must fight to regain its cultural pride and self-esteem. These communities have a strong distrust of messages from the government, as well as, by extension, from white educators in general. These conditions virtually necessitate the generation of outreach and education strategies that are developed by and for the specific tribal and cultural groups to which they are directed.

Ethnic misclassification of AI/NA with AIDS is a persistent problem, and has resulted in a lack of understanding of the impact of HIV in this population. The core of the problem is a misunderstanding of the AI/NA community generally. Health departments in both Los Angeles and San Francisco Counties have identified ethnic misclassification as a problem. A study conducted in King County, Seattle concluded that misclassification occurs in both provider reports of people with AIDS and on death certificates. According to the study, death certificates cannot be entirely relied upon for racial/ethnic classification (Hurlich, Hopkins, Sakuma, and Conway, 1992).

Many Native Americans also face issues of personal and cultural alienation, conditions which lead to depression and risk-taking behaviors on a personal level, and which make the development of coherent community-based messages difficult. Urban and rural reservations and agencies need to share information, resources, and experiences, in part to address the

urban/reservation tension that exists for individuals as they travel between California cities and their reservations. There is also a strong need for education that is inclusive of spiritual traditions and of links to spiritual healers, as well as for literature developed and produced by Native Americans (San Diego County Indian Community Assessment, 1993).

The lack of visibility of Native American populations remains a significant concern and challenge for the HIV educator. Prevention strategies must seek to identify particularly those Native Americans who are living directly within urban environments in which access to drugs and/or high-risk activities may be more accessible, or less subject to community censure. Prevention programs must also overcome barriers of inadequate funding, and of the fact of Native American AIDS educators being isolated or marginalized within larger 'multicultural' agencies. Perhaps most importantly, HIV prevention outreach and education must be situated within the context of the myriad challenges facing Native Americans in their daily lives, challenges which make HIV only one complex issue within a larger complex of issues including cultural identity, substance abuse, economic pressures, and urban/rural tensions. Until HIV prevention outreach to Native Americans explicitly confronts these complexities of Indian life, the crisis will continue to exponentially increase throughout the state of California.

TRANSGENDER/TRANSVESTITE INDIVIDUALS

A) Introduction to the Population

This population category describes a large and diverse group of Californians who live all or part of their lives as members of the opposite gender, or who have either undergone or are in the process of undergoing sexual reassignment surgery or other gender characteristics modification. Whereas many groups have attained notable visibility during the AIDS epidemic, California's transgender and transvestite populations have remained largely invisible, and have been excluded from the mainstream of HIV education efforts within the state. Transgender and transvestite men and women are frequently derided in the popular media, and are given short shrift by the AIDS education community. However, while transvestite and transgender individuals may choose to adopt gender-opposite identities for a wide variety of reasons, these reasons are nearly always grounded in significant psychological and emotional cross-gender identification that demands to be taken seriously, and must be treated with respect by all members of the HIV prevention community.

Unfortunately, due in large part to their aforementioned invisibility, and to the stigma attached to revealing transgender status, accurate estimates of the total the population of Californians who are transgender or transvestite simply do not exist. **Estimates of the total number of transgender men and women across the United States vary between 20,000 and 200,000, but no one has even a good rough guess concerning the total number.** At the same time, some prevention researchers have estimated that a total of between 4,000 and 6,000 transgenders may currently live in the San Francisco Bay Area alone.

We do know that transgender and transvestite individuals are of all sexual orientations, and that personal sexual orientation itself bears virtually no relation to the decision or drive to alter gender identity. Transgenders and transvestites may be lesbian, gay, or heterosexual. Transgenders themselves may self-identify as transgender, or they may identify themselves simply as members of their chosen gender. The term transgender may also include pre- and post-operative transsexuals, transvestites, drag queens, and men and women who pass as the opposite sex. It is a group that, both behaviorally and in terms of personal identity, defies easy categorization.

A focus group of male-to-female transgender individuals conducted for the San Francisco HIV prevention plan in the San Francisco Bay area in August, 1994 elicited a number of key group characteristics that may help point the way to more appropriate education and outreach programs directed to these populations (although it should be noted that the group did not express the specific perspective of female-to-male transgender individuals). Focus group members noted, for example, the high degree of homelessness among transgender individuals, and the lack of either sensitivity or safety within shelter facilities attended by transgender/transvestite men and women. Focus group participants also noted the lack of central information, support, and service facilities at which networking can take place, and in which health and emotional issues could be discussed and shared. Substance abuse, battering by boyfriends and spouses, discrimination, and depression were other issues frequently discussed by group participants. A focus group of transgender persons was held in San Diego as a part of the state planning process. Participants of this focus group described the wide-spread distrust among transgenders of activities perceived in someway to be officially sponsored. The discussed their personal experiences of social rejection and abuse for being transgender.

The recent announcement by San Francisco police Sergeant Stephanie Thorne of her intention to complete a transition to a male identity, and the resulting acceptance of that decision by the Department, has helped to publicly raise the issue of transgender and transvestite individuals in the workplace in California, a debate which will help to confront the frequent problems experienced by transgender and transvestite individuals in both securing and maintaining employment. The difficulty experienced particularly by transgender persons in locating jobs and in maintaining them was expressed repeatedly in the San Francisco focus group sessions. At the same time, the issue suggests the potential appropriateness of the workplace as an arena for beginning to confront and come to terms with gender transition issues.

Transgender and transvestite individuals may also be gaining a new measure of visibility and understanding, partly as a result of their increasing media exposure, often within the context of the daytime talk show format. There, more and more individuals who choose or who feel compelled to live gender-opposite lives, or to transform their physical gender identities to match their internal emotional ones, are sharing their stories in a candid and open manner. This process, if not yet leading to full understanding and acceptance, at least may

contribute to a greater visibility and awareness of the presence of transgender and transvestite individuals among the general public. Newly-emerging 'celebrity' transgender figures such as British model Tula, tennis star Renee Richards, and American synthesizer pioneer Wendy Carlos (formerly Walter Carlos) may also be helping somewhat to increase awareness of the prevalence of transgender and transvestite communities both nationally and within the state of California.

In San Francisco, a recent ordinance has passed to add the category of "gender identity" -- that is, behavior, feelings, and thoughts that do not always correlate with a person's physiological status -- to the list of categories in the city's Human Rights Ordinance. Such an amendment mirrors similar ordinances already in effect in Santa Cruz, California, as well as in cities such as Seattle and Milwaukee. Such signposts of an awakening of awareness and acceptance are a hopeful sign, despite the tremendous distance these communities have yet to go in gaining acceptance and respect.

B) Risk Behaviors of the Population

Perhaps the most difficult issue confronting transgender/transvestite individuals in regard to their personal risk for HIV/AIDS involves the frequency and extent to which members of the population are compelled to work in the sex industry as their only means of earning a living wage. It is generally believed that transgenders in the sex industry are at greater risk than females in the sex industry, and that HIV risk may be proportionately increased. A study of female and transsexual prostitutes in Tel Aviv, for example, found that a higher proportion of transsexual prostitutes than female prostitutes were HIV positive.

In some cases, the suggestion has been made that many transgenders base their sense of personal self-worth directly upon the amount of money that they can charge for performing sex acts. Since the cost is usually higher for sex without a condom, transgender and transvestite persons may be more willing to engage in unsafe behavior both to prove their self-worth, and to increase their income. But the inability to escape from the sex industry also contributes to a descending self-esteem spiral, expressed succinctly by one of the San Francisco focus group members:

> Because I was making twenty-six dollars an hour, and I was turning tricks, I did it for eighteen years. And I get paid very well for what I do. But if you're not satisfied with yourself, then nothing's going to matter....All of us were taught that we were no good because of the way we were. We gettin' dumped on by a lot of people. But what if you have your sex change, or a job, or housing - nothing seems to matter if you don't have a life.

Participants in the focus group held as part of the state planning process stressed the pervasive lack of self-esteem which leads to transgenders' unwillingness or inability to adopt

safe sexual behaviors. Low self-esteem also has a close relationship to behaviors such as substance abuse, continued involvement in abusive relationships, and other wide-ranging self-destructive behaviors; substance abuse, according to the focus groups, appears to be a particularly prevalent problem within this community. Drug use, they said, may be a way to self-medicate and anesthetize the pain of social and personal rejection. While transgender members of the San Francisco focus group had relatively high levels of HIV/AIDS knowledge, for example, there was extensive evidence for the fact that low self-esteem (based largely on societal messages) made continual application of safe sex practices difficult.

> "As a transgender individual you are outcast by both the gay and the straight communities; however, you are worthy enough, special enough, and God loves you enough for you to protect yourself from a traumatic and rapidly growing disease like HIV."
>
> --member of the public, Long Beach meeting

Sexual abuse appears to be relatively commonplace within the transvestite and transgender communities, with one member of the San Francisco focus group reporting having been raped two times, and many others reporting beatings by lovers or by tricks, or bashings in public. Because of the stigma attached to transgenderism, the vast majority of these attacks go unreported to the police, leading to a vicious cycle of abuse in which the transgender/transvestite individual is denied the means to take power over abusers by using the system to his or her advantage.

C) Barriers to HIV Prevention Within the Population

One key barrier facing transgender and transvestite individuals is the difficulty in accessing health and social services that are both sensitive to their needs and respectful of them as individuals. Many San Francisco focus group members complained of discriminatory treatment by mental health and medical personnel, whose ignorance concerning this population led them to treat transgender individuals with callousness and even cruelty. Participants in the San Diego focus group said that often transgender persons feel that they need to "revert" to their previous gender role in order to get services. Hence, some providers think they have no transgender clients, when, in fact, they do.

Transgender and transvestite communities are stigmatized within the AIDS service community itself, where no training currently exists to sensitize HIV prevention and service personnel to the needs and cultures of transgender/transvestite communities, and in which no tailored HIV prevention campaigns have emerged to meet the community's education and prevention needs. This is particularly tragic in the case of transgender and transvestite communities, wherein poor self-esteem makes the adoption and maintenance of self-protective behaviors much more difficult to attain than in other communities.

Transgenders themselves are extremely mistrustful of social services, in part because they have been mistreated and misunderstood most of their lives. The fact that transgender and transsexual individuals often live invisible, closeted lives means, by contrast, that they are a difficult population for social and health service providers to reach. It has been suggested that the key to reaching and changing the behaviors of transgender communities may be through peer-based outreach and education programs, since it is believed that only transgender individuals can truly understand the experiences and needs of other transgender persons.

PEOPLE IN THE CRIMINAL JUSTICE SYSTEM

A) Introduction to the Population

In the past decade, the U.S. has experienced an accelerating expansion of the prison population. Four states, including California, have had threefold increases in prison populations since 1980. Approximately one million people are confined in American's prisons and jails. The National Commission on AIDS, in its 1991 report on HIV disease in correctional facilities, notes that, "The HIV epidemic was guaranteed, from the outset, to have a disproportionate impact on the nation's prisons and jails because of the intimate connections between HIV infection, illicit drug use and incarceration....Because drug use increases one's risk of incarceration as well as of HIV infection, the inmate population often constitutes a distillate of the infection in the community.... Presently, the U.S. maintains a de facto policy of incarcerating more and more HIV infected individuals by choosing mass imprisonment [particularly of poor Blacks and Hispanics] as the federal and state governments' response to the use of drugs. Under a scheme of mandatory sentencing for drug offenses, the percentage of drug offenders in the federal prison will rise by 1995 from 47% to 70%." (National Commission on AIDS, 1991)

The incarcerated and criminal justice-involved population of the state of California is by far the largest in the United States, and indeed is larger than the incarcerated population of most of the countries of the industrialized world. **According to the California Department of Corrections, there were within the state of California as of July 17, 1994, a total of 231,421 individuals who were either currently incarcerated or in some way involved with the criminal justice system.** A total of 118,810 of these men and women were being held in institutions or in camps; 5,317 were detained in community correction centers; and a total of 426 individuals were incarcerated in state hospitals operated by the Department of Mental Health. Another 5,409 persons were held in institutions outside of the jurisdiction of the Corrections Department, or were not under the Department's control, while 15,720 individuals were either in other settings or under the control of other departments. An additional 85,739 men and women were on parole and/or on probation as of July 17th of this year.

This criminal justice population is overwhelmingly male (94%), with male parolees constituting 90% of the paroled population. People of color are over-represented within this system, with only 30% of prison inmates being white, but with 32% being African

American/Black, 34% Latino, and 5% belonging to other ethnic groups. The ethnic profiles for parolees are virtually the same, although Latinos have slightly higher representation (35%) among parolee groups.

Further, there are some 600,000 admissions to public juvenile facilities annually in the U.S. Over 50,000 adolescents are confined on any given day. Drug crimes account for 5.6% of all offenses. Moreover, recent surveys of juveniles in custody found 63% of these youth used drugs regularly and that youth in detention are significantly more likely than students of the same age to report ever injecting drugs.

According to National Commission on AIDS, the cumulative number of AIDS cases among inmates increased by 606% between 1985 and 1989 nationally. California, New York, New Jersey, Florida, and Texas have been particularly hard hit. A 1987 study by the Correctional Association of New York suggests that prisoners with AIDS may be dying at twice the rate of nonprisoners with AIDS. Further, a resurgence of tuberculosis in corrections facilities is a growing cause for concern. A CDC survey of 29 states in 1984-85 found prisoners to be three times as likely to develop tuberculosis than age-matched controls who were not incarcerated (National Commission on AIDS, 1991).

Numerous studies have confirmed that rates of HIV infection among prisoners are high (National Commission on AIDS, 1991). Studies of persons entering prison have shown rates of HIV seropositivity ranging from 0% to 17% (Horsburgh, 1990). HIV seroprevalence rates are commonly higher among female inmates than among male inmates. Among males entering prison systems, rates ranged from 2.1% to 5.9%; for females they ranged from 3.2% to 7.8%. Among jail system entrants the rates in men ranged from 2.3% to 7.6%, and in females from 2.5% to 14.7% (Hammett, 1994).

Of the California prison population, approximately 2.6% of males and 3.1% of females were estimated to be HIV infected as of 1988. However, officials estimate that based on 1988 findings, at least 4% of both male and female California prison populations may now be carrying the AIDS virus. **Excluding parolee populations, this percentage would translate to a total nearly 6,000 male and female inmates currently infected with HIV in California.**

Most HIV-positive inmates were infected prior to incarceration. Data suggest that transmission occurs in correctional facilities, but at quite low rates. Several studies have found seroconversion rates of less than 0.5%. In most states studied, as a part of a sample of Federal Bureau of Prisons studies, rates have been stable for five years (Hammett 1994).

B) Risk Behaviors of the Population

Although several studies have been conducted of specific populations in individual incarceration settings, there are no broad estimates of the specific levels of HIV-related risk behaviors in which prison populations may be engaging. However inmates frequently report

injection drug use both before and during incarceration, and these represent high-risk activities for the transmission of HIV (Hammett, 1994). For example in a study of inmates in Tennessee, 26% reported intravenous drug use (Horsburgh, 1990). One focus group held in San Quentin Prison by the Marin County AIDS Project in October of 1993 found that between 7% and 10% of inmates continue to inject drugs while in prison. In conducting research for this plan, we found no studies examining needle-cleaning behaviors, but it is unlikely that sterilized syringes are consistently utilized by prisoners who inject drugs.

Several studies have found higher rates of HIV infection in non-whites and women. This may be "a reflection of higher rates of IV drug use in non-white inmates or of higher rates of HIV infection in non-white IV drug users, or both. The increased rate of HIV infection in incarcerated women may reflect an increased percentage of incarcerated women who are either IV drug users or sex partners of drug users." (Horsburgh, 1990). According to the Federal Bureau of Prisons, about 60% of women in federal custody are serving sentences for drug offenses. A large number of women in prison have alcohol and drug dependency problems, estimated to be between 70% and 80%. (National Commission on AIDS, 1991)

Sex (both consensual and rape) occurs in correctional facilities. The Tennessee study found that 17% of inmates reported homosexual activity while in prison (Horsburgh, 1990), for example. In its 1991 policy statement on HIV education and condoms in correctional facilities, the American Journal of Public Health in noting that "people who are incarcerated and denied freedom of sexual activity do engage in consenting sexual behavior which will be unsafe if they are not provided with condoms, and further noting that rape is violent and predatory behavior which has nothing to do with this consenting sexual activity...urges state policymakers to amend laws which prohibit the distribution of condoms in correctional facilities." (APHA, 1991)

While the actual rate of HIV infection among adolescents in custody is unknown, many youth who come under the jurisdiction of juvenile detention facilities have a history of behaviors that places them at higher risk of HIV infection than the general population of adolescents (National AIDS Commission, 1991). A study conducted by DiClemente, Lanier, Horan, & Lodico (1991) suggests that incarcerated youth are at substantially increased risk of HIV infection as compared to their school-based counterparts, and that incarcerated young people should be a primary target of HIV primary prevention programs. Incarcerated youth in this study were less aware of HIV risk-reduction behaviors, and report markedly higher rates of risk behavior than youth 'outside the walls'.

Early age of first intercourse and multiple sexual partners may increase the risk of sexually transmitted diseases and HIV. In a regional study of urban detention populations, the average age of first intercourse was 12 years, compared to 16 years for the nation. Most of these individuals have had multiple partners and have little or no knowledge of their partners' prior sexual or drug related behavior, placing them at risk for HIV infection. Seventeen percent of 262

respondents to a survey of 16 to 17 year olds incarcerated in the Los Angeles area reported a history of sexually transmitted disease and 47% reported drinking alcohol in situations that led to unprotected sexual intercourse. Further, of 184 youth offenders taking advantage of services offered by the San Francisco Youth Guidance Center, 35% reported exchanging sex for drugs or money and 46% agreed with the statement, "Sex without condoms is worth the risk of getting AIDS" (National Commission on AIDS, 1991).

C) Barriers to HIV Prevention Within the Population

Many of the barriers to HIV prevention for the incarcerated are the barriers of the composite populations of prisons -- substance users, gay men, people of color, the poor, women, and youth. For example, users of illicit substances are wary of law enforcement and may not self-identify as drug users nor seek out the support they need to effect long-term behavior change. Approaches to changing HIV-related risk behaviors among IDUs must be tied to a spectrum of services such as drug treatment, mental health care, and job placement. Youth and adolescents are often trying new behaviors, forming their sexual identities, maintaining a sense of invulnerability to death and disease. The National Commission on AIDS notes that "HIV education programs for incarcerated youth should recognize the behavioral, social and developmental diversity of the adolescent population."

> Nine and a half years ago I was incarcerated in jail, and I was asked if I wanted to have an HIV test. I took it. When I was called into the infirmary, they told me I had AIDS and locked me in a room and posted "AIDS" on my door for everyone to see. I was uneducated and they didn't educate me. So I just stayed there and waited to die."
>
> --member of the public, Fresno meeting

Eighty percent of female prisoners have children, and of those 70% are single parents. Prior to their incarceration, 85% of female prisoners had custody of their children. Further, a significant number of women give birth to children shortly before they begin to serve prison sentences, or are pregnant and give birth during their incarceration. The Bureau of Justice Statistics reports that about 25% of women in correctional institutions are pregnant or post-partum. In addition to the services available to their male counterparts, women in prisons need HIV education regarding perinatal transmission and pediatric AIDS (National Commission on AIDS, 1991).

Condoms are prohibited in California prisons (permitted only in conjugal visitations). The National AIDS Commission, in its report on HIV in Correctional Facilities, expressed "distress to find that only a handful of prison systems distribute condoms. Vermont was the first in the nation to do so. In Mississippi, Philadelphia and New York City condoms are

available at institutional infirmaries. In the few systems where condoms have been distributed, correctional officials' fears that they might be used as weapons or as containers to smuggle drugs have not materialized. Representatives of the Department of Health Services for the City of New York and the medical care providers for Rikers Island report that two years of experience with condom availability in the New York City system have resulted in no adverse security incidents." (National AIDS Commission, 1991)

The lack of education of both inmates and staff creates fear and discrimination toward individuals with HIV disease. Without education in correctional facilities, individuals return to their communities with insufficient knowledge and support to prevent HIV. Those with HIV in correctional facilities face an uneven delivery of medical services. A 1973 Supreme Court decision found that "deliberate indifference to the serious medical needs of inmates" constitutes "cruel and unusual punishment". Since that time, local, state and federal correctional facilities have worked to improve medical services for inmates, but the complicated medical picture that HIV presents still troubles many of these facilities.

For most HIV-positive incarcerated persons, exposure occurred in the community prior to incarceration. However, comprehensive education and prevention programs will help to prevent any possible spread of HIV infection within correctional facilities, and change behavior to prevent infection once inmates re-enter their communities (National AIDS Commission, 1991).

HOMELESS AND TRANSIENT INDIVIDUALS

A) Introduction to the Population

Homelessness is widespread in California. It occurs in all parts of the state, including rural, urban, and, as described in the section on communities of color, meso-urban areas as well. There are no accurate figures for the number of homeless on a statewide basis, and few for any local area. 1990 U.S. Census figures are generally agreed to be least reliable in regard to their estimates of homeless populations; they are thought to be inordinately low for nearly all areas of the state. The Census' totals of 30,806 persons living in "emergency shelters for the homeless", and 18,081 persons "visible in street locations", accounts for a total of only 48,887 homeless and sheltered individuals in California. The U.S. Census Bureau has acknowledged that these figures are completely inadequate as a means to represent the scope of the homeless crisis in the state.

Statistics from the state's Homeless Assistance Program, which counts the number of homeless families who apply for aid, provide a slightly better portrait at least of California's large number of homeless families. Their estimates indicate that during FY 1990-91, a total of 99,983 families, made up of an estimated 295,945 separate individuals and 195,966 children, applied for assistance as homeless persons at some time during the year. Even this figure is, however, a severe undercount, as it tabulates only families who are eligible for public

assistance. These numbers do not include single individuals, childless couples, or any family who does not apply for the program.

Additional research by the California Homeless and Housing Coalition (1993) has instead indicated that members of families actually accounts for only about one-third of the entire population of homeless people in the state of California. **Combining this with the Homeless Assistance Program's estimates suggests that as many as 1% to 3% of the total California population may have been homeless at some time during 1990-91 - a total of between 300,000 and 900,000 on the streets or in shelters at some time during the course of the year.**

There are already 125,000 known cases of HIV which have not yet advanced to a diagnosis of AIDS among California's homeless (State of California Department of Housing, 1993). The U.S. Department of Housing and Urban Development (Ibid.) concurs with these estimates, stating that between one-third and one-half of the California homeless population is currently infected with HIV, and that over 21,000 cases of AIDS probably exist within this community. Contradicting both of these assertions, however, is a study conducted last year by the University of California at San Francisco and by San Francisco General Hospital of HIV seroprevalence among the homeless in San Francisco, a study that included people in shelters as well as homeless individuals who did not utilize social services. **This study estimated HIV prevalence among the homeless to be at 9%.** Of these individuals, 90% were asymptomatic, and 75% were unaware of their HIV status. The same study suggests that HIV prevalence among the homeless in San Francisco is also likely to be higher than in other areas of the state.

At one time, homelessness was considered to be a problem primarily of single men. Single men still remain a large segment of the overall homeless population, but they are now only one component of the population as a whole. No accurate data are available to estimate the population of different homeless categories, but we know that they include at least the following groups: adult single men; adult single women; families with children; couples without children; women with children; (a few) men with children; and single young people, both male and female. Generally, single men greatly outnumber single women among the homeless. Women with children are the most common family type, but both couples with and without children are significant components of the state's homeless population (State of California, 1993).

The homeless include members of all racial and ethnic groups, but again, no specific data exist to estimate precise numbers. There are wide variations in ethnic compositions based, for example, on geographic area, at times corresponding generally to the presence or absence of significant numbers of particular ethnic or racial group members within the local housed population. Because migrant farmworkers are predominately Latino (see corresponding section), Latinos predominate among the homeless in many farming areas around the time of year when agricultural employment is at its peak (State of California,

1993). Although many homeless people reside in rural areas, even less is known about these individuals than is known about their urban homeless counterparts.

The U.S. Conference of Mayors report entitled, *A Status Report on Hunger and Homelessness in America's Cities, 1992* estimates a national ethnic composition among the homeless that is 52% African American/Black, 33% white, 11% Latino/Hispanic, 3% Native American, and 1% Asian/Pacific Islander. These estimates embody, of course, a significant over-representation particularly of African American/Blacks, but are not significantly different from nationwide poverty estimates for the country as a whole.

Single homeless persons are of all age ranges, from the teenage to the elderly. The elderly, however, are represented in a proportion below their presence in the general population as a whole. In one Sacramento study, the average age of single homeless men in the city was found to be 33, and for single homeless women, 36, with only 3% of the homeless in Sacramento being over the age of 60 (California Homeless and Housing Coalition, 1993). Members of homeless families of all ages, including the youngest of infants, but elderly families are also underrepresented in comparison with their percentage of the overall state's households (State of California, 1993).

B) Risk Behaviors of the Population

Very little data are available by which to estimate the risk behavior rates of the homeless populations of the state of California. Studies have demonstrated that frequent correlates of homelessness include depression, fatalism, and low self-esteem, and these factors can contribute significantly to neglect of personal health needs, including neglect of HIV-protective behavior (Green, R., 1993). Furthermore, a relatively high percentage of the homeless are thought to be suffering from more severe mental health conditions; these, too, can make homeless individuals susceptible to exploitation or to non-protective behavior choices. For women, living on the streets also makes them extremely vulnerable to rape and sexual assault, placing them at even higher risk for HIV infection.

Based on national and local substance use studies and estimates, it is believed that, on a nationwide basis, 10% to 20% of the homeless have alcohol and other drug problems, and that an additional 20% to 30% are severely mentally ill and have alcohol and other drug problems concurrently (State of California, 1993).

C) Barriers to HIV Prevention Within the Population

A number of specific problems serve as important causal factors in homeless, and act as concurrent barriers to providing effective HIV prevention services. Many among the homeless, for example, fall into one or more of the following categories: the mentally ill; the physically ill or disabled; substance abusers; victims of domestic violence; and runaway or abandoned youth. Many of the homeless are clinically depressed, with one Sacramento study

(California Homeless and Housing Coalition, 1993) indicating that 71% of the city's homeless experience a depressive state as a result of their homeless condition. Because many homeless have multiple problems, helping homeless men, women, and families requires dealing with the whole person, and the whole family.

Many of the homeless cannot manage their health adequately, in part because of conditions such as mental illness, substance abuse, limited education and literacy skills, limited English skills, and transient status. Governmental regulations that require a mailing address in order to qualify for certain benefits acts as an additional barrier. The homeless may also rank any number of life concerns and issues as being on a higher level than the issue of HIV/AIDS itself. Examples of such key life needs include: housing, counseling, child care, employment referrals and assistance, transportation, mental health care, transitional housing, case management, personal safety, and education and training (State of California, 1993).

> "You're telling me about dying in 10 years. I might not be alive. I'm hungry right now, and it's raining, and I don't have a place to stay. The important thing is let me stay alive right now. Let me eat today."
> --member of the public, San Diego meeting

Many thousands of homeless people also struggle to stay well out of public view, and are reluctant to participate in programs or support activities. Furthermore, the service system that exists to assist low-income and homeless people is inconsistent and incomplete. Few service programs designed to help the homeless are actually geared to meeting the full needs of any one person (California Homeless and Housing Coalition, 1993). One social worker employed by AIDS Indigent Direct Services in San Francisco said that many of the individuals who could be served by her agency are afraid to access services because they feel that they will be judged because of their sexuality or their disease.

Traditional emergency shelters may not be suitable for people with AIDS because of their specific, complex medical needs. The incidence of tuberculosis among homeless persons with AIDS is one strong reason to provide an alternative to homeless shelters for HIV-diagnosed homeless and transient men and women. Residential AIDS Shelters (RAS) provide homeless persons with AIDS with an alternative to emergency shelter, but the number of beds available is far less than what is needed in relation to the crisis (State of California, 1993).

IMMIGRANTS AND UNDOCUMENTED PERSONS

A) Introduction to the Population

The estimated 6.8 million foreign-born immigrants currently living in California account for nearly 22% of the state's population of 31 million persons. This population includes a large percentage of the estimated 29% of California's residents who speak a

language other than English at home. Immigrant individuals and families originate from all corners of the globe, with special concentrations of Latin American, South American, European, and Asian points of origin in the case of California, and have significant overlapping characteristics with the populations described in the Communities of Color section in this document.

By contrast, **credible estimates of the number of undocumented immigrants in California range from 600,000 to 1 million** at any one time. The state's Department of Finance estimates that roughly 100,000 more undocumented persons enter the state each year than leave it. **These data are sketchy at best, however, and many believe these figures to be inordinately low (California Senate Office of Research, 1993). The U.S. Census Bureau has suggested that fully half of the nation's undocumented immigrants reside in California.**

In addition, there are 600,000 officially-recognized refugees currently living in California, with 29% percent of these persons settling in Los Angeles County as their final destination within the state. **It is a matter of record that it takes many years to achieve officially-recognized status as an immigrant to California, and that this figure does not represent the possibly millions of documented but not officially recognized immigrant individuals currently living in California.**

To give a sense of the diversity of the new populations that arrive in California each year, the following chart details the specific point country of origin for immigrants who arrived in the state of California during calendar year 1992.

Exhibit 3.4
ETHNICITY OF NEW CALIFORNIA IMMIGRANTS, 1993

Country of Origin	% of New Immigrants	# of New Immigrants
Mexico	17%	26,677
Philippines	16%	25,602
China	7%	10,894
Iran	6%	8,859
Korea	6%	8,849
Taiwan	4%	6,128
El Salvador	4%	5,443
India	3%	5,273
Other Locations	38%	58,986

Source: 1990 U.S. Census

Again by contrast, over 80% of the state's refugee population are Southeast Asian, the majority of whom are from Vietnam. The majority of the state's non-Southeast Asian refugees originate from within Eastern Europe (California Senate Office of Research, 1993).

The average age of California's new immigrants is much younger than the statewide average age: an average of 25 years compared to 34 years for long-time Californians. The median household income of legal immigrants who arrived in California between 1980 and 1990 is currently $22,300, as compared with $34,900 for residents who have lived in California since before 1985. In a study of 150 undocumented immigrants in San Diego County, pay averaged $131 per week, or $6,812 per year for respondents, with 89% saying that they send any "extra" earnings they may receive to relatives outside of the United States (California Senate Office of Research, 1993).

Of the more than one million formerly undocumented immigrants who received amnesty under the Immigration Reform and Control Act of 1986, 65% had completed six years or less of formal schooling in their home countries, and 28% had completed schooling totalling three years or less. A third were not literate in their native language. Overall, only 3.8% of households headed by immigrants were receiving public assistance in 1990 -- a smaller ratio than the native population. However, this may say more about access to services than it does about economic status and financial success (California Senate Office of Research, 1993).

It is believed that a smaller proportion of immigrants define themselves as homosexual than does the long-time California population. In part, this is due to the fact that the very concept of 'sexual identity' is in many ways a western one, unknown to many recent arrivals to this country. However, in terms of HIV risk, immigrants face many of the same risks as does the long-time California population, although the degree of risk and the specific behaviors involved vary from community to community, and from culture to culture.

B) Risk Behaviors of the Population

In general, studies have demonstrated that immigrant populations tend to have less knowledge about HIV transmission than do long-time California residents. Immigrants, especially undocumented immigrants, have significantly reduced access to HIV-related prevention and support services. However, very little is known about the specific HIV-related factors which may place both immigrant and undocumented populations at risk for HIV infection. Certainly, the same behaviors that place all Californians at risk for HIV also affect newly arrived populations. Medical services and HIV prevention services in either English or in the individual's native language are often unavailable. As a consequence, immigrants may possess inadequate understanding of HIV and reinforcement for behaviors which can prevent HIV infection.

> "We are faced with a moral and ethical dilemma. We have individuals sick and dying in Tijuana, and activist asking us for help. Our own nurse practitioners have practiced in Tijuana's only AIDS clinic. Sometimes the best we are able to do is smuggle the leftover AZT from our own dead, to people who are still living in Tijuana."
>
> --member of the public, Long Beach meeting

Extensive research is needed to determine the specific degree of risk for state's newly-arrived populations, and to design outreach and prevention strategies and programs which meet their special needs and respond to the special fears and apprehensions of immigrant and undocumented communities.

C) Barriers to HIV Prevention Within the Population

According to the California Senate Office of Research (1993), although California leads the nation in absorbing newcomers, it "trails other states in tracking what becomes of them, in coordinating public and private services available for them, and in giving them a voice in the fierce public debate over the impacts of the foreign born." The state of California, for example, has no office responsible for gathering and analyzing data that would give a clearer picture of its immigrant and refugee populations, nor does the state attempt to coordinate or make referrals regarding state and community-based services that might be available to new immigrants other than refugees.

In addition, there is no state spokesperson specifically charged with giving Californians a broad, informed look at immigration issues. Economic literature suggests that many negative assumptions concerning immigrants are false, and government is in a special position to counter divisive myths, such as the longstanding assumption that more long-time immigrant residents than native Californians are living on welfare (California Senate Office of Research, 1993).

The frequently low literacy levels of immigrant populations, even in their native languages, act as significant barriers to the receipt and absorption of HIV prevention messages, even those that strive to be culturally sensitive. However, because immigrants often have low or no English skills, particularly upon their first arrival in the U.S., the absorption of HIV prevention messages in English is often impossible. The many varied cultural backgrounds of immigrants arriving in California each year also makes it difficult to provide culturally specific educational messages, and to develop culturally appropriate methods and strategies for delivering those messages. And as with many ethnic populations, discussions of sex and illness are often not as frank as in mainstream U.S. culture, serving as a significant barrier to family and community-based dialogues concerning the risk factors surrounding HIV.

These issues are compounded in the case of undocumented or non-legal immigrant populations, who must continually hide their presence and identity in order to have any chance of remaining in the state for an extended period of time. For these individuals, concerns of HIV and AIDS are far from being priorities, with economic and survival issues remaining foremost for most newly arrived undocumented adults and families. These populations are unlikely to voluntarily access HIV prevention programs or services, and only seek health and medical care when illness is greatly advanced, or when there is no other alternative. In addition, current immigration laws restricting the rights of HIV-positive individuals to become legal residents often drives infected and at-risk individuals even further underground; as a result, these individuals may be even less likely to get tested, access early intervention services, or inform their sex partners of their HIV status and protect them from HIV exposure.

In order to reach these communities, strong bonds of trust and cultural compatibility must first be established, and educators must be able to assure individuals both of their disinterest in reporting immigrants, and of their understanding of cultural and behavioral issues related to the specific cultural group or nationality being addressed. Meeting the HIV prevention needs of immigrant and undocumented California residents is a daunting task requiring special skills, sensitivity, and dedication.

WOMEN AND THEIR SEX PARTNERS

A) Introduction to the Population

The 51% of California's population which is female constitutes a total of approximately 15,180,000 individuals, including over 12 million women over the age of

18. With the exception of the population of persons engaging in heterosexual sex, women make up the largest single target risk group described in this document, and are among the groups within which HIV/AIDS incidence has been rising most rapidly over the past three years, particularly within poorer communities and among African-American and Latina women, who currently make up nearly 75% of all reported AIDS cases among women. The annual number of new AIDS cases among women jumped by 139% between 1984 and 1990, alone. Nationally, the CDC reports that AIDS has now become the fourth leading cause of death among women 14-55 years of age, while it has been the number one cause of death for African American/Black women in New York and New Jersey since 1988.

HIV and AIDS have become community epidemics among African-American women in hard-hit areas of the state such as South Central Los Angeles and East Palo Alto, where high rates of AIDS diagnosis among women have been tied to high local incidences of injection drug use among men who are the sex partners of AIDS-affected women. In 1989, the death rate from AIDS was nine times higher among African American/Black women than among white women. Women with AIDS also tend to be younger than men, with women 20-29 years of age accounting nationally for nearly 25% of all AIDS cases as of late 1990, versus 20% of all male cases, pointing in turn to an earlier time of infection for many women with HIV.

Women are somewhat more likely to be poor in California than men. According to 1989 statistics, 12% of adult females in California had incomes below the poverty line, compared to just under 11% of males. In turn, women in poverty are much more likely to be single mothers living on fixed incomes, who must spread existing resources among a larger family unit. Poverty functions much more strongly as a key indicator both of HIV incidence and of life expectancy following an AIDS diagnosis among women than among men in California and elsewhere.

Women now account for over 10% of all reported AIDS cases, with well over half of those cases being reported since 1989. However, because of the gender-specific early manifestations of HIV in women, it has been frequently recognized (*e.g.*, Zamichow, 1991) that AIDS cases among women are being underreported on a nationwide basis, even after the revised CDC definition of AIDS that went into effect in 1992. Women infected with HIV often suffer a range of recurring gynecological disorders, such as abnormal Pap smears, cervical cancer, chronic yeast infections, pelvic inflammatory disease, irregular or stopped periods, and early menopause, conditions which also frequently affect women without HIV, but which affect women with HIV acutely and repeatedly over time. Because many women do not view themselves at risk, and because physicians also tend to de-emphasize HIV risk among women, subsequent testing to determine HIV seroprevalence or T-cell counts is often not performed. In addition, HIV/AIDS-related medical research has frequently not included older or younger women within study populations, and thus has often 'shut out' women from the process of developing and testing new drugs and treatments which address HIV-related manifestations.

B) **Risk Behaviors of the Population**

According to the American Public Health Association (1991) the epidemic of HIV among women is closely related to the problem of injection drug use. Although the figures are far less for California, nationally over half of all women with HIV are believed to have contracted the disease through injection drug use. In California, far more women are believed to be infected with HIV through an infected male partner who is an injection drug user. A recent study of female partners of injection drug users (Carbo, Wolitski, Thornton-Johnson, & Tanner, 1991) showed that levels of knowledge regarding HIV transmission were high (82% correct on a 16-item test) but that almost all respondents had engaged in unprotected vaginal intercourse during the previous six months.

HIV is also spread among women through both homosexual and heterosexual activity, and the virus has been isolated from both the semen and vaginal secretions of AIDS patients. Heterosexual activity is the dominant form of HIV transmission in Africa and in several other developing countries. Most women (approximately 63%) who have contracted HIV through heterosexual contact have done so through sex with an injection drug using partner, but 10% of women with heterosexually transmitted AIDS have been the partners of bisexual men. Women with multiple sex partners are considered to be at somewhat higher risk of HIV infection because of the larger number of possibly infected men with whom they come into contact; in the study of female partners of IDUs described above (Carbo, Wolitski, Thornton-Johnson, & Tanner, 1991) black interviewees were more likely than whites or Latinas to have multiple sex partners or engage in prostitution. Among Hispanics, however, less acculturated men and more highly acculturated women were more likely to report having multiple heterosexual partners (Van Oss Marin, Gomez, & Hearst, 1993).

> "What about the woman that is married to a man that has other sexual partners? That is also a drug user? That stays home and takes care of their children? Who is there to educate her?"
>
> --member of the public, Fresno meeting

One major study (Grinstead, Faigeles, Dinson, & Eversley) found that single women aged 18-49 living in California urban areas were much more likely than others to have multiple sex partners, and that white women with more than 12 years of education were most likely to have multiple partners than less educated white women. The study also found that younger African American/Black and Latina women were more likely than their older counterparts to have multiple partners, and that Latina married women and Latina women with more than 12 years of education were more likely than others to have an at-risk primary sexual partner, a finding which is reversed among white women. **In general, across all ethnic and age groups, women with an at-risk primary partner are the least likely to use condoms consistently.**

Many women are at pronounced HIV risk as a result of the sexual practices of their partners. The same urban women's study referred to in the preceding paragraphs found, for example, that 17% of women between the ages of 18 and 49 living in urban areas of California with no other risk factor report that they do not know their main partner's HIV risk status. Women who are primary partners of closeted gay or bisexual men are at especially high risk for HIV infection, particularly because they often have no indicators in their partner's behavior to suggest personal HIV risk.

The risk of HIV transmission to and by female prostitutes has been an ongoing concern, although studies are inconclusive as to how large a risk these populations face or represent. Certainly female rates are highest among sex workers who report a history of injection drug use. Recent data suggest that the risk of transmission to prostitutes in this country is more closely associated with drug use than with multiple sexual contacts (Chu, et. al., 1990). The section on Sex Industry Workers in this chapter describes more fully the scope of HIV risk among women who rely on prostitution to make ends meet economically.

Similarly, the Children's risk category section describes the increasing concern about in transmission of HIV from mother to infant, an issue which is receiving new prominence in light of recent findings suggesting the importance of AZT in preventing the rate of perinatal transmission to infants.

Finally, lesbians constitute a significant percentage of California's female population, although fewer studies are available on the prevalence of same-gender activity among women than there are concerning men. Specific activities that put lesbians at risk for HIV infection in California include injection drug use, rape or sexual assault by an HIV-infected male, and sexual activity with an HIV infected man. The relative risk of lesbian-to-lesbian HIV transmission through sexual activity remains a point of controversy, although the potential for HIV transmission between two women is acknowledged.

C) Barriers to HIV Prevention Within the Population

Women face extensive barriers to adequate and appropriate HIV prevention education throughout the state, due in large part to the fact that women are often presented with prevention messages that are slanted in terms of women's membership in a specific targeted HIV-related subgroup such as IDUs or prostitutes, rather than as members of a larger-scale risk group of their own. Many women in California are unaware of any potential personal risk of HIV infection they may face individually, for example, and, if they are aware of risk, their personal feelings of susceptibility are often expressed in terms of a fatalism that can serve as a barrier to taking adequate precautions against infection on a personal level.

The National Institute of Mental Health's summation of community-based HIV prevention and research programs (1994) particularly notes that programs that do not focus on altering social norms regarding safer behavior within communities, or that do not instill

personal motivations for making attitudinal and behavioral changes in both female and male partners will have significantly lower success rates than programs that do stress these aspects. In part, this is due to the power imbalances that exist between men and women in American society, imbalances which make it easier for women to maintain safer sex behavior when a male partner is supportive. Partner resistance, or a need for partner control, can act as a significant barrier to the maintenance of safe sexual behaviors for all women, especially within communities in which female assertiveness regarding sexual activities is regarded as a threat. Individual life circumstances or family situations that isolate women from the support of their communities and of other women can make the initiation and maintenance of safer behaviors an extremely daunting task.

Furthmore, woman-focused prevention education emphasizing condom usage and skills is continually complicated by the fact that it is not specifically women who wear condoms, but men. While women do need access to education concerning how to use condoms, they often do not themselves have the power to either compel or convince a male partner to wear one. Prevention messages that place the responsibility for assuring condom usage squarely on the shoulders of women can actually have the effect of creating conditions that lead to the physical and emotional abuse of women by male partners, and condom education campaigns must continually both take account of and present supportive referrals in the case of such situations. **In addition, because the results of two nationwide studies (Crime Victims Research and Treatment Center of the National Victim Center, 1992) indicate that 1.3 women are raped in the U.S. every minute, HIV prevention efforts for women must also consider the risk of HIV infection as a direct result of non-consentual sex.**

Because women frequently serve as the caregivers for all members of their family unit, and must perform multiple time-consuming tasks each day, it is also difficult to expect women to participate in supportive behavior change activities and programs that are not integrated with the circumstances of their daily lives, and with the specific social and cultural communities in which they live. Prevention activities that do not take into account the extent to which a woman's existing social networks and systems can be used or modified to support behavior change will frequently meet with failure in its attempts to promote long-term behavior change.

Outreach to female partners of injection drug users, as well as to women who use injection drugs, must be multi-dimensional and focused on the specific IDU community in order to be effective. The emphasis must be on supporting long-term behavior changes, particularly in the form of long-term drug treatment, and on helping to instill a strong sense of self-esteem, self-respect, and self-worth in women who are seeking to escape the difficulties in their lives through drug use, or who are unable to break away from partners who sexually threaten their lives.

A history of childhood sexual abuse may be another significant barrier to women adopting and maintaining HIV-related prevention measures. Within the U.S., one in three

girls are sexually assaulted before the age of 18 (Crime Victims Research and Treatment Center of the National Victim Center, 1992). Rosenfeld & Lewis (1993) list a range of personal tools needed to practice consistent HIV risk reduction behaviors, including a sense of personal power, trust in others, skills to negotiate safer sex, sense of self-worth, and ability to set limits and boundaries. These skills may be difficult for victims of childhood sexual abuse and sexual assault to enact and maintain. Rosenfeld & Lewis (1993) specifically note that outcomes of childhood abuse such as feeling depressed, feeling guilty, having difficulty in communicating and in trusting one's own personal perceptions, low self-esteem, and self-abusive behavior, are specific barriers to the adoption of self-protective HIV-related behaviors on the part of abused women.

The American Public Health Association (1991) notes that HIV-infected women are often misdiagnosed during the early stages of their disease, and that they lack adequate access to prevention and early intervention services to prevent more severe courses of HIV illness. Drug treatment access, family planning services, HIV prevention education, the continued development and promotion of barrier contraceptives, and the continued availability of voluntary HIV counseling are all key strategies that must be addressed by overcoming the barriers to appropriate and extensive availability of these services.

A lack of cultural appropriateness and an insensitivity to the moral and spiritual foundations of specific women's beliefs have doomed many prevention efforts for women from the outset, because these programs have not approached HIV/AIDS issues from an appropriate perspective, especially in the case of women of color. As with other target populations, the lack of peer-based support and prevention assistance -- in this case, women-to-women support and assistance -- is a further crucial hurdle that must be overcome if prevention outreach and services to women are to address the growing crisis of HIV infection within this diverse population.

SEASONAL/MIGRANT FARM WORKERS/AGRICULTURE-RELATED WORKERS

A) Introduction to the Population

The 1990 Census counted a total of 382,000 persons, or approximately 1% of California's population, working in the farming, forestry, and fishing industries combined, with no distinction made as to how many persons were working in each industry. However, 77% of all those working in the three industries (296,000 persons) are listed by the Census as being foreign born. Governor Pete Wilson's Farm Worker Services Coordinating Council reports that such figures substantially undercount the number of actual farm workers in the state of California (California Senate Office of Research, 1993). In 1993, for example, a group called Organization SIDA Tijuana estimated that there were between 10,000 and 12,000 homeless Latino migrant workers in San Diego County alone (Hispanic Medical Consultants, 1993).

The majority of migrant farm workers are male. Many of these workers arrive from Mexico and Central America as young single men who are at particular risk for HIV infection because they are unconstrained by family and by their home communities. A 1992-93 study of migrant farm workers in San Diego County found the age range of these workers to be between 15 and 69, with an average age of 28 years. The most frequently given age among respondents was 18, but many of those claiming to be 18 are believed to be much younger (Hispanic Medical Consultants, 1993). The community of seasonal/migrant farm workers and agriculture-related workers emobides a wide range of non-Latino ethnic and cultural backgrounds as well, particularly Asian/Pacific Islander nationalities.

The socioeconomic conditions of migrant farm worker life are generally bleak, and conditions for seasonal agricultural workers are not substantially better. Many farm workers and their families do not have even their most basic human needs met, and most camps in which migrant farm workers live lack safe running water or sanitation facilities (Hispanic Medical Consultants). Seasonal and agricultural workers of all types work long hours, often in inaccessible areas, and lack access to either transportation or to medical and social services. Low literacy levels are also believed to be prevalent among migrant farm worker populations.

B) Risk Behaviors of the Population

It is difficult to estimate the range or the nature of behaviors that may put seasonal/migrant farm workers and other agricultural workers at risk for HIV infection, because little information is available concerning these populations. In the same way, it is difficult to estimate the degree to which HIV seroprevalence affects specific farm-related communities. Seventy-one percent of the participants in a 1992-93 study of migrant farm workers in San Diego County agreed to undergo an HIV antibody test, and none tested positive for the AIDS virus. At the same time, HIV-positivity may have been disproportional among the 29% who declined testing (Hispanic Medical Consultants, 1993).

The key behavioral risk factor often cited for agricultural workers is sex with prostitutes. One 1991 Orange County survey described a situation in which heroin-addicted prostitutes and their procurers were regularly seeking undocumented Hispanic workers as customers. Informants reported that the female sex workers served as many of the men as possible, often in rapid sequence. Hispanic Medical Consultants (1993) reports that sex professionals from Tijuana often provide regular service to the migrant and seasonal farm worker camps, and that many migrant workers travel once or twice a season to Tijuana for the weekend, where they purchase sex. **In an Orange County study, only 26% of respondents reported that they had used a condom each time they had sex over the prior six months** (Hispanic Medical Consultants, 1993). And research has consistently shown that prostitution is most frequently undertaken without the use of a condom, with the most frequent reason given being that condom use, by its very nature, could somehow imply that one already had a sexually transmitted disease (Ibid.).

Male-to-male sex was found to be the primary HIV exposure category for men in Mexico and in Central America, areas from which the vast majority of California's migrant farm workers originate. However, this tells relatively little about the possible rate or degree of risk of unsafe sexual behavior between men in agricultural communities. As with incarceration settings, farm worker camps are predominately male, which may indicate higher levels of men having sex with men in these settings. Studies regarding such behaviors, however, simply do not exist.

> "This is a population that nobody wants to talk about--the neglected people. Not all migrant farm workers are *mojados* or wetbacks. These people are also infected with HIV. They have the same problems that people with HIV have in Los Angeles or San Francisco. The only difference is that we don't have the services."
>
> --member of the public, Fresno meeting

Finally, alcohol use has been reported to be widespread, and widely abused, among young male single farm workers (Hispanic Medical Consultants, 1993). The extent to which this exacerbates HIV exposure rates is not known, although alcohol consumption within all California communities is clearly linked to consistently higher levels of HIV risk-taking behavior.

C) Barriers to HIV Prevention Within the Population

Seasonal, migrant, and other farm workers are generally transient male employees who are a long way from their homes, and from the support of their families and their home communities. Working long hours, often in remote or inaccessible areas, farm worker populations are extremely difficult for HIV prevention outreach workers to reach, while the transient nature of their work makes it almost impossible for them to receive consistent support on even a short-term basis. And because farm worker populations have little access to transportation, they are not able to voluntarily access health or support services on their own, and frequently do not know what services are available to them in a given region, if any. These problems are similar for sex industry workers who serve these populations, who are also deprived of access to HIV-related treatment or prevention services, and who require specialized outreach and prevention in order to meet their specific support needs.

Language and literacy barriers place further roadblocks in the way of effective receipt and application of HIV prevention messages and support. The fact that many migrant populations originate from cultures in which open discussions of sexual behavior and sexuality are uncommon is a further complicating factor. The development of effective HIV prevention outreach and education for seasonal and migrant farm worker populations will no doubt need to accompany a broader awareness of and concern for the needs of these groups among the

California population before effective strategies for providing them with a comprehensive range of supportive services can be put in place.

PERSONS ENGAGING IN HETEROSEXUAL SEX

A) Introduction to the Population

The category of persons engaging in heterosexual sex is by far the largest single target group described in this report, encompassing between 85% and 95% of the total adult population of California over the age of 18. In terms of the state's 1990 Census population of approximately 24 million adult residents, this translates to a total of between 20.4 million and 22.8 million persons engaging in heterosexual sex, a figure that does not include young people under 18. The number of older adults who no longer participate in heterosexual sex because of age or illness is difficult to estimate, as are populations that do not engage in sexual activity due to other factors such as illness, personal preference, or religious commitment. The 3% to 6% of Californians who are exclusively same-sex in their behavior is accounted for through the sliding percentage estimate.

The sheer scope of the heterosexual sex population clearly cuts across all racial, cultural, economic, geographic, and demographic boundaries within the state. Heterosexual sex takes place both inside and outside of marriage and of primary relationships; involves single or multiple partners; can assume an infinite range of frequencies; and can take any number of forms in practice. In the great majority of cases, heterosexual sex also involves at least some degree of risk for exposure to the AIDS virus.

Known cases of AIDS in which heterosexual sex has been the single identifiable route of transmission account for 3% of all AIDS cases within the state of California, while many of those included in the 4% of Californians for whom exposure risk has been undetermined are thought to be heterosexuals. Even more disturbing is the fact that 6% of all AIDS cases among young adults aged 20-24 and 9% of all AIDS cases among adolescents 13-19 years of age are cases in which heterosexual sex is the sole transmission category. Among women, the rate of so-called 'heterosexual' transmission skyrockets to 37% of all AIDS cases in California -- the second largest risk category among women after injection drug use (California Department of Health Services, April, 1994).

Many of the target populations and communities described in this document that are at some risk for HIV exposure as a result of participation in heterosexual sex, in many cases because of simultaneous exposure to more than one risk behavior, such as in the case of injection drug users who practice unsafe sex. Among the heterosexual sex populations described in other sections of this document are the following:

- Substance Users and Their Sex Partners
- Sex Industry Workers

- Youth/Adolescents
- People of Color Communities
- Transgender/Transvestite Individuals
- Homeless/Transient Individuals
- Immigrants and Undocumented Persons
- Women and Their Sex Partners
- Seasonal/Migrant Farm Workers/Agriculture-Related Workers
- People in Group Living Situations
- The Disabled Community

For all of these groups, a variety of factors make heterosexual sex risky or more likely to occur. The range of groups also emphasizes the extent to which heterosexual sex is a potential HIV-risk behavior for every category of Californian, regardless of cultural affiliation or economic background.

B) Risk Behaviors of the Population

Existing research has not yet resolved what is perhaps the central question in heterosexual sex transmission, namely, whether the risk of HIV infection is greater during intercourse for an unprotected receptive female partner of a male, or whether the risk is roughly equal for both partners. Some researchers have suggested that the relative transmission risk during heterosexual intercourse depends more upon a combination of factors, rather than upon whether a partner is receptive or penetrative. Specific physical conditions such as malnutrition or illness, or abraded skin or open sores, may be more important as determining factors than whether a partner is receptive during intercourse.

> "I was a housewife. My husband was tested in 1987 and he was told that he was infected [with HIV]. I was then negative. Because of the confidentiality law, they were not able to tell me, and because of his lack of ability to confront the issue, he did not tell we as well. So when I was diagnosed, I did not have the luxury of having HIV. I was told I had full-blown AIDS."
> --member of the public, Fresno meeting

But whatever the relative role of specific risk factors may be, there is general agreement that the number of different partners an individual takes can markedly increase his or her risk of encountering an infected partner, and that the type of sexual activity engaged in can influence the degree of HIV risk exposure within a specific sexual encounter. Condom use during intercourse remains the single most effective means of preventing transmission of the AIDS virus during heterosexual sexual activity, but using condoms every time is practiced by only a small minority of heterosexual sex partners who are not exclusively involved in a primary relationship. Some HIV education specialists have noted that it is believed by many

in the field that while heterosexual sex participants "negotiate condom use more, they use condoms less."

It is as yet unclear what impact the release of the so-called 'female condom' will have on the use of barrier contraceptives in heterosexual sex. The female condom is already thought by many to be a somewhat awkward and cumbersome device for females to use to prevent pregnancy and STDs. Many of the individuals who participated in the prevention planning process have speculated that the overall impact of the female condom will not be substantial, since utilization of the device will still generally require negotiation and consent from a male partner, a factor which has been and remains the key factor in preventing universal condom use among partners.

C) Barriers to HIV Prevention Within the Population

Most HIV prevention specialists continue to believe that targeting specific risk communities within the larger community of heterosexual sex participants -- including people of color, women, injection drug users, young people, and others -- will remain an infinitely more effective and efficient means of providing HIV prevention outreach than will large-scale media or public information campaigns aimed solely at the overall heterosexual population. At the same time, mass media public education efforts aimed at persons engaging in heterosexual sex remain a crucial means of raising general awareness of the HIV infection issue, particularly to the extent that this awareness motivates individuals to question their personal or familial level of HIV risk, and to seek out testing and prevention support options in their community. Public education campaigns can also enhance service involvement, offering individuals opportunities to become involved in community HIV prevention efforts through volunteerism.

In the final analysis, the greatest barrier to prevention education among these groups may lie in what is also the state's greatest strength: namely, the diversity and complexity of its vast population. It is simply not feasible to target the entire heterosexual sex population in a manner that will have a significant impact on the level of risk behavior of individuals, but it is equally important that providers not forget the fact that heterosexual sex participants represent a group that is at risk for HIV infection. A balancing of awareness of heterosexual sex risk with the need for focused, individualized HIV prevention intervention will remain the key means for assuring appropriate, effective prevention outreach to this target population.

PEOPLE IN GROUP LIVING SITUATIONS

A) Introduction to the Population

In general, the category of group living situations refers to institutionalized settings in which individuals live together in non-household units. A group of individuals sharing rent in an apartment, or college students living together in a dorm would not qualify as people in

group living situations within this category. However, individuals living together in a military barracks, court-ordered residents of a halfway house for parolees, or recovering drug users living in transitional housing do fit the definition of group living situations for purposes of this component.

Many group living situations overlap with settings described in other categories of this section. Among these are correctional institutions, described in the People in the Criminal Justice System section, and emergency shelters for homeless persons, described in the Homeless/Transient Individuals category. **For purposes of this section, we will refer specifically to non-correctional and non-homeless-related categories of group living situations such as nursing homes, mental hospitals, military quarters, halfway houses, and a variety of non-correctional institutional group settings.**

According to the 1990 U.S. Census, a total of 145,539 Californians currently live in nursing homes; another 9,734 individuals are permanent or long-term residents of state mental hospitals; and 116,865 persons are housed in group military quarters. Several categories recorded by the Census, such as "other institutions" (22,876 residents) and "other noninstitutional group quarters" (87,703 residents) also include non-incarcerated, non-homeless populations, particularly in the latter category. We have estimated for purposes of this report that approximately 50,000 combined individuals from the two above categories fit the present definition. **This results in a total estimated population of 322,138 Californians living in group situations, or nearly 1.3% of the state's total population.**

In addition, California, through the San Diego Naval Hospital, is also one of three sites in the country designated to provide monitoring and follow-up care for HIV-positive active duty personnel enlisted in either the Navy or the Marines. These individuals are offered the choice between San Diego, California; Bethesda, Maryland; and Pearl Harbor, Hawaii to relocate themselves and their family members within 200 miles of the base. These individuals and families often require HIV education, prevention, and support services from both civilian and community-based organizations. (The San Diego site also houses 20% of all U.S. Navy vessels and 20% of all enlisted U.S. Marines.)

B) Risk Behaviors of the Population

Very little information is available concerning the HIV-related risk behaviors of group living populations, although it is known that the extent and nature of risk behaviors almost certainly varies widely from setting to setting. The extent of unprotected heterosexual sex that takes place in a military barracks versus a nursing home will of course differ radically. Conversely, however, it would be imprudent and unfounded to make assumptions about risk behavior based solely on factors such as age, setting, or gender.

The lack of specific information concerning the risk-related behaviors of group living residents points to the need to address the problem of researching and describing the

composition and HIV risk levels of group living populations in greater detail. However, the degree of attention must be determined by the nature of the population that calls the group residency home. While a relatively large number of HIV prevention researchers and providers are addressing the needs of substance users, for example, many of whom live in residential facilities, much less attention is being paid to the HIV-related prevention needs of nursing home or psychiatric hospital residents

There is strong reason to believe, however, that group living residents do face a complex plethora of risk behaviors that in many cases may not be addressed at the present time. The degree of sexual risk of psychiatric hospital residents, for example, is simply not known, and may constitute a threat to health which is going unaddressed. Other individuals in group living situations may face many sexual and substance-related options that place them in jeopardy, but without corresponding educational and preventative interventions.

C) Barriers to HIV Prevention Within the Population

The problem of finding additional information concerning group living residents is complicated by the fact that many of these residences are institutional settings, in which the information presented to residents is controlled by an agency or a government body. The U.S. military, for example, maintains strict controls over both the nature and amounts of information it presents to service men and service women in relation to HIV risk factors, although recent internal crises around gender and sexual orientation discrimination may have raised awareness. In the same way, residents of mental hospitals are restricted from receiving certain kinds of information or interventions - often with good reason - and these facilities may not be amicable to the idea of HIV prevention providers intervening on behalf of their patients.

Residents of group living situations, however, are frequently individuals who must be reached with highly specialized interventions, which will generally require careful and comprehensive integration with interventions and protocols designed and practiced by the specific institution in which group residents are housed. Group living residents, for this reason, present challenges to HIV prevention specialists, for they require interventions which both fulfill complex and specific needs, and which require integration with already-complex systems of control and education in heavily regulated settings.

THE DISABLED COMMUNITY

A Introduction to the Population

Just as the complexity and productivity of California depend to a large extent upon the diversity of its ethnically and sexually identified populations, so too does the state rely on the contributions of its disabled communities to give the state a large measure of its character and value. Disabled communities, while facing and overcoming their unique and diverse challenges, teach us important lessons about self-reliance, independence, and the primacy of

those internal qualities of intellect, spirit, and courage that define the true worth of an individual, and the quality of his or her contribution to the community. It is vital that we continue the work we have begun to both recognize and empower disabled women and men to become ever more integrated into every aspect of California life.

Although no comprehensive estimate of the number of disabled individuals living in the state has been produced, our awareness of several subgroups within the disabled a community has expanded significantly in recent years, due largely to the passage of the Americans With Disabilities Act. According to the 1990 U.S. Census, estimates of the number of Californians with either work disabilities and mobility and/or self-care limitations (only two of many possible categories of disabled persons) are as follows:

Exhibit 3.5
Persons with Disabilities in California

Age Group	Work Disability		Mobility And/Or Self-Care Limitation	
	Number of Individuals	Percentage of Age Group	Number of Individuals	Percentage of Age Group
16-64	1,441,215	8%	933,708	5%
Over 65	932,593	31%	567,332	19%

Source: 1990 U.S. Census

In addition, the conditions listed on the following chart were reported as being a primary cause of physical, ADL, or IADL limitations among persons 15 and over in the U.S. from 1991 to 1992. We have translated these percentages into a percentage of California's 1990 Census population in order to estimate a possible number of individuals in each group currently living in the state of California.

Exhibit 3.6
Persons with Specific Types of Disabilities

Name of Condition	National Percentage	Projected # In California
Blindness or Vision Problems	3.5%	1,050,000
Deafness or Hearing Impairment	2.6%	780,000
Mental or Emotional Disorder	1.9%	570,000
Metal Retardation	1.2%	360,000
Missing Limb, Paralysis, or Head or Spinal Cord Injury	3.8%	1,140,000

Source: US Dept. of Commerce, Household Economic Studies, December, 1993

The combined tables above offer an projected estimate of over 6.3 million Californians, or over 20% of the state's population who are living with some condition that places them in the category of disabled persons. However, this estimate cannot be considered reliable for a number of reasons. The totals do not take into account, for example, overlap between the populations of individuals living with mobility care restrictions and those with physical, ADL, or IADL limitations. Nor do they take into account the wide range of sight problems for those in the "Blindness or Vision Problems" category -- for many of these individuals, such limitations may not be significant, and/or may not play a role in daily life. Finally, they do not include persons with hemophilia, who have been devastated by the HIV/AIDS epidemic in California, and whose specific situation is described in greater detail in the section below. These figures do, however, in spite of their limitations, provide an insight into the scope and magnitude of the disabled population in California, and indicate the diversity of physical and emotional conditions which alter the degree to which these individuals' experience of day-to-day life is made more challenging.

Just as little is known about the precise scale of the California disabled population, however, so is our understanding limited concerning the extent of HIV infection within and among the various disabled populations living in California. One study conducted in 1987 of developmentally disabled persons in 44 U.S. states identified a total of 45 individuals who were HIV-positive, approximately 41% of whom were symptomatic -- overall, a total that suggests a very low HIV-incidence within this population. However, a duplicate study of the same population conducted in 1989-90 identified 98 HIV-positive developmentally disabled persons, reflecting a doubling of the HIV infection rate among this population in only 22 months. While the absolute number of HIV-positive persons among the developmentally

disabled may still be small, this rate of increase suggests a risk for infection faced by these individuals (Crocker, Cohen, & Kastner, 1992).

B) Risk Behaviors of the Population

Anecdotal evidence concerning developmentally disabled-communities indicates that members of these communities are at significant risk through both consensual and coerced sexual relations, especially within congregate living situations. It is believed that a large number of developmentally disabled persons are taken advantage of sexually by non-developmentally disabled youth and adults, although little specific data exist to document the scope of this phenomenon.

The risk of abuse of people with disabilities appears to be at least one and one-half times higher than the risk for non-disabled people of similar age or gender. Girls and women with disabilities are more often sexually abused than boys and men with disabilities, although males living in institutions may be at increased risk. (Sobsey, 1994)

Studies of sexual abuse perpetrated against victims who have developmental disabilities in particular suggest an increased risk for HIV exposure through unprotected sex. "...it is likely that 15,000 - 90,000 people with developmental disabilities are raped each year in the US. Along." (Sobsey, 1994) Sobsey and Doe (1991) and Sullivan and colleagues (1991) found multiple incidence of sexual abuse among 79.6% and 82.6% of study participants respectively. A California study found that out of a sample of 95 people with developmental disabilities, 83% of the women and 32% of the men had been sexually assaulted. Another study found strong evidence of sexual assault in about half of the cohort of 35 women with mental retardation living in a single residence.

A study of adults with learning disabilities found that vaginal or anal penetration occurred or was attempted in 67% of the cases. Sobsey and Doe's most current information indicates penetration in 62% of cases involving victims with developmental disabilities. (1994).

A special risk is also indicated for deaf gay and bisexual men, who may have difficulty communicating or negotiating with non-deaf sexual partners, or who may feel unable to express their needs in regard to risk-preventive behavior with non-signing sex partners.

> "Mike was a mildly retarded. He could not read nor write. Mike would not tell you if he understood what you were telling him, because he was a strong-willed and opinionated man. I attempted to educate him about AIDS; however, he refused to believe that it would eventually take his life. One of the saddest moments was on a day that he felt good. He said 'See, I'm cured. I don't have AIDS anymore.'"
>
> --member of the public, Fresno meeting

The California disabled population that has been perhaps the most thoroughly devastated by the HIV/AIDS epidemic thus far has been the population of individuals living with hemophilia. Hemophilia is a congenital blood clotting disorder that affects about 20,000 Americans, and an estimated 2,000 Californians at the present time, according to the California Hemophilia Council. A person with hemophilia has either an inadequate or inactive supply of one of several factors needed for blood to clot normally, a condition which results in periodic internal bleeding, with or without cause. Often, internal bleeding among persons with hemophilia or other clotting disorders results in arthritis or crippling, and people with clotting disorders require treatment throughout their lives.

An estimated 50% of persons with hemophilia in the state of California are currently living with the AIDS virus. During the mid-1980's, just after the time when introduction of the HIV antibody test allowed contaminated blood supplies to be largely eliminated, this percentage may have been as high as 75%. The Hemophilia Foundation of Northern California notes that while some sources contend that there have been no documented cases of HIV infection the U.S. through blood products since 1984, many blood banks are believed to still not be using adequate precautions to protect the blood supply on which persons with hemophilia depend. More disturbingly, a recent U.S. Food and Drug Administration (FDA) report stated that between 1987 and 1993, roughly 300 new cases of HIV transmission through whole blood transfusion were reported in the U.S., an extremely high number if all of these individuals were infected with HIV prior to 1984 alone. According to the CDC, the highest proportional increase in AIDS case reporting in 1993 as a result of the revised definition of AIDS occured among persons with hemophilia (Morbidity and Mortality Weekly Report, March 11, 1994).

C) Barriers to HIV Prevention Within the Population

As with many other groups in the state, the lack of information concerning the disabled community is the key barrier to effective and comprehensive HIV prevention efforts on their behalf. Even with more extensive research that unifies disabled populations under one rubric in terms of determining their HIV infection risk, the extent of HIV infection among them may never be known. Crocker, Cohen, & Kastner (1992) note that disabled communities are served by different components in the social service system in a fragmented fashion, and that services may never be unified effectively under current bureaucratic frameworks. This situation closely parallels the barriers that keep HIV prevention efforts from effectively reaching persons in the criminal justice system and persons in group living situations.

The lack of appropriate HIV prevention materials in Braille for the blind, and the paucity of prevention presentations in American Sign Language for the deaf, have been cited as key barriers throughout the state. There is also a need for effective outreach to those who cannot access service providers because of physical mobility limitations. Perhaps most urgently, appropriate and adequate prevention education and communication and assertiveness

skills training is needed for the developmentally disabled, including the mentally retarded, in order both to educate and protect them from the dangers inherent in unsafe behaviors, and from the emotional and sexual exploitation by others to which they are particularly vulnerable.

PEOPLE WHO PIERCE AND TATTOO

A) Introduction to the Population

The growing popularity of piercing and tattooing in California, particularly among the urban young, is a well-documented phenomenon. Mass media outlets regularly report on the trend, and key informants throughout the state have attested to the popularity of piercing and tattooing in high schools and junior high schools, in colleges, and in urban centers among persons of all ages. No special statistics exist to document the claim for the rise in these practices, but the phenomenon is observable throughout the state, and goes far beyond the previously common practice of ear piercing to include piercing many other body areas and body parts. Both visible and non-visible tattooing for women and men has significantly increased in popularity over the past five years.

B) Risk Behaviors of the Population

Fears of HIV infection through piercing and tattooing extend to two distinct categories of activity: a) piercing and tattooing that takes place in non-regulated, non-controlled, or non-sanitary facilities or businesses, usually on a payment basis; and b) tattooing or piercing that takes place within private homes or residences, usually on a non-payment basis. In both instances, HIV transmission risk stems from the possibility of direct blood exchange through unsanitized or shared needles or other piercing equipment, or though the use of unclean or home tattooing equipment.

The practice of home-based tattooing is considered a special risk for young people who participate in gang or gang-related activities. Covering the skin with gang markings applied by other gang members is common, and is absolutely not controlled for the prevention of infection or the possible transmission of HIV. As more and more young people of all economic levels engage in piercing, the fear is that unsafe sharing of piercing implements such as safety pins, sewing needles, paper clips, and other objects will lead to the possibility of multiple HIV infections.

C) Barriers to HIV Prevention Within the Population

The key barriers to safe piercing and tattooing is the lack of governmental regulation of for-profit tattooing and piercing establishments, and education and information to prevent unsafe home-based and gang-based piercing and tattooing. Both the Association of Professional Tattooists and the Association of Professional Piercers promote the use of the

same Universal Precautions used by the American Dental Association. A bill currently under consideration in the California State Legislature would require health departments to regulate piercing and tattooing in their counties, including ear piercing, and to enforce cleanliness and hygiene standards to prevent the transmission of HIV virus, among other conditions, through unclean equipment or workplace conditions. Barriers to education for those engaging in home-based piercing and tattooing include a lack of awareness of the seriousness of the issue for California, and a lack of knowledge concerning those populations who are most at risk for such behavior.

CHILDREN

A) Introduction to the Population

According to the 1990 U.S. Census, there are currently 5,455,867 children between the ages of 0 and 11 living in the state of California. This represents a total of over 18% of the state's total population, and is a figure which is growing disproportionately to the rest of the state's permanent residents. There were 359 cases of AIDS among children aged 0 to 13 in California as of early 1994, and the numbers continue to increase on a quarterly basis. Fully 67% of all pediatric AIDS cases in California occur among children of color.

The children of California are disproprotionately impacted by poverty. Nineteen percent of all California's children live below the poverty line, versus 12% of the State's population as a whole. However, contrary to popular myth, children in the state are not disproportionately represented among communities of color. Forty-six percent of California's children are reported by the Census Bureau to be white; 8% are African American/Black; 10% are Asian/Pacific Islander; 1% are Native American; 35% are Latino; and less than 1% belong to other ethnic or cultural categories.

> "We need to include education that deals with compassion for those who are sick and dying. Populations are rolling into our schools who are coming from families that have [HIV] tearing them apart. We've got to deal with children who have grief and children who are not understanding what's happening to their lives."
> --member of the public, Long Beach meeting

B) Risk Behaviors of the Population

The risk factors that may expose children between 0 and 11 to HIV occur along the continuum of age ranges within this group. Infants are at risk of HIV infection through in utero transmission via an infected mother, since the AIDS virus can in many cases (the percentage is estimated to be 25%) can be passed on to an unborn child in the womb. Many infant HIV cases take place disproportionately among injection drug using populations, and

among populations living in extreme poverty. In addition, because the incubation period leading up to viral antibody production can last between three and four years, the serostatus of infants of infected mothers is often not known for several years, with the child requiring continual surveillance for the virus over that time.

At the other end of the age spectrum, many children are engaging in sexual activities that put them at risk for HIV exposure well before the age of 12. **More than 15% of children under the age of 13 have engaged in sexual intercourse,** according to one study (Durbin, et. al., 1993). The same study also revealed that young people whose first sexual activity occurred before age 13 were nine times more likely to report three or more sexual partners compared with those whose first sexual intercourse occurred at age 15 or 16. **The majority of young people who begin engaging in sexual intercourse before the age of 18 do not use condoms during sexual activity.**

Finally, a significant number of children along the 0-11 continuum are at risk of HIV transmission and infection as a result of childhood sexual abuse or assault. The Crime Victim Research and Treatment Center of the National Victim Center (1993) reports that one in every three girls and one in every six boys are sexually assaulted by the age of 18, and that of these, 29% of all rapes occur when the victim is less than 11 years old, and 32% occur when the victim is between the ages of 11 and 17. This means that approximately one in nine girls and one in eighteen boys will have been molested by the age of 11, creating a potential risk of HIV infection either directly through sexual contact or indirectly due to factors outlined previously in the section on Women.

Currently, the CDC does not include sexual abuse as a separate risk factor for AIDS reporting, but the February 1993 CDC surveillance report lists 208 children under the age of 13 who have been infected with HIV through sex, 109 through sex with an IDU, and an additional 187 AIDS-diagnosed children under 13 whose risk category was not specified. According to Annunziato & Frenkel (1993) the number of documented cases of HIV infection of children through sexual abuse are believed to be "erroneously low," with one pediatric AIDS center reporting that 14 of their 96 patients were confirmed victims of sexual abuse, and with a confirmation that at least four cases of HIV transmission in these pediatric cases occured directly through sexual abuse.

C) Barriers to HIV Prevention Within the Population

In terms of in utero HIV transmission, a key barrier to preventing infant HIV may be the lack of incentives or systems for encouraging women at risk to undergo HIV antibody testing either prior to or during their pregnancy. The issue has recently been given urgent meaning by the research findings that indicate that the drug AZT may be effective in preventing in utero HIV transmission in up to 60% of all infected women. The fact that a specific drug therapy intervention now exists to curb or curtail the chances for in utero infection will no doubt give impetus to efforts to design protocols which encourage HIV

testing and counseling for HIV positive women who are pregnant, or who are considering becoming pregnant. More research, however, is needed to accurately assess the effect of AZT exposure in infants. There is concern that AZT may result in a slowing of the developmental stages of children exposed to it inutero.

Clearly, many of the same boundaries facing those who would strive to provide effective HIV prevention for adolescents as exist for those who provide prevention to sexually active children. In the case of children, however, the issues related to school-based and non-school-based prevention become even more controversial, and the populations become more difficult to confront in the same manner as one would confront young people in their teens. Separate interventions and approaches may be needed to instill safe behavior lessons in pre-teen youth, but such messages must be integrated with other health and lifestyle-related messages. These issues are at the very border of what this country has shown itself willing to tolerate in terms of confronting issues of sexuality as a result of HIV, and those who address such issues are aware of the controversy and even hostility that their efforts engender.

CHAPTER 4: PREVENTION STRATEGIES AND INTERVENTIONS

INTRODUCTION TO STRATEGIES AND INTERVENTIONS

The following section provides a general survey, review, and summary of the relevant existing literature related to the principal HIV/AIDS prevention strategies proposed within the present document. The review seeks to provide a concise analysis of what is currently known about the effectiveness of specific HIV prevention strategies. The section also offers a comprehensive overview of the principal strands in HIV prevention theory, incorporating as much as possible the practical experiences and lessons learned by prevention outreach workers and program specialists who have been active in the field for many years.

This review places particular emphasis on two crucial aspects of HIV prevention interventions, by offering, first, a thorough description of the nature, content, and purpose of each specific intervention described, and, second, by providing an assessment of the effectiveness of each intervention strategy. Among the elements contained in the description sections are the following:

- A general overview of the intervention's components;
- A discussion of the documented and/or perceived need for the strategy, as defined by the target population wherever possible;
- A discussion of the values, norms, and consumer preferences related to the strategy; and
- An overview of applicable scientific theory related to the intervention, most notably focusing on three key questions: 1) Does the strategy occur over time?; 2) Does the strategy involve the participation of target audience members, such as through discussion or question and answer response?; and 3) Does the strategy focus on behavior change as an outcome?

Each of the above topics is explained in varying degrees of detail and length, based upon the amount of relevant information available at the time of this writing.

The sections on effectiveness deal with the quality of each strategy's usefulness from two perspectives: 1) from the perspective of outcome effectiveness, which assesses what a given intervention accomplishes; how well it accomplishes it; and how often it accomplishes it; and 2) from the perspective of cost effectiveness, which compares the scope, quality, or frequency of a given strategy's outcomes with what it costs to carry out that specific intervention for the target population. Whenever possible, we attempt to take into account

cost-effectiveness as the cost per number of infections averted; however, we found little information regarding this.

For many of the strategies discussed in this section, no specific literature or documented information was found. Such a lack of information was not unexpected. Much of the existing literature consists of behavioral studies that focus on the risk behaviors and behavior changes of specific groups over time. These studies often do not specifically examine either the outcome or cost effectiveness of the specific interventions used to address these groups, and frequently do not even present a basic description of the specific prevention strategy used for the target group.

In addition, many studies assume that people are exposed to multiple interventions either simultaneously or over time, particularly in the case of individuals engaging in high-risk behaviors who may be receiving outreach, testing, and individual and group interventions concurrently. This keeps many studies from examining the effects of any one exclusive intervention on most target populations. In fact, many researchers, and most providers, believe that a range of different strategies, executed either sequentially over time or concurrently , are more effective than a single strategy.

Of the relatively small number of studies that do specifically examine the effects of a given strategy or strategies, many examine the differences in approach between one version of a strategy and another, but do not compare the effectiveness of one whole category of intervention with another. For example, several studies explore the amount of behavior change resultant from two types of group presentations, but few, if any, discuss the effects of group presentations versus outreach as an effective HIV prevention approach.

We found few attempts to evaluate the effectiveness of a given type of strategy as a whole. Most articles discussing effectiveness examined a particular intervention as it occurred with a specific group, but did not deal with the larger question of how effective the strategy itself might be with a larger population or target audience. Two strategies stand as notable exceptions to this: 1) counseling and testing (C&T); and 2) needle exchange programs (NEP). These two strategies have historically been the subject of intense debate, and that debate has resulted in a careful look at both of these strategies' effectiveness.

Even within one type of strategy, variations exist, and these variations almost certainly affect the outcome of a given intervention to some degree. One such variation is the degree of cultural competency of the prevention providers for a given intervention; another is the flexibility or lack of flexibility of a given strategy's approach to fitting in with consumer preferences.

This literature review indicates that the need for HIV prevention services in the U.S. has opened a public discussion of a number of subjects that have previously been considered taboo. Amid the public and political controversy around HIV intervention, new terms of

discourse have been invented, and new mainstream organizations have developed an openness in the discussion of these topics. There are, however, many populations at risk that do not share the values, understandings, and vocabulary of the mainstream; and there are many populations at risk within which it is still a very difficult and sensitive matter to discuss sexual behavior and/or injection drug use. A review of the literature makes it eminently clear that all prevention strategies, if they are to be effective, must be culturally, socially, and linguistically appropriate to the target populations they propose to serve if they are to be effective in achieving their stated objectives.

PROGRAM CATEGORY #1: HIV ANTIBODY TESTING AND COUNSELING

1. Description

HIV counseling, testing, referral, and partner notification (CTRPN) provides opportunities for individuals to learn their serostatus and to receive prevention counseling and referral to other preventive, medical, and social services. There are two types of testing:

- **Anonymous testing** involves a testing procedure for which the client or patient is identified only by a number or code. Individual or small group presentations are followed by testing, and later, when results are given, by counseling and referral ; and

- **Confidential testing** involves a testing procedure for which the client or patient is identified by name but the results are only available to the individual testing and those who provide care for that person. Individual information and orientation is given in the context of a clinical exam, followed by testing, and later, when results are given, counseling and referral services are provided.

For both confidential and anonymous testing, publicly funded sites in California are required to provide individual pre- and post-test counseling sessions, which may be supplemented through a video or group presentation but may not be replaced by such a presentation. Anonymous and confidential testing are provided through a number of settings including:

- **Mobile** - Using a mobile test site, such as a van or portable exam room, individual information presentations are followed by testing, and later, when results are given, individual counseling and referral;

- **Off-site** - testing takes place outside of a clinical setting such as in a park, on the street, in a motel room, bathhouse, et cetera;

- **Free standing test sites** -- testing is offered through a separate program which offers HIV testing and perhaps other related services. Clients come to these sites specifically seeking HIV counseling and testing services;

- **Other clinical settings** - testing is offered as a part of other clinical services such as sexually transmitted disease, tuberculosis, family planning, or prenatal services. Clients come to these sites seeking the primary service and are offered HIV counseling and testing as an option; these sites may be part of clinical services of a drug treatment program or primary physician office.

The **referral** component refers to the individual information provided before or after anonymous, or confidential testing for both HIV negative and HIV positive individuals.

Other components of the testing strategy include **partner notification,** which can use any of three methods:

- Notification of parents of infants, and referrals. Notification is a traditional control intervention used in fighting sexually transmitted diseases (STDs) in which public health officials take responsibility for locating and notifying the sexual partners of people who have tested positive for HIV;

- Self-referral which involves the person testing positive notifying their partners and referring them in for counseling and testing; and

- Contact referral which involves the patient taking primary responsibility for contacting partners and the public health worker contacting those the patient is not able or does not want to contact.

Consumer preferences for testing vary among populations and regions. In many areas, counseling and testing programs are inadequate in meeting the cultural and linguistic needs of potential users. Knowledge of the availability of testing, the degree to which individuals are able to access the service, and the usefulness of the service in initiating behavior change should be considered for each population.

In one study of urban adults in four cities (Berrios, et. al., 1992), African American/Blacks were significantly less likely than whites to be aware of "a blood test that can detect the AIDS virus infection" (58% vs. 77%), but African American/Blacks who knew of the test were more likely than whites to have been tested (47% vs. 37%). Only 11% of study subjects reported a major risk factor for HIV infection, and of those, HIV testing was most common among homosexually active men; intermediate among IDUs; and least common among the sexual partners of IDUs. This suggests that programs promoting HIV testing and providing pre and post-test counseling have been comparatively successful in reaching the gay/bisexual community. This finding is mitigated by the fact that a significant proportion of those who reported a risk factor were homosexual men. Other information gathered from test sites indicate that gay men at highest risk and large numbers of bisexual men are not testing.

Scientific theory supports the belief that screening has little point unless there are follow-up activities to reduce the continued spread of the virus. What is needed to accomplish this, in turn, is a coherent description of policy alternatives (Nahmias & Feinstein, 1990). A good testing program will focus on behavior change; will involve an individual in discussion; and will link that individual to follow-up activities. Thus, it fulfills the basic elements of theory, but is limited in the extent to which it can go beyond the basics. Nonetheless, according to the Institute for Health Policy Studies (1993), "Extending counseling and education interventions appear to provide substantial benefits in most settings."

2. Effectiveness

A. Outcome Effectiveness

The effectiveness of HIV counseling and testing of behavior change has been examined for several populations, mainly to inform the debate about the value of public and privately-supported wide-scale testing programs. Higgins, et. al. (1991) compiled and compared a group of studies, and her findings are presented here. **The findings support the assertion that while HIV counseling and testing programs are important, they should not necessarily be the center of HIV prevention efforts (e.g., Coates & Stryker, 1991).**

The central question pertains to the usefulness of HIV testing in initiating safer sexual and needle-related behaviors. One study (Stall, Coates, & Hoff, 1988) found that neither, "...receiving advice from a physician about AIDS, testing for HIV antibodies, nor counseling at an alternative test site was associated with participation in safe sex."

For gay and bisexual men, changes in risk-taking behavior as a result of the test were similar for those aware and those unaware of their antibody status, suggesting that behavior change was not a direct result of testing. Although there were significant declines in risky sexual behavior, there was found no association between risk reduction and knowledge of serostatus or actual serostatus. On the other hand, some studies showed that seropositive men made greater reductions in risk behavior than either seronegative men or men unaware of their serostatus, suggesting that, **for gay and bisexual men, learning that one is HIV-positive may have an impact on behavior.** It is difficult to draw firm conclusions about the impact of HIV testing on risk behavior through the actions of this group (Higgins, et. al., 1991).

Four of ten studies conducted on injection drug users (IDUs) showed no significant differences between groups aware and unaware of their HIV antibody status with regard to needle hygiene, frequency of using a needle exchange program, or sexual risk reduction. Two of 10 studies with comparison groups reported improved needle hygiene behavior regardless of serostatus. **Several studies show improvement in needle use behaviors and reduction in sexual risk taking behavior among IDUs receiving counseling and testing within the context of a drug treatment program.** Such behavior changes, however, were not dependent upon learning one's own HIV serostatus (Higgins, et. al., 1991).

In the case of women who learn of their HIV status while pregnant, studies suggest that HIV testing and counseling does not have an impact on the decision to terminate pregnancy, and **all studies that include pregnancy data suggest that counseling and testing does not have a significant impact on this individual variable**. However, among female sex industry workers, **a study of prostitutes showed an increase in condom use and reduction in participation in anal sex following the receip· of HIV counseling and testing** (Higgins, et. al., 1991).

Among other individuals who engage in heterosexual sex, **studies of HIV-discordant couples** (couples in which one partner is HIV-positive and the other is HIV-negative) **uniformly show that HIV counseling and testing interventions were all followed by reductions in unprotected sex, and by increases in condom use and safer sex behavior** at six-monthly follow-up. **One study of STD clinic users indicated no meaningful difference in the risk taking behavior or those tested and those not tested** following the testing experience. Variations in these studies make them extremely difficult to categorize or to compare, however, and results overall are decidedly mixed (Higgins, et. al., 1991).

Most of the studies cited in Higgins report do not examine the effect of counseling but rather examine the effect of HIV testing or knowledge of serostatus. Many of the studies make no reference to whether the individuals received any counseling or if they did to what extent. A more thorough examination of the studies cited reveal that even those studies that did provide counseling vary from viewing a video to a didactic lecture format to extensive counseling. When studies are viewed in this context, it appears that when HIV counseling and testing affects behavior change it is because it is provided in a manner consistent with the recommendations provided by the Centers for Disease Control on "appropriate" counseling.

B. Cost Effectiveness

One analysis conducted by David Holtgrave (1993), which utilized standard methods for cost-benefit analysis from a societal perspective (as opposed to a client or other viewpoint) found a benefit-cost ratio in HIV antibody testing of 20.09. This finding was based on several major assumptions used in the base-case analysis, including: 1) the assumption that without public funding, counseling, testing, referral, and partner notification (CTRPN) programs would not be provided; 2) the assumption that for every 100 HIV-seropositive persons identified and reached by CTRPN services, at least 20 new HIV infections are averted; and 3) the assumption that for every $100 spent of direct and indirect costs of CTRPN services, an additional $60 is spent on the ancillary costs of alerting people to HIV issues and to CTRPN availability. Additional benefits due to CTRPN services were ignored for the sake of model simplicity, such as the role of CTRPN in protecting the nation's blood supply; delayed morbidity and mortality due to early intervention; and the likelihood that HIV counseling provides an overall net reduction in risk for those who are found to be negative.

Sensitivity analysis showed that the benefit-cost ratio is greater than 1 for all considered cases. Such analysis indicated, for example, that it is important for persons who test negative to continue to be thoroughly counseled about HIV risk reduction and about maintenance of low-risk behavior. **Holtgrave's analysis strongly suggests that publicly funded CTRPN services result in a net economic gain to society**. However, other research is necessary in order to determine whether, and to what degree, knowledge of HIV-negative serostatus may result in a small, net increase in risky behavior, as has been suggested by some investigators.

Another study (Nahmias & Feinstein, 1990), which, like the above, suggests that counseling and testing is only effective for individuals engaging in high-risk behaviors who change behaviors as a result of testing, arrives at a different conclusion. When looking at the cost-effectiveness of screening the general population for HIV, the study found that the cost of detection varies inversely with the prevalence rate, and that the exact relationship is hyperbolic. For example, when the prevalence rate is one in 20, the cost per detected case is approximately $750; when the prevalence rate is one in ten the cost is approximately $400; and when the prevalence rate is one in four, the cost is approximately $200. A program in Illinois that mandated prenuptial HIV screening, for example, detected 26 cases of HIV infection out of 155,458 total persons tested. The cost of detecting a single HIV infection in this population was thus at least $208,000. **Screening programs applied to persons engaging in high-risk activities would be more likely to be cost-effective.**

On the other hand, it should also be noted that a focus group of HIV-positive women conducted as part of this planning process found that approximately half of the women participants had not been aware when they took the HIV antibody test that they were at any risk for HIV infection. Testing of these women would not have been considered cost-effective, yet clearly they had much to gain from taking an HIV antibody test.

PROGRAM CATEGORY #2: INDIVIDUAL LEVEL INTERVENTIONS

Individual level HIV prevention interventions provide health education and risk reduction counseling that help individuals learn about transmission and risk behaviors; make plans for individual behavior change and for ongoing appraisals of their own behaviors; and facilitate linkages to resources that support behavior change on other levels. The common thread linking these strategies is their mutual focus on one-on-one interactions that take place between educator and person served within the prevention experience.

EDUCATION, INFORMATION, AND REFERRAL HOTLINES

1. Description

Toll-free HIV hotlines provide education, risk assessment, and referral information to callers, related either to general HIV prevention, referral, and support, or for specialized

AIDS-related referrals or counseling. The anonymity of hotline services fits the preferences of those who are too embarrassed, closeted, or frightened to receive services elsewhere. In most cases, hotlines serve as convenient access points to obtain needed information and referrals related to all aspects of HIV and AIDS. Hotlines can serve both as a crucial first link to other services, and as an information source for individuals who are geographically or physically isolated. One survey of 130 repeat callers to the AIDS Project Los Angeles Southern California AIDS Hotline showed that 92% of callers felt the service they received was good (AIDS Project Los Angeles, 1993).

While hotlines focus primarily on information, they also promote behavior change. Although some callers may use a hotline repeatedly, that is not part of the design of the strategy. The length of communication is typically brief, a matter of minutes on average, but it can be highly interactive. Some calls involve very lengthy, crisis-oriented interactions that can significantly impact or diffuse desperate needs or situations.

The following information on the usage of the three state-funded AIDS Information Hotline was collected by hotline volunteers. Each hotline collects slightly different information and has slightly different methods of reporting. Not all information is collected from each caller, and not all questions are asked every day. Statistics for the Northern California hotline are from the fourth quarter of FY 1993-94. Statistics for the Spanish language hotline in Southern California are from the third quarter of FY 1993-94. The statistics from the Southern California AIDS Hotline are also from the third quarter, with the exception of the number of total calls for a three-month period, which comes from the fourth quarter. The coordinator of the hotline attests that the demographics of callers to the hotline remains surprisingly consistent from quarter to quarter.

Exhibit 4.1
Statewide Hotline Caller Demographics

	Southern California English Language Hotline	Southern California Spanish Language Hotline	Northern California Tri- Lingual Hotline (English, Spanish, Tagalog)
Total Calls for 3-Month Period	10,242	1,186	17,600
	Race/Ethnicity		
Latino/Latina	15%	65%	8%
Asian/ P. I.	5%	2%	5%
White	63%	27%	61%
African American/Black	10%	4%	7%
American Indian/Alaskan Natives	4%	0%	1%
Other/Unknown	4%	2%	16%
	Gender		
Male	59%	67%	59%
Female	41%	33%	40%
Unknown			1%
	Sexual Orientation/Risk Factor		
Heterosexual	68%	66%	45%
Homosexual	20%	19%	17%
Bisexual	12%	8%	2%
Transgender			<1%
Unknown		2%	35%
IDU		5%	

Source: Statewide Hotline Coordinators

Not surprisingly, the percentage of Latino callers to the Southern California Spanish language hotline is considerably higher than to the other two hotlines. More interesting is that the percentage of Asian and Pacific Islanders callers to the tri-lingual Northern California hotline, with Tagalog speaking volunteers, is no higher than to the Southern California English language hotline. This can possibly be attributed to the higher percentage of callers of unknown ethnicity to the Northern California hotlines. Although the percentage of

homosexual callers is relatively consistent for all three hotlines, the percentage of heterosexual callers to the Northern California hotline is lower than for the other two hotlines. Again, this may be attributable to the higher percentage of callers in the "unknown" category. Only the Northern California hotline collects information on transgenders, and has only been doing so since June, 1994.

According to coordinators of all three hotlines, the most common concerns of callers are about HIV antibody testing. Aside from questions about availability, callers continue to have confusion about the "window period" when a person may be infected with the virus, but not yet test positive for the antibody. Other common concerns regard risk reduction, safe sex, transmission, symptoms of AIDS, and requests for referrals.

2. Effectiveness

A. Outcome Effectiveness

While hotlines may have limited usefulness in directly promoting behavior change (and indeed, as mentioned earlier, this is not their principal stated purpose), they are very useful in disseminating information, particularly to people who are geographically isolated, and to people who might otherwise not seek services. Hotlines are often a first link to other prevention and care services, and are a useful informational and supportive access point to individuals in crisis or with questions, such as individuals who have just learned of a friend or relative's HIV status and does not know where to turn for HIV-related information or support. And while studies show that, although knowledge is not sufficient to cause behavior change, it is a necessary basis for behavior change to take place (Stall, Coates, & Hoff, 1988).

While no formal studies of hotlines were found, a survey of repeat callers to the Southern California AIDS Hotline indicated that the hotline was effective as a prevention strategy. Fifty percent of callers reported that they had increased their practice of safer sex, and 37% reported no change in their practice of safer sex. For 72% of all callers, the hotline had been the only source of HIV/AIDS information since their last call (AIDS Project Los Angeles, 1993).

B. Cost Effectiveness

Hotlines are rarely inexpensive to run and maintain, particularly when they exist to serve wide geographic regions. On the other hand, their per unit cost is low, largely because volunteers are most often utilized to provide the actual answering of phone lines. While the direct impact of hotlines on averting new HIV infections is uncertain, they are probably cost effective even if they avert only a few infections.

STREET AND COMMUNITY OUTREACH

1. Description

Street and community outreach refers to HIV prevention education and counseling that is delivered at informal sites where persons engaged in high-risk activities congregate, such as streets, bars, parks, shooting galleries, bathhouses, beauty parlors, etc. The strategy involves a broad range of models, from occasional condom drops to the long-term placement of highly skilled workers in the community. Street and community outreach programs may be highly interactive and engaging, or they may involve only a cursory risk message and delivery of referral information. Some outreach programs strive to develop long-term relationships with individuals on the street, thus the service is repeatedly delivered to an individual over time.

Street outreach involves more than the distribution of condoms and bleach. The more difficult task of the outreach worker is encouraging lifestyle changes by developing relationships through repeated outreach and a continuous presence. Not surprisingly, studies have found that **increased exposure over time results in more significant behavioral changes** (Stephens, et. al., 1993). However, the same studies have also indicated that there were not significant differences in behavioral changes based on the level of intensity of the intervention. Other studies of outreach projects, however, including a report by the Centers for Disease Control on the AIDS community development project, indicate that **the presence of outreach workers needs to be consistent and continuous, not just sporadic visits** (Johnson, et. al., 1990; Stephens, et. al., 1993; Dorfman, et. al., 1992).

"The NADR study of enhanced vs. standard interventions indicates that there is some, but not major, difference between the responses to the enhanced and standard interventions offered. Their recommendation is that more and not less enhanced intervention would make an outreach program more successful. The CDC study also confirms this analysis: "Counseling oriented interventions may need to address other issues or behaviors in an individual's life (such as childbearing plans among female sex partners of IDUs; crack use among IDUs; addiction to injectable illegal drugs; and alcohol abuse among gay/bisexual men) before HIV prevention can be effectively addressed." (Centers for Disease Control, 1992).

"Street outreach workers become trusted health care professionals. Lack of transportation and an intimidating appointment system can be a barrier to historically underserved risk groups receiving HIV counseling and testing as well as STD and other health care services. Street outreach workers bring the services to the streets instead of asking people to make a production of getting to a clinic. Information that is presented in pamphlets kept at health clinics or broadcast through other media sources like newsprint and television are less likely to impact historically underserved individuals engaging in high-risk behaviors on the streets. The street outreach workers make it easy to get information by being accessible and available instantly." (Watters, et. al., 1990).

In the study of community-based outreach to urban sex workers conducted by Dorfman, et. al. (1992), it is noted that the dedication of street outreach workers was noticed and appreciated by the community. Johnson, et. al. (1990) put it even more strongly; their analysis of 28 street outreach programs around the country concludes that, "To a large degree, the success or failure of community-based HIV prevention programs is dependent on the skills and dedication of the outreach worker."

"Field staff should be indigenous to the community. It is important that outreach workers can relate to their contacts. It is important for street outreach workers to know when people are approachable. It is well documented from the earliest studies involving outreach that it is important for outreach workers to speak the same language (including the slang/jive of the community) and come from the same ethnic and socio-economic background as their contacts. **Reports indicate that street outreach workers are more readily trusted if they have at some point in their lives experienced the activities that they are talking about."** (Dorfman, 1992).

"Different types of outreach strategies work in different types of communities. One study compared proactive and reactive strategies of street outreach. Proactive outreach consists of cold calls, walking up to people and making an introduction, and actively initiating contact and interacting with individuals. Reactive outreach is a more passive form of outreach. This type of street outreach involves a constant community presence. Outreach workers "hang out" and are available for people to approach with questions. With this technique, the contacts have control over when outreach happens. The conclusion of the study indicated that different strategies worked for different risk groups. The proactive style was used most frequently within African American/Black communities by black outreach workers. The reactive strategy "emerged as a calculated response to the idiosyncrasies of particular communities....The black, Hispanic, and gay multi-ethnic neighborhoods differ in their general willingness to openly acknowledge and discuss drug abuse, illness, and HIV-related diseases....The emergence of a proactive style of outreach in the black community was appropriate to the setting. On the other hand, the Hispanic community generally views drug abuse and HIV related diseases as taboo subjects." (Johnson, 1990).

2. Effectiveness

A. Outcome Effectiveness

Several of the studies discussed the effectiveness of outreach programs and of the core elements that influence that effectiveness. Several studies state that **the most critical factor to effectiveness is the outreach staff themselves**. Staff field workers, as much as pamphlets, condoms, and bleach handed out, need to be considered as intervention strategies in themselves. For an outreach program to be effective, **the staff delivering the intervention needs to be respected, trusted, credible, open, and friendly, dedicated, and non-threatening or judgmental.** Once such trust is established, however, the results can be

impressive. In one study of 554 IDUs in San Francisco, almost one quarter (24%) reported learning about bleach use from a community health outreach worker (Watters, et. al., 1990).

"The hardest behavioral change to initiate is safer sexual relations including condom use with main partner." (Watters, et. al., 1990; also others). A study of outreach to sex workers, for example, found that condom use with their clients increased while condom use with personal partners remained inconsistent.

In an analysis of outreach prevention activities in three U.S. cities, Birkel, et. al (1993) offers the following explanation for the poor response to condom promotion: "Overall, the data suggests that **the presence of indigenous outreach workers in the neighborhoods of these three cities created significant reductions in both needle and sex risk behavior**...The intervention appeared to be **least effective in lowering sex risk, particularly among females, and among subjects 25 years and younger...**"

The authors of the above study suggest several reasons why outreach seemed less effective among females and among younger persons. "Perhaps age differences between outreach workers and younger IDUs existed which led to their having less credulity with this group. It may also be that the dynamics of risk among young people are quite different from those in older cohorts and, as a result, may be less affected by street outreach techniques. For example, younger IDUs may be more influenced by group norms and values, and may need to feel that peer group acceptance of certain behaviors exists before adopting. In relation to sex risk, younger IDUs may engage in more spontaneous sexual relations and/or sexual relations following drug use, resulting in less consideration of risk reduction." (Birkel, et. al., 1993).

"A combination of the following reasons may be linked to the lesser reduction of sexual risk that occurred and the continued high rates of unsafe sexual practices among females....1) desire to have children; 2) IDUs surveyed were almost entirely Hispanic-Catholic, and religious beliefs and values that were anti-birth control may undermine the use of contraceptives; 3) culturally based values regarding male sexual behavior; 4) many females feel powerless to protect themselves through insistence on safe sexual practices...." (Birkel, et. al., 1993).

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

INDIVIDUAL PEER EDUCATION

1. Description

Peer education describes education, counseling, risk assessment, and service and support referrals provided by peer educators for peers of all ages in a variety of settings. By

definition, such education must involve a shared set of values between the educator and the person served on at least some identifiable level. Peer education is usually used as a part of a larger, highly interactive strategy. Whether it focuses on behavior change or is repetitive over time depends upon the format of the strategy which uses peer education. Peer education may also involve one-to-one or group interventions, such as in the case of individual peer counseling versus support group facilitation. (Group peer education is discussed separately in this chapter.)

One exploratory study in San Francisco of Latinos and non-Latino whites found that community (and family) members "revealed high willingness to provide AIDS prevention advice to drug using friends and family members." (Marin, Marin, Juarez, & Sorenson, 1992). This approach may be particularly effective among Latinos where there is a high degree of importance placed on the family.

2. Effectiveness

A. Outcome Effectiveness

Peer-directed interventions may be useful in providing a credible and positive role model for education recipients, and in creating a network of support to encourage self-protective behaviors (DiClemente & Hamilton-Houston, 1989). It has been demonstrated that **positive support from friends, family, and lovers is related to changes in sexual behavior and increased condom use**, and peer interventions strive to mirror this level of empathy and communication (Ibid.). Peer educators, for example, may be effective in teaching gay men, who may have become quite skilled in condom use, to incorporate new skills, such as learning how to initiate frank discussion about HIV status, or reducing the number of sexual partners with whom anal intercourse occurs (McKusick, Hoff, Stall, & Coates, 1992). Peer educators may also be effective in eroticizing condom use, and in emphasizing the erotic appeal of safer sex, both of which are critical components of interventions designed to change sexual behavior (Catania, et. al., 1991).

Participants in all five focus groups sponsored in conjunction with the state prevention planning process emphasized the importance of receiving information from peers. **Peer education plays an important role in helping people perceive their own personal HIV-related risks.** Perception of personal risk is an important factor in ultimately changing personal risk behavior.

B. Cost Effectiveness

No specific information is available on this subject in relation to peer education itself.

ON-SITE RISK REDUCTION EDUCATION AND COUNSELING

1. Description

This strategy refers to education and counseling provided at sites where individuals at risk formally congregate for purposes other than receiving HIV prevention or education, such as drug treatment centers, work sites, welfare offices, or even concerts and sporting events. On-site education programs vary in both their scale and approach. They may be one-time individual counseling sessions focusing on knowledge, or ongoing multi-group sessions at drug treatment sites that focus on behavioral change among target population members. Depending on the type of intervention provided, the issues of scientific theory (i.e.., behavior change, interactivity, repetition over time) vary widely. On-site programs are, by definition, very convenient to consumers, although the degree of acceptance for such programs will depend on the methods used. One study notes that, "Extending counseling and education interventions [in these settings] appears to provide substantial benefits in most settings." (Institute for Health Policy Studies, 1993).

2. Effectiveness

A. Outcome Effectiveness

On-site prevention interventions appear to vary in their effectiveness. It has been found that **more formal sources of information (e.g., physicians, psychologists, etc.) have less influence on behavioral changes.** (Catania, et. al., 1991). According to Stall, Coates, & Hoff (1988), reading a safe sex brochure, and receiving advice about AIDS were not associated with participation in safe sex."

On-site interventions are useful in reaching populations that might not otherwise receive HIV/AIDS education. A study of the effects of short-term counseling in 322 Cleveland IDUs in 1988-89 found that 28% more intervention subjects reduced drug risk than did controls (Stephen, 1991). Changes included decreases in risky drug behavior, and, to a lesser extent, risky sexual behavior (Institute for Health Policy Studies, 1993).

Interventions that rely solely on the didactic transfer of information seem to be less effective than those that are more intensive, and that emphasize skills building, communication, and behavior change. How the presenter is regarded by the audience also influences the effectiveness of the intervention.

An evaluation of an AIDS intervention program operated at a shelter for homeless adolescents in New York **demonstrated significant increases in condom use and decreases in risky behavior**. The intervention had no effect on abstinence. The intervention focused on skills training, self-management, and group and social support from peers (Borus-Rotherman, et. al., 1991).

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

PREVENTION CASE MANAGEMENT

1. Description

Prevention case management is an intensive, individualized support intervention designed to assist persons at high risk for or infected with HIV in their battle to either remain seronegative, or to reduce their risk of transmission to others, by identifying, coordinating, and delivering primary and secondary HIV prevention services to them. Prevention case management offers services in a repeated, intensive manner in order to promote and support ongoing safer behavior. Prevention case managers require intensive training; must be culturally competed for the population with which they are working; and should strive to develop a relationship of trust to the person served.

2. Effectiveness

A. Outcome Effectiveness

Because prevention case management is a relatively new concept in HIV prevention, there are no formal evaluations to which to refer. There are, however, many reasons to believe that it could act as an effective strategy. Extensive evidence supports, for example, comprehensive and intensive prevention programs, and prevention case management is able to assist an individual to address all of the potential risk factors that can lead to unsafe behavior.

In addition, personal efficacy is one of the strongest predictors of low sexual risk-taking (Stall, Coates, & Hoff, 1988). Personal efficacy can be built through prevention case management.

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

NEEDLE EXCHANGE PROGRAMS

1. Description

Within this intervention framework prevention workers distribute clean needles (syringes) and other supplies to individuals who use needles to inject drugs, usually in exchange for used needles. They also provide referrals to HIV-related services in areas where persons involved in high-risk behaviors congregate. A limited opportunity for one-on-one health education and/or risk reduction intervention may occur in this context, as may a chance to help link an infected or possibly infected person to the HIV early intervention system. Needle exchange programs (NEPs) focus specifically on behavior change related to needle usage, and less on sexual behaviors. NEPs usually involve only brief interaction and discussion, partly due to police presence. NEPs are designed to reach individuals on a repeated basis.

In order to be effective, injection drug users being addressed must trust the service provider, and not feel the threat of possible arrest or harassment. NEPs are usually highly accepted by the people they serve, however. For many years, particularly during the period in which needle exchange programs were first being established, they were criticized by some African American/Black community leaders, who believed NEPs went against the value of building drug-free communities; some critics went so far as to suggest that NEPs constituted an attempt to impose a sort of genocide upon higher-risk African American/Black neighborhoods. These controversies have diminished with evaluations indicating that NEPs do not increase drug use.

Today, local emergency declarations sanctioning needle exchange are in place in the following California communities: Alameda County, the city of Berkeley, the city of Los Angeles, Marin County, the city of Oakland, the city and county of San Francisco, Santa Clara County, and Sonoma County. Needle exchange programs are operating legally within each of these locations, and on a clandestine basis in many more. The agency Prevention Point has been repeatedly cited across the State of California as being the key community-based advocacy agency responsible for the successful proliferation of needle exchange programs throughout the State.

2. Effectiveness

A. Outcome Effectiveness

An extensive evaluation of needle exchange programs has been conducted and described. **The majority of studies demonstrate decreased rates of HIV drug risk behavior through needle exchange, but not sex risk behavior. Available quantitative data do not provide evidence that NEPs change overall community levels of drug use** (Lurie & Reingold, 1993). There is also evidence to suggest that laws restricting access to syringes can potentially increase HIV infection rates.

The U.S. General Accounting Office (GAO) examined studies of nine needle exchange programs that had published results assessing the impact of their NEP interventions. According to the GAO, "Only three of these had findings based on strong evidence. **Two of these three reported a reduction in needle sharing while a third reported an increase.**" (United States General Accounting Office, 1993)

Meanwhile, seven of the nine projects examined by the GAO looked at whether NEPs led to increased injection drug use. Five had strong evidence to report on these outcomes, and according to the GAO, "All five found that **drug use did not increase among drug users; four reported no increase in frequency of injection; and one found no increase in the prevalence of use.**" (United States General Accounting Office, 1993). The GAO also found that the forecasting model developed at Yale University was sound and credible. "The model **estimates a 33 percent reduction in new HIV infections among New Haven, CT needle exchange program participants over 1 year.**" (United States General Accounting Office, 1993).

In summary, the GAO noted that, "Data from several projects support the view that needle exchange programs are reaching injection drug users and referring them to drug treatment or other health services." That is, NEPs assist injection drug users in obtaining services that may address core issues behind their risk behavior. However, although NEPs make referrals, there are not always available slots in drug treatment programs to accommodate them (United States General Accounting Office, 1993).

B. Cost Effectiveness

California Planning Working Group (CPWG) member James Kahn, Ph.D. of UCSF has examined models for determining the cost-effectiveness of NEPs using different models and various assumptions. He found that **in almost all cases the cost per HIV infection averted is far below the $119,000 lifetime cost of treating an HIV-infected person. Estimates range from $3,773 to $12,000.** (Lurie & Reingold, 1993). The median annual budget of U.S. and Canadian needle exchange programs is relatively low, at $169,000, equal to the cost of about 60 methadone maintenance slots per year (Ibid.)

CONDOMS, OTHER BARRIERS, AND BLEACH DEMONSTRATION AND DISTRIBUTION

1. Description

Through this strategy, health workers distribute bleach, condoms, and risk reduction barriers; demonstrate their use; and provide referrals in areas where people at risk for HIV congregate. Limited opportunities for on-on-one health education or risk reduction are offered by this strategy, which is by definition focused on behavioral change. There is usually only one brief interaction through the intervention, and the service is not frequently repetitive in terms of matching the same worker with the same individual over time.

Distribution of condoms is often valued and enjoyed by recipients. Eroticizing condom use and emphasizing the erotic appeal of safer sex are critical components of interventions designed to change sexual behavior through condom use (Catania, et. al., 1991).

2. Effectiveness

A. Outcome Effectiveness

While the availability of condoms, other barriers, and bleach are obviously necessary for the adoption of their use, distribution of these items is not a complete intervention without instruction in their use. Similarly, distributing condoms and other barriers will not be effective if recipients are not motivated to practice safe behaviors. However, **those who receive condoms with erotic instructions have significantly enhanced attitudes toward their use,** while those who receive condoms without any instruction show no significant change in their attitudes toward condoms (Tanner & Pollack, 1988). One study of sexually active inner city junior high school students found that respondents who perceived the cost of condoms in general to be low were 1.9 more likely to be consistent condom users than those who did not.

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

PROGRAM CATEGORY #3: GROUP LEVEL INTERVENTIONS

Group level interventions provide education and risk reduction support to groups of individuals in order to help them initiate and maintain safer behaviors, and to provide interpersonal skill training in negotiating and sustaining appropriate behavior change. The common denominator of these strategies is their focus on groups as a target for HIV prevention outreach and intervention.

SPEAKERS BUREAUS

1. Description

Speakers bureaus are groups of trained individuals, usually volunteers, who are available to travel to sites to provide one-time educational seminars related to HIV and AIDS, sometimes to specialized groups, and sometimes to large general audiences. Sites for speakers bureau presentations may include schools, work sites, clubs, treatment clinics, etc. Speakers bureaus are usually group presentations with some time for discussion at the conclusion or during the presentation. They may focus on knowledge or behavior, or acceptance of persons with HIV/AIDS. They may also focus on AIDS knowledge within the particular context of the audience receiving the presentation; for school children, for example, the presentation may focus on the acceptance of a classmate who has been diagnosed with HIV. Speakers bureaus are usually single-session interventions.

2. Effectiveness

We were unable to identify any specific information or literature related to either the outcome or cost effectiveness of Speakers Bureaus as an HIV prevention approach.

GROUP PRESENTATIONS

1. Description

In group presentations, individuals attend a gathering in order to discuss risk assessment; gain risk reduction skills such as condom usage or condom negotiation; and/or develop motivation to maintain safer sex practices. Groups may be led by trained peer facilitators or by professional health educators.

Short one-time presentations can provide information, create awareness, and raise consciousness. However, short one-time group presentations may have limited ability to work on the more profound issues that are generally the cause of unsafe behavior. Longer interventions that are carefully targeted, intensive, interactive, and presented in a culturally appropriate manner are more effective, if feasible. A study of African American/Black male adolescents from Philadelphia, PA found that a one-time, five-hour intervention designed to increase AIDS-related knowledge and weaken problematic attitudes toward risky sexual behavior was effective. The intervention used videotapes, games, exercises, and other culturally appropriate materials to reinforce learning and encourage active participation (Jemmott, Jemmott, & Fong, 1992).

Presentations that target skills training and/or emphasize the erotic appeal of safer sex are critical components of interventions designed to change sexual behavior (Catania, et. al., 1991). As mentioned earlier, an effective approach for working with already motivated gay

men who have become skilled in condom use is to teach new skills, including communication skills and strategies for reducing the incidence of anal intercourse (McKusick, Hoff, Stall, & Coates, 1991).

The acceptance of group presentations largely depends on the cultural "fit" and skill of the presenter. For African American/Blacks from Philadelphia during a one-time, five-hour intervention, the effect of the AIDS intervention on lowering less favorable attitudes was greater with female facilitators than with male facilitators (Jemmott, Jemmott, & Fong, 1992). In a presentation to Vietnamese women there were difficulties writing translations that were accurate, useful, and appropriate. Commonly used terms were not direct enough, and direct translations were possibly offensive to the women. In this case the English word "condom" and the acronym "AIDS" were used instead of translations (Flaskerud & Nyamathi, 1988). For many target groups, it is necessary to make the presentations as culturally and linguistically appropriate as possible, and this sometimes raises substantial difficulties of translation.

2. Effectiveness

A. Outcome Effectiveness

There are many studies evaluating the effectiveness of group presentations as an HIV prevention strategy. **Presentations that emphasize skills for behavior change and that are more interactive are more effective than those that simply rely on the didactic transfer of information.** The effectiveness of the didactic transfer method for information is still uncertain. Some studies say it does effect behavior, while others claim that it does not. It is safe to say, however, that basic information on HIV transmission and prevention is an essential element for changing behavior.

A study of African American/Black male adolescents from Philadelphia found that a one-time, five-hour intervention designed to increase AIDS-related knowledge and weaken problematic attitudes toward risky sexual behavior was effective. Compared to a control group, at a three-month follow-up assessment, the intervention group had higher AIDS knowledge, weaker intentions to engage in unsafe sexual activity, and reported engaging in less risky sexual behavior in the three months following the intervention. "Adolescents who received the AIDS intervention were less likely to engage in sexual activities, and those who did were more likely to engage in safer sexual activity." (Jemmott, Jemmott, Fong, 1992).

"Calabrese, Harris, & Easely (1987)...found that neither attendance at a safe sex lecture, reading a safe sex brochure, receiving advice from a physician about AIDS, testing for HIV antibodies, nor counseling at an alternative test site were associated with participation in safe sex." (Stall, Coates, & Hoff, 1988).

Two one-day peer-led interventions for gay and bisexual men in Philadelphia were evaluated. Intervention I, a small group AIDS 101-type lecture was less effective in increasing condom use than Intervention II, which included skills training utilizing role play and group process. Although Intervention II was more effective, both interventions increased condom use for insertive anal sex, but neither had an effect on receptive anal sex (Valdiserri, et. al., 1989).

A project in Los Angeles that used peer leaders for 4 to 15 gay and bisexual men in groups lasting several hours found that subjects "improved in terms of knowledge, attitudes, and behavioral intentions." (Institute for Policy Studies, 1993).

A didactic slide/tape presentation to Vietnamese women, led by a Vietnamese nurse at a Women, Infants, and Children health program in Los Angeles, was successful at increasing knowledge and positively influencing intended practices (Flaskerud & Nyamathi, 1988).

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

MULTI-SESSION GROUPS

1. Description

Multi-session groups are closed, structured groups, drop-in groups, and support groups related to HIV/AIDS prevention and education, possibly among other topics. Participants attend multi-session groups in order to learn risk reduction skills, and to receive ongoing education and psychosocial support needed to maintain safer sex and behavioral practices. Multi-session groups usually focus on behavior change and the many barriers to maintaining behavior change that may exist for individuals served. They usually involve a great deal of discussion, and by definition, they are repetitive over time.

"The importance of self-worth issues for increasing condom use suggests that AIDS prevention programs that focus on changing sexual behavior must also act on broader personality issues in addition to relevant sexual, health, and relationship concerns." (Catania, et. al., 1991). Personal efficacy is one of the strongest predictors of low sexual risk-taking. Multiple session groups have the ability to effect self-worth and other broader personality issues (Stall, Coates, & Hoff, 1988). An evaluation of an AIDS intervention program at a shelter for homeless adolescents in New York demonstrated that a greater number of intervention sessions resulted in a greater decrease of risky behavior (Borus-Rotherman, Koopman, Haignere, & Davies, 1991).

Presentations that target skills training and/or that emphasize the erotic appeal of safer sex are critical components of interventions designed to change sexual behavior

(Catania, et. al., 1991); multi-session groups usually have this outcome as one component of the intervention approach.

The acceptance of a multi-session group by a given audience depends to a large extent upon the cultural "fit" and skill level of the facilitator. Some cultural groups look more favorably on group processes such as multi-session groups; other cultural groups shy away from group discussions of HIV-related issues such as sex, illness, and internal feelings. Facilitators of multi-session groups must be culturally and linguistically competent to understand and address the specific cultural issues that relate to the topics being presented and discussed.

Some aspects of the literature suggest that in the context of interventions such as multi-session groups, it may be more effective to reinforce and shape existing attempts to avoid HIV infection, rather than to teach whole new behavioral strategies to participants. For example, it may be more effective to increase a person's interviewing skills for assessing a potential partner's likely HIV status, rather than simply focusing on promoting condom use as a general rule. "Similarly, to further promote existing norms regarding monogamy may be much more effective in the heterosexual world than in the gay community, where community norms have traditionally endorsed nonexclusivity." (McCusick, Hoff, Stall, & Coates, 1991). Multi-session groups have the ability to ascertain members' norms and barriers, and to work to foster better norms and skills among group participants.

2. Effectiveness

A. Outcome Effectiveness

There is much data suggesting that multi-session groups can be very effective at changing the risk behavior of group participants, and certainly at changing their level of knowledge. Multiple sessions have a greater possibility of effecting consistent behavior changes than one-time interventions. They also have more potential to deal with the underlying causes of unsafe behavior. Multiple session groups, however, can only be as effective as the facilitator or teacher who leads them. A facilitator or teacher who is not trained in AIDS education, or is not comfortable speaking frankly about sexuality and drug use, cannot lead an effective HIV prevention program.

A study of a two-session classroom AIDS education program involving seventh and tenth grade classes in Rhode Island showed positive results. "Following instruction, students reported more knowledge, greater tolerance of AIDS patients, and more hesitancy toward high-risk behaviors, but the changes were modest....Data lends support to the potential usefulness of school-based education programs, especially if behavior and coping skills are emphasized in the education (Brown, Fritz, & Barone, 1989). Similar results were found in a school-based AIDS prevention program presented in an inner-city school in Northern California serving predominately African American/Black and Asian students. In this

population, however, changes in high-risk behaviors could not be detected, perhaps due to the small number of sexually active students (Siege, et. al., in press).

A study of an open-enrollment, pass/fail course at UCLA in 1988 showed positive impact on students' AIDS-related knowledge, attitudes, and behaviors. Compared to a control group, the students who took the lecture course changed their attitudes about critical public policy issues (e.g., mandatory HIV testing) to be in line with current public health policy. "The nature of the effect was to bring students toward greater appreciation of 'individual rights'". "Students were not likely to carry and use condoms subsequent to participation in the course. Conversely, through not statistically significant, students in the class were also perhaps less likely to engage in unprotected vaginal sex." (Abramson, Seckler, Berk, & Cloud, 1989).

An evaluation of an AIDS intervention program at a shelter for homeless adolescents in New York demonstrated significant increases in condom use and decreases in risky behavior. The intervention had no effect on abstinence. The intervention focused on skills training, behavior self-management, and group and social support from peers (Borus-Rotherman, et. al., 1991).

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

GROUP PEER EDUCATION

1. Description

Peer education consists of education, counseling, risk assessment, and referrals provided by peer educators of all ages. Peer education on a group level may involve speakers bureaus, group presentations, or multi-session groups. The level of focus on behavior change and the repetitiveness of the presentations over time varies with the specific intervention when peer education is used. Generally, peer education involves a high degree of interpersonal interaction, and by definition, a shared set of values and beliefs between the educator and the individual(s) addressed.

The five focus groups sponsored as a component of the state planning process discussed effective prevention programs conducted with different populations. We found that focus group participants consistently indicated that people prefer to hear prevention messages from members of their same group, be it racial, ethnic, or sexual.

2. Effectiveness

A. Outcome Effectiveness

Groups led by peers may be more effective at motivating behavior change than those led by non-peers. Positive support from friends, family, and lovers is related to changes in sexual behavior and increased condom use. "Helpful support from more formal sources (e.g., physicians, psychologists, etc.) was not associated with changes in condom use." (Catania, et. al., 1991).

Using peers as educators may be useful for helping targeted population more accurately perceive their personal level of HIV-related risk. **Peer educators can positively effect group norms, and peer educators are better able to talk frankly about sensitive issues around sex and drug use.** Eroticizing condom use and emphasizing the erotic appeal of safer sex are critical components of interventions designed to change sexual behavior (Catania, et. al., 1991). Peer educators may be better equipped to understand what a particular group may or may not find erotic.

An evaluation of a program that trained popular people in gay bars to serve as informal peer educators showed a reduction in high-risk behavior. **The results support the utility of norm-changing approaches to reducing HIV risk behavior, accomplished through the use of peer educators** (Kelly, et. al., 1992).

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

PROGRAM CATEGORY #4: COMMUNITY LEVEL INTERVENTIONS

Community-level interventions seek to reduce risk behaviors by changing attitudes, norms, and behaviors through health communications, social (prevention) marketing, community mobilization, and community-wide events. The common denominator of these strategies is their focus on community and social group identity.

SOCIAL MARKETING

1. Description

Social marketing refers to advertising such as billboards, television and radio presentations, bus placards, and other mass audience devices that seek to increase knowledge or to change norms or behaviors. Social marketing may focus on behavior change, but those social marketing programs supported by federal funds must generally be approved by administrations that are uncomfortable in presenting sexually explicit messages, and messages

in which frank portrayals of drugs and drug use are included. Social marketing advertising is often repetitive, as audience members see the same messages again and again. By definition, social marketing is not interactive.

Social marketing attempts to precisely fit the values, norms, and preferences of persons addressed through carefully targeted messages. Advertisements and public service announcements should therefore feature actors, models, or spokespersons who are members of the specific racial, ethnic, cultural, or subcultural group that is being targeted.

2. Effectiveness

A. Outcome Effectiveness

While there are few studies evaluating the effects of social marketing as an HIV prevention strategy, this educational approach has been widely regarded as being instrumental in helping to change community norms regarding safe sex among gay men in San Francisco in the 1980s. **"Media programs, effectively designed and executed, can change behavior significantly.** The evaluations of the Swiss and French media campaigns have taught us that." (Coates & Stryker, 1994). As Coates & Stryker (1994) note, "We need bold, innovative, and aggressive public health measures to slow the epidemic...We are talking about bold social marketing programs such as those used, with great success, in Africa and Europe....Programs that change community norms are essential for impact effectiveness." Social marketing can be effective at changing community norms.

An evaluation of an intervention for migrant farm workers in San Diego that used fotonovelas and radionovelas to disseminate AIDS prevention information met with notable success. Post-test knowledge scores increased significantly for those groups who were given the prevention material, but not for the comparison group. The data also clearly shows a direct effect of the program on attitudes. In one of the two study locations, the materials resulted in the target behavior change of greater condom use among prostitutes (Conner, 1992).

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

MEDIA RELATIONS

1. Description

Media relations activities seek to gain in-depth media coverage or concentration on issues related to HIV prevention or risk reduction. Depending upon the media source addressed, the work of media relations may focus on behavior change, or upon increasing the

extent of media dissemination of HIV-related education and information. For example, a television news story dealing with homeless persons with AIDS may raise awareness of the prevalence of AIDS among impoverished individuals in the community. On the other hand, an organization may lobby a newspaper to do a more in-depth piece describing specific risk-reduction behaviors, and giving vital related support information, which could impact individual behaviors. By definition, however, media relations presentations are not interactive. In a sense the outreach strategy is repetitive, in that it strives to obtain frequent coverage of HIV information through media outlets.

Media relations works with mainstream values and norms, generally as perceived by editors or producers, and attempts to move these values to a mode in which they are more accepting of HIV, as well as of frank discussions of HIV. **Attempts to build media relations must not neglect the wide variety of different media available within any area, particularly media that addresses specific individuals involved in high-risk behaviors, such as through so-called 'underground' media, and media for specific ethnic and cultural communities.**

2. Effectiveness

A. Outcome Effectiveness

Media relations as a stand-alone strategy for HIV prevention is unlikely to be successful. The placement of prominent media stories that are accurate and informative does play an important role in raising public consciousness, however, and in increasing knowledge of HIV/AIDS within a given community. Media relations can also be useful for dispelling myths and misconceptions concerning the disease.

B. Cost Effectiveness

Establishing and maintaining positive media relations can be accomplished with very few resources; however, it is unlikely that many actual new infections will be averted with this strategy. It is therefore difficult to measure the costs of media relations activities against the cost saved through AIDS cases averted.

PUBLIC EVENTS

1. Description

Public meetings or events offer outreach and education through booths or other displays through which printed information and referrals are offer. Limited opportunities may exist within this framework for providing one-on-one health education or risk reduction information dissemination. **Generally, however, a presence at public events accomplishes more to raise awareness concerning a specific organization and its services, rather than**

HIV risk reduction behavior in general. Public events are extremely limited in their ability to focus on behavior change, despite the encouragement offered at many events to support behavior change.

2. Effectiveness

We were unable to identify any specific information or literature related to either the outcome or cost effectiveness of Public Events as an HIV prevention approach.

NATURAL OPINION LEADERS

1. Description

This category utilizes the appeal and influence of natural opinion leaders such as Magic Johnson or Elizabeth Taylor to promote and disseminate HIV prevention messages. Celebrities or other well-known public figures make well-publicized statements about the importance of HIV infection through this approach, and hopefully raise awareness and motivate behaviors. The selection of natural opinion leaders is determined by both the population being addressed, and by the messages that are being transmitted. A natural opinion leader for one population may not be a natural opinion leader for another, and the usefulness of the natural opinion leader depends on the values, norms and preferences of the target population.

2. Effectiveness

A. Outcome Effectiveness

No specific information on outcome effectiveness was found. However, there is substantial evidence that after specific announcements of personal HIV status by public figures such as Rock Hudson or Magic Johnson, hotlines and informational outlets become deluged with questions from concerned individuals, usually relating to their own HIV risk behaviors. Certain celebrities clearly have a powerful ability to draw attention to an issue such as HIV, and to prompt people to consider their own personal levels of HIV risk.

As a strategy for preventing HIV infections, however, the usefulness of natural opinion leaders (*e.g.*, Magic Johnson) may be limited. **Natural opinion leaders, due to their high profile and visibility, can be instrumental, however, in increasing awareness and knowledge of HIV/AIDS and related prevention services.**

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

COMMUNITY MOBILIZATION

1. Description

Community mobilization is a strategy that involves grassroots outreach and education that takes place within a specified neighborhood or community, with the goal of increasing awareness of HIV/AIDS issues and of providing a foundation for the greater participation of residents in HIV prevention and service activities. Community mobilization can take many forms, ranging from volunteer recruitment, to solicitation of participation in public events or forums, to assistance with attaining specific policy ends, and generally strives to work within a community's specific value systems and norm set. Depending upon the form community mobilization takes, it may or may not focus on HIV-related behavior change; involve interactive discussions; nor be repeated over time.

2. Effectiveness

A. Outcome Effectiveness

A number of studies have preliminarily indicated that community mobilization, by involving the entire community in its efforts and by addressing the root causes of HIV-related risk behavior, can potentially have dramatic effective on community norms, and can effect a reduction in risky behavior. An exploratory study in San Francisco of Latinos and of non-Latino whites, for example, found that community and family members "revealed a high willingness to provide AIDS prevention advice to drug using friends and family members." Such an approach may be particularly effective among Latinos where there is a high degree of importance place on the family. The literature also indicates that effective community-specific HIV/AIDS prevention strategies should originate from community members themselves, as a way to assure both accessibility and applicability.

The different inter-community environments in which community mobilization messages are presented must vary to reach as many at-risk individuals as possible. In the case of community mobilization to reach young people engaged in high-risk behavior, an effective mobilization model can be visualized as three interlocking circles, involving, in the case of adolescents, home, school, and the community. Health education projects have been most successful in these model when parents have been involved as an integral component (Ibid).

B. Cost Effectiveness

No information on cost effectiveness was found for this category.

PROGRAM CATEGORY #5: PUBLIC INFORMATION PROGRAMS - LOCAL, REGIONAL, AND STATEWIDE

Interventions within this category are provided to the general public for the purpose of dispelling myths about HIV transmission; supporting volunteerism; reducing discrimination toward individuals with HIV/AIDS; and promoting support for strategies and interventions that contribute to HIV prevention. While public information programs may also seek to raise personal or community awareness concerning the need to practice safer behaviors on the personal level, the principal distinction between public information programs and community-level interventions is the extent to which the focus is on risk behavior. **Public information programs are distinguished from community-level interventions described in the previous category because they focus not on a specific group of individuals, nor on behavioral change, but rather on the community's capacity to support programs to produce changes in relation to HIV/AIDS.**

SOCIAL MARKETING

1. Description and Effectiveness

Social marketing refers primarily to advertising using billboards, television, radio, bus placards, and other mass dissemination devices in order to achieve the objectives described in the summary above. No information was found to support or deny the effectiveness of such methods in accomplishing their stated goals, although some agencies have informally reported that inquiries concerning HIV/AIDS to outlets such as public information hotlines increase during social marketing campaigns. Social marketing can increase the effectiveness of strategies simply by raising public awareness of their existence. For example, billboards can advertise the phone number for a hotline, making that service available to people who otherwise would not be aware of the service, or know where to find the number. The central question to be asked in assessing the effectiveness of such programs is, Is social marketing effective in achieving the goals of dispelling myths; supporting volunteerism; reducing discrimination; and/or supporting HIV/AIDS programs.

MEDIA RELATIONS

1. Description and Effectiveness

Media relations activities seek to gain expanded or in-depth media coverage on issues such as myths, volunteerism, discrimination, or education programs and strategies that contribute to HIV prevention. No information could be located that addressed the issue of

media relations in regard to HIV/AIDS, although many HIV/AIDS organizations consider the function of media relations to be indispensable to publicizing their programs and services to the general community; in obtaining support for activities; and in notifying potential service populations of the availability of services. As with social marketing programs, an effectiveness evaluation would need to ask how effective media relations strategies are in accomplishing the general goals of public information programs.

PUBLIC EVENTS

1. Description and Effectiveness

Public meetings or events that offer community booths or other displays were HIV-related printed information and referrals are offered are the central public events activities referred to under this strategy. The focus of public events campaigns is on achieving the goals of public information programs, but not studies have been conducted or literature produced to give evidence concerning the effectiveness or lack of effectiveness of this approach.

LINKAGES BETWEEN PRIMARY PREVENTION AND SECONDARY PREVENTION

The remainder of the chapter describes the linkages between primary prevention and secondary prevention. Linkages between primary and secondary prevention services are important to California's overall approach to the AIDS epidemic. Secondary prevention in California is generally seen as having two central components:

1. Activities that prevent a more rapid progression to advanced HIV-related conditions for HIV-positive persons; and

2. Efforts that interrupt further transmission of the AIDS virus by HIV-positive persons to other individuals.

Within California, there are several ways in which secondary prevention services are delivered. An important means through which secondary prevention services are provided in California is via primary, community-based providers, such as contractors of the State of California Education and Prevention programs. Secondary prevention services offered by community-based providers disseminating information about treating or preventing disease progression, referring individuals to early intervention services; or discussing with HIV-positive individuals specific ways in which to interrupt transmission of the virus to needle sharing or sexual partners. Secondary prevention providers also offer emotional support and group and individual counseling services to help HIV-positive individuals maintain behaviors that preserve health and prevent infection of others.

In general agencies that provide secondary prevention services exclusively are rare. More often, such services are provided as part of a larger range of services that offer general

psychosocial or medical support to persons with HIV and AIDS, such as drop-in centers, food banks, community clinics, or multi-service AIDS organizations. Within this context, secondary prevention services often parallel primary prevention services, or are even provided co-incidentally with them, such as in the case of support groups to help maintain safe sex behavior among gay men that do not specifically distinguish between HIV-positive and HIV-negative persons, or in the case of community forums on emerging HIV-related drug treatments that are open to the general public.

Frequently, secondary prevention efforts by community-based service agencies also support health and prevent further infections among persons with HIV through more indirect means, which can nonetheless be helpful in furthering secondary prevention efforts. Nutritionists at food banks, for example, provide valuable health maintenance information to individuals. Social service agencies that provide free transportation for persons to medical appointments can help individuals maintain health by ensuring that they arrive on time for treatment appointments. Social workers who function as case managers at AIDS service organizations also often serve as informal counselors to persons with HIV, providing the direct contact and support that is sometimes essential to maintaining safer behavior.

Often this informal linkage between primary and secondary prevention works in even more complex ways. Many agencies attest, for example, to the fact that programs in which an HIV-negative or HIV-undetermined volunteer delivers supportive services to an HIV-positive person via a 'buddy' program may provide essential prevention support to both participants in the system. The HIV-positive individual who receives buddy services has a chance to share personal issues and to obtain support for preserving health, preventing infection of others, and maintaining positive outlook. At the same time, the HIV-negative individual delivering buddy services receives reinforcement for maintaining safer behaviors in his or her own life.

Extensive informal and formal linkages also exist at the community level between providers of primary medical services and providers of HIV-related social and supportive services, linkages that promote the goals of secondary prevention by serving as community 'safety nets' to link HIV-positive persons to essential care and information sources. Many individuals with HIV or AIDS, for example, first learn of their serostatus when they are admitted to a hospital or emergency room for treatment of an HIV-related opportunistic infection or condition. Most major AIDS service organizations now maintain networks of formal liaisons to hospitals and other primary health care institutions in their community, and through these liaisons patients can be linked to organizations while they are still in the hospital or under a physician's care. Many AIDS service organizations have the capacity to offer a range of supportive secondary prevention services immediately upon the patient's release.

Secondary prevention services are provided through the State Office of AIDS Early Intervention Program as described in the Chapter 5 Resource Inventory. This program specifically addresses both elements of secondary prevention described above. Funds authorized through Title III B of the Ryan White CARE Act enable local health clinics to

provide early intervention services to persons who are HIV-infected, services that for the most part focus on interrupting the more rapid progression to HIV disease for HIV positive persons through application of a medical model intervention.

During the past year, the state Office of AIDS itself has made a concerted effort to provide more coordination and linkage between its Early Intervention Program (EIP) and the Prevention Branch that funds and monitors testing and counseling programs and Education and Prevention contracts. This push for coordination and integration at the state level well serves the public's need for linkages between primary and secondary HIV education on a provider level. Already this interaction has led to the Education and Prevention Branch's publications being distributed to Office of AIDS and EIP staff as well as to the local projects. Both Branches also now have representatives participating in the planning process for the new Women's Early Intervention Centers, and staff from both Branches will be invited to attend the annual EIP All-Projects Conference.

Because the state's program for HIV early intervention services is sometimes erroneously assumed to be solely a medical program, the EIP's links with prevention programs both locally and at other governmental levels have been difficult to form and maintain. In the past year, however, new efforts have begun to strengthen prevention linkages at all governmental and administrative levels. The Early Intervention Program, for example, has been included for the first time in the California Community Prevention Planning efforts. At the same time, staff of the Early Intervention Program have attended the meetings of the Community Planning Working Group, at which presentations concerning the Early Intervention Program have been made.

Partly as a result of this education, the Community Planning Working Group has established two goals specifically focusing on secondary prevention. One goal contains five objectives that address the outcome of interrupting the transmission of HIV from HIV-positive persons to others. Another goal contains four objectives that speak to the need for information, referral, and access to early intervention programs. The state Early Intervention Program is also informing local Early Intervention Projects of the progress and outcomes of the HIV Prevention Community Planning process and encouraging these local projects to participate at the local level. Local EIP project staff receive HIV counselor training and updates currently, and these trainings facilitate a smooth referral system.

The Early Intervention Program receives referrals from a variety of different sources. The diversity of referral sources is an indication of the linkages that exist between the Early Intervention Program and primary prevention services. These referral sources include Alternative Test Sites (29% of referrals); physicians and clinics (12%); and word of mouth (14%). These referrals indicate that the EIP program is well-linked to the Alternative Test Sites as well as to local public health departments. They also indicate that the EIP programs are known in communities in California, and that information is spread as well through word of mouth.

The state's Alternative Testing Site (ATS) program provides an essential link between primary and secondary prevention through its Partner Notification Program, which directly brings the sex partners of HIV-positive individuals into the testing setting to learn of their HIV serostatus. The ATS program also uniformly refers HIV-positive individuals to AIDS prevention and service agencies within a person's local community. Linking individuals to such agencies immediately can reinforce the effectiveness of the testing experience by turning the traumatic experience of learning one's HIV status into a positive experience of beginning to take control of the circumstances of one's life and health, often for the first time.

CHAPTER 5: INVENTORY OF RESOURCES

PREVENTION FUNDING FOR CALIFORNIA

There are two main sources of funding for prevention programs in California--federal and state. Although significant funds used for prevention in the state do not originate from these two sources, (*i.e.*, private foundations, fund-raising) state and federal funds are relatively stable and continuous. The focus of this chapter will be on the federal and state funds received, where they originate, how these funds are used.

Exhibit 5.1 depicts the federal and state funds available for prevention services for 1994. Exhibit 5.2 depicts the same funding information for 1995. Displaying funding information is particularly challenging because state funds are allocated by state fiscal years, while federal funds are allocated by calendar years. A state fiscal year funding includes 12 month time period of July through June. Both exhibits reflect funds by calendar year; however, all state funds appropriated for FY 1993-94 are included in Exhibit 5.1. The state funds appropriated for 1995 are displayed in Exhibit 5.2.

For 1994, California received a total of $66.6 million in funds for prevention services; $36.2 million in federal funds and $30.3 million in state funds. For 1995, California received a state fund augmentation of $5.6 million for prevention programs to include an additional $3 million for the Education and Prefention Program, $1.9 million for HIV Testing, and $600,000 for two new Early Intervention Programs specifically for women. The total estimated federal and state funds to be received for 1995 in California will be $71.2 million; $35.3 million in federal funds and $35.9 million in state funds.

Exhibit 5.1
Federal and State HIV Prevention Funding (in thousands) 1994

Program	State	Federal	Total
Education and Prevention	$15,100	$1,600	$16,700
Federal CBO Projects		$10,000 *	$10,000
Subtotal			**$26,700**
Block Grant (Local Surveillance)	$4,000 *		$4,000
HIV Testing (Local Health Depts.)	$6,400	$1,600	$8,000
Community Clinics	$2,000		$2,000
HIV Testing (SAMHSA)		$8,800 *	$8,800
Subtotal			**$18,800**
Training (Testing Programs)	$255,000	$260,000	$515,000
Early Intervention Programs	$2,600	$600,000	$3,200
CDC Cooperative Agreement To Cities (Los Angeles and San Francisco)		$13,400 *	$13,400
TOTAL	**$30,355**	**$36,260**	**$66,615**

*Not Administered by Education and Prevention Branch Revised 7/94

Source: California Department of Health Services, Office of AIDS

Exhibit 5.2
Federal and State HIV Prevention Funding (in thousands) 1995

Program	State	Federal	Total
Education and Prevention	$18,100	$1,600	$19,700
Federal CBO Projects		$10,000 *	$10,000
Subtotal			**$29,700**
Block Grant (Local Surveillance)	$4,000 *		$4,000
HIV Testing (Local Health Depts.	$8,300	$1,600	$9,900
Community Clinics	$2,000		$2,000
HIV Testing (SAMHSA)		$7,900 *	$7,900
Subtotal			**$19,800**
Training (Testing Programs)	$255,000	$260,000	$515,000
Early Intervention Programs	$3,200	$600,000	$3,800
CDC Cooperative Agreement To Cities (Los Angeles andSan Francisco)		$13,400 *	$13,400
TOTAL	**$35,855**	**$35,360**	**$71,215**

*Not Administered by Education and Prevention Branch Revised 8/94

Source: California Department of Health Services, Office of AIDS

Federal Funds to Office of AIDS

Federal funds to the Office of AIDS are provided through a Cooperative Agreement Grant from the federal Centers for Disease Control and Prevention (CDC). These funds are awarded on a yearly basis and funds are used for Office of AIDS administrative costs and for local assistance (i.e., grants to local county health departments and Community based organizations to implement prevention programs). Approximately $1.6 million is provided for Education and Prevention projects. An additional $1.6 million is used for an HIV Testing Program to provide testing in sexually transmitted disease (STD) clinics and for out-of-treatment drug users utilizing local health department clinics for primary care services. The Training Program uses $260,000 of the prevention funds, and $600,000 is provided to the Early Intervention Program. It is important to note that not all Early Intervention Program services are focused on education and prevention services. A good portion of the funds, an estimated two-thirds of the funds, is used for medical monitoring and psychosocial support and case management services. The remaining one-third of the funds is used in the Early Intervention Program for education and prevention services targeted to persons who are HIV positive.

Federal Funds to Other State and Local Agencies

Exhibits 5.1 and 5.2 also list $8.8 million that is currently available from the federal Substance Abuse Mental Health Services Administration (SAMHSA) to local health jurisdictions for HIV counseling and testing services and other therapeutics to persons who are in substance abuse treatment programs. These funds are administered through the California Department of Alcohol and Drug Program (DADP). The funds are provided to local programs providing treatment services to substance using individuals.

The Centers for Disease Control and Prevention (CDC) also provides federal funds directly to local public and private agencies. In California, CDC has Cooperative Agreement Grants with San Francisco County Health Department and the Los Angeles County Health Department. Each of the cities/counties are involved in implementing a community planning process and receive funds of $350,000 each for these planning activities. In addition, the cities receive prevention funds to implement prevention activities in their locality. San Francisco receives approximately $5.5 million and Los Angeles receives $7.9 million for a total of $13.4.

CDC funds are also provided directly to community-based organizations in California. There are 28 community-based organizations in California that receive $10 million directly for education and prevention programs and activities in local communities.

State Funds to Office of AIDS

Exhibits 5.1 and 5.2 also depict the state funds that are appropriated for HIV prevention programs that are administered through Office of AIDS Education and Prevention Branch for 1994 and 1995. There was a total of $26.3 million allocated for prevention activities in 1994 and $31.9 million allocated in 1995. An additional $4 million in state funds was allocated for both 1994 and 1995 to local health departments for surveillance activities through the Local Assistance Block Grant; these activities often support local prevention activities.

The Education and Prevention Program received $15.1 million in 1994 and $18.1 million in 1995 for prevention activities. These funds were allocated to local health departments and community-based organizations to implement prevention programs/activities in local communities throughout California. These funds have been historically allocated through a request for proposal (RFP) process.

A total of $8.4 million was allocated for HIV Testing Program in 1994. Approximately $6.4 million of these funds, was allocated to local county and city health departments for HIV counseling and testing services in county/city administered programs. The remaining $2 million was allocated to community-based family planning clinics, rural community primary care clinics, and Indian Health Clinics. In 1995, a total of 10.3 million was allocated for the HIV Testing Program.

The Training Program for HIV counselors received $255,000 of the state funds. The Early Intervention Program received $2.6 million state funds; however, this entire amount is not used solely for prevention activities. As stated before, it is estimated that one-third of the Early Intervention Program funds support prevention activities for HIV positive individuals enrolled in EIPs; the remainder of the funds are used for medical monitoring and case management.

State Funds to Other State Agencies

Exhibit 5.3 shows AIDS budget information from the state general fund to several state agencies for HIV prevention-related activities for the period from FY 1990-91 through FY 1993-94. This overview of state spending on HIV prevention is incomplete. Activities of all state agencies involved in HIV prevention are not included in these Department of Finance figures. In addition, dollars spent on HIV prevention by agencies with major missions related to AIDS, for example, the Department of Corrections, and the Department of Alcohol and Drug Programs, are not broken out to distinguish between prevention and treatment dollars. (This information and Exhibit 5.3 which follows was updated and taken from *HIV Prevention in California, Final Report, HIV Education and Prevention Evaluation;* prepared by the Institute for Health Policy Studies, University of California, San Francisco, April 1993.)

Exhibit 5.3
State of California AIDS Funding, Selected Agencies and Categories
State General Fund Spending (in thousands), FY 90-91-FY 93-94

Agency	FY 1990-91	FY 1991-92	FY 1992-93	FY 1993-94
Dept. of Health Services (education and prevention)	16,079	15,134	15,134	15,133
Dept. of Mental Health (AIDS counseling)	1,500	1,500	1,500	1,500
*Dept. of Corrections (AIDS treatment and facility)	5,267	6,142	8,316	8,395
Youth Authority (AIDS screening)	200	200	200	200
**Dept. of Alcohol and Drug Programs (IDU treatment)	1,300	1,239	1,079	1,079
Commission on State Mandates (AIDS testing, education, and prevention)	1,050	1,338	1,808	2,072

* These budget figures do not indicate dollars spent by the Dept. of Corrections on HIV prevention.
** These budget figures do not indicate dollars spent by the Dept. of Alcohol and Drug Programs on HIV prevention related to drug treatment.

Other Funds

Two other funding sources support HIV prevention programs in California. Although they are not as stable as the state and federal funding streams described above, they comprise a meaningful share of the prevention resources available in the state.

The first of these is county funds. In California, many counties allocate some of their local revenues for HIV prevention. While the counties that have experienced the greatest number of cases (*i.e.*, Los Angeles, San Francisco, San Diego, Alameda) have set aside their own funds to prevent the disease, these counties are also the jurisdictions that have likely experienced the brunt of the economic recession in the state. Unfortunately, there is no

consistent data on the amount of county funds used for HIV prevention. Recently, the Office of AIDS attempted to survey California counties to determine the extent of local support for HIV prevention. The response to the Office of AIDS survey was too low to allow for any meaningful interpretation. Additional research is needed in this area.

The second funding source is from the private sector. This includes organized philanthropy as well as individual giving. In the arena of organized philanthropy, California has some of the most active foundations in the nation with regard to HIV. In three regions of the state, local grantmakers have entered into a funding collaboration with the National Community AIDS Partnership. The Northern California Grantmakers' AIDS Task Force, the Los Angeles Community AIDS Partnership and the San Diego Grantmakers AIDS Collaboration are participants in this national funding collaborative which brings funding from the Ford Foundation and other national funders into the state. Much of that funding is used for prevention programs. For example, in the San Francisco Bay Area, the Northern California Grantmakers' AIDS Task Force made prevention grants totalling $647,000 for 1993-94.

Other private funders have also undertaken significant grantmaking initiatives in HIV prevention. For example, The Sierra Health Foundation in Sacramento recently concluded a four-year initiative in Northern California which allocated over $1 million for prevention activities in rural areas between 1988 and 1992. The James Irvine Foundation has also made significant grants for HIV prevention throughout the state. Between 1988 and 1993, the Foundation made grants of $330,000 for HIV Prevention. The San Francisco Foundation (which grants approximately $75,000 for HIV prevention annually), the Marin Community Foundation, the California Community Foundation, the Levi Strauss Foundation and others have been very supportive of HIV prevention activities. Many United Ways across the state have also provided support for HIV prevention activities, much of it with a focus on youth.

Additionally, a few community based agencies receive significant funds from private donations. In the San Francisco Bay area and Los Angeles, major fundraising events, such as the AIDS Walk, are held annually. These events have become a fairly reliable source of revenue.

The problem of quantifying the amount of funding for HIV prevention from county governments and the private sector is that there is no consistent source of data. There is no common reporting requirement for these sources or any common location where these data are maintained. A common set of data from these sources would probably reveal funding for HIV prevention activities in excess of $8 million but not likely to exceed $20 million annually statewide. A reason why this estimate covers such a wide range is that many private funders typically make only a short-term commitment to support programs in a particular area. A commitment to support programs in one field of service may not be continued past a single year. Many community-based agencies cite this as a disadvantage of pursuing private funding

-- there is no consistent support from year to year. Such variation makes reliable figures difficult to estimate.

PREVENTION PROGRAMS IN CALIFORNIA

The Office of AIDS has two branches that deal with prevention activities, the HIV/AIDS Epidemiology Branch and the Prevention Branch.

HIV/AIDS Epidemiology Branch

The HIV/AIDS Epidemiology Branch within the Office of AIDS has primary responsibility for monitoring the scope and trend of the HIV/AIDS epidemics in California. The mission of the Branch is to collect, analyze, and disseminate epidemiologic information for HIV/AIDS prevention, program evaluation, and policy development efforts. To accomplish this mission, the Branch employs a broad spectrum of epidemiologic monitoring strategies, including analysis of AIDS case trends, serologic monitoring of HIV infection, and surveys of risk behavior prevalence in various subpopulations. The Branch regularly provides ongoing technical assistance and information to local health departments, community-based prevention programs, planning groups, researchers, control agencies, and the State Legislature.

AIDS Case Registry Section

There are three main program elements within the Epidemiology Branch. The largest of these is the AIDS Case Registry Section. Under the direction of a single manager, the registry's major mission is to promote, improve, and evaluate active AIDS case surveillance in 59 of 61 local health departments in the state (San Francisco and Los Angeles Counties receive direct AIDS surveillance funding from the Centers for Disease Control and Prevention).

In collaboration with local health departments, Registry staff work continuously to assure the timeliness, accuracy, completeness, confidentiality and dissemination of AIDS case data in California by: 1) collecting and verifying AIDS case data from all health departments in California; 2) assisting local health departments, hospitals, and care providers to develop confidential AIDS case reporting procedures; 3) providing health departments with surveillance training, program evaluation, computer support, analytical assistance and direct surveillance support in less urbanized areas; 4) assisting local health departments with field investigations of cases with no identified risk for infection, potential occupational exposures (*e.g.*, health care workers) and other special investigations; 5) regularly developing and disseminating AIDS case statistical reports to hundreds of requestors each year; and 6) evaluating of other data sets (*e.g.*, vital statistics, cancer, and registries) to determine the completeness of AIDS case reporting.

Epidemiology Studies Section

The Epidemiology Studies Section is responsible for designing and conducting scientific studies, analyzing and interpreting study results, and disseminating the information to prevention programs and local health departments through out the state. The three major program elements are serologic monitoring, analytical epidemiology, and behavioral/prevention studies.

Serologic Monitoring - This Section conducts and supports studies that collect blood specimens from high and low risk populations and examines them for evidence of HIV infection. In some instances, these studies involve face-to-face interviews with study participants and, in other cases, blood collected for another purpose is anonymously tested for HIV. The Section routinely monitors and analyzes HIV antibody test results collected among sentinel populations such as military recruit applicants, job corps applicants, blood and plasma donors, childbearing women and persons attending drug treatment and sexually transmitted disease programs.

In addition to sentinel populations, Epidemiology Studies Section conducts special sero-surveys among groups that appear to be at emerging risk for infection. During the next year, the Section will conduct multi-site surveys among young gay men, out-of-treatment drug users, migrant farm workers, and correctional inmates. The section provides scientific, organizational and financial support to assist local health departments, in collaboration with local prevention groups, to conduct rapid sero-surveys in populations deemed to be at risk. During the next year, the Epidemiology Studies Section will support special studies in twelve local health departments. The data from these studies will be used to guide local prevention planning and program evaluation efforts.

Analytical Epidemiology - The Epidemiology Studies Section is responsible for the more complex analysis of AIDS case data including geographic/demographic trend analysis, HIV prevalence estimates, AIDS case projections, evaluation of case reporting delay, and quantitative evaluation of surveillance strategies. In addition, the Section analyzes other databases such as hepatitis B, tuberculosis, and sexually transmitted disease data that serve as surrogate markers for high risk behaviors.

Behavioral and Prevention Studies - The Behavior and Prevention Studies Section is responsible for developing statewide epidemiologic profiles for community planning and assisting local health departments to develop profiles for local and regional planning. An important component of these community profiles is risk behavior prevalence surveys. Surveys of knowledge, attitude, belief and behaviors (KABB) provide proxy measures of HIV-related risk taking behaviors. During 1994 the Section will work with local health departments and community-based prevention groups to strengthen local capacity for KABB data gathering and interpretation.

Program and Policy Development Section

The Program and Policy Development Section is responsible for HIV-related legislative and policy analyses, administration of the local assistance block grant, development and maintenance of memoranda of understanding with local health departments, management of research contracts, administration of the federal surveillance grant, and publishing the *California HIV/AIDS Update*. This section also provides support services for the Epidemiology Branch, maintains a resource library, organizes the Tuesday Seminar Series, coordinates the Interagency Coordinating Committee, and responds to constituent information requests.

HIV/AIDS Epidemiology Proposed Allocations for FY 1994-95

General Fund

County Block Grants (Surveillance/Local Need)	$4,100,000
Special Epidemiologic Studies:	($1,097,000)
1. Sentinel Sero-Surveillance	100,000
2. Local Serosurveys	250,000
3. Pediatric Spectrum of Disease	200,000
4. Risk Behavior Prevalence Surveys	200,000
5. UC Berkeley School of Public Health	100,000
6. UC Davis Epidemiology Graduate Group	100,000
7. Native American Women's Survey	25,000
8. Laboratory Support Costs	25,000
9. T-Cell Evaluation Study (San Diego)	25,000
10.Lesbian/Bisexual Women's Survey	50,000
Total General Funds	$5,197,000

Federal Surveillance/Seroprevalence Funds

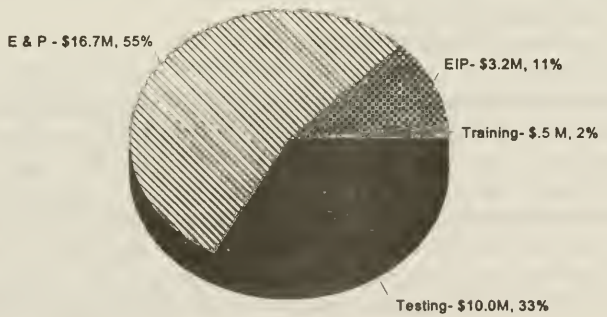
Family of Surveys	250,000
Survey of Childbearing Women	450,000
Local Surveillance Support (ends 12/31/94)	600,000
Federal Funds	$1,300,000
TOTAL	**$6,497,000**

Education and Prevention Services Branch

The federal and state prevention funds are combined and allocated through established state administrative procedures for all prevention programs/activities. Different administrative allocation procedures are used for each program depending on the type of activities the program provides and the type of agency the Office of AIDS contracts with to conduct these activities. Federal funds received at the beginning of the calendar year are held until the beginning of the state fiscal year, July 1, and combined with state funds for allocation.

All prevention funds are administered through the Education and Prevention Services Branch in the Office of AIDS. These funds are used to implement education and prevention, HIV counseling and testing, and training programs at the local level. The Early Intervention Program is also funded with CDC funds from the Prevention Cooperative Agreement; however, the Early Intervention Program is housed under the HIV Care Branch in the Office of AIDS. Exhibit 5.4 illustrates the entire $30.4 million federal and state funds available in 1994 for Office of AIDS Education and Prevention Branch.

Exhibit 5.4
Office of AIDS Prevention Funds by Program (in millions) 1994



Source: California Department of Health Services, Office of AIDS

Education and Prevention (E&P) Program

The Education and Prevention Program operates under the Education and Prevention Services Branch in the Office of AIDS. The Program funds projects at the local level to prevent HIV transmission among persons who are practicing risk behaviors for HIV infection. In 1994, the combined state and federal budget for this program was $16.7 million. The Office of AIDS provides these funds to local public and private agencies/entities to develop and implement community-based HIV education and prevention programs and interventions. These prevention programs provide for development of risk reduction skills and practices, increased knowledge, and changes in beliefs and behaviors. These programs also promote changes in community social norms which sanction unsafe risk behaviors that place individuals at risk for HIV infection.

The Education and Prevention Program currently funds 150 projects to include with 38 county health departments, 70 community based organizations and one formal interagency agreement with the California Department of Education (DOE). Some of these agencies have funds to implement more than one Education and Prevention project. Included in these projects are the 11 statewide projects funded to provide special services to Office of AIDS contractors. The 11 statewide projects include:

Four Training Programs
Three Hotlines
One California AIDS Clearinghouse
One Multicultural Aids Resource Center
One Hemophilia Council
One Youth in Schools Initiative

Funds for all Education and Prevention projects are allocated through a request for proposal (RFP) process which requires submission of a competitive proposal. Historically, the RFP process has been highly controversial because of the competitive nature of the process, the changes in focus for the projects that has been dictated by the epidemiologic trends in the State, and the number of agencies responding. The last RFP process was initiated in December 1992 and involved review of 277 proposals requesting over $77 million in funds. Given that the RFP was requesting proposals for allocation of $13.7 million, the need as demonstrated by the number of proposal requests received is much greater than the Office of AIDS's.

The current projects are funded for a two year funding cycle. At the time of this writing, the projects are into the second year funding and implementation. These projects are due to end in the state, on June 30, 1995. Future funding of Education and Prevention projects will be dictated by the statewide Prevention Plan.

Contractual arrangements between the Office of AIDS and local health departments may involve collaborative arrangements among community-based organizations within the local jurisdiction. Collaborative projects involve the county/city health department acting as the lead agency within the jurisdiction. Subcontract relationships are established between the health department and community-based organizations that provide prevention and education services to targeted populations within the jurisdiction. There are 38 formal agreements with local health departments for Education and Prevention projects, 23 of these agreements are for collaborative projects.

There are three major Areas of Focus funded with Education and Prevention Program funds for local education and prevention projects. These are:

1. **Men having sex with men.** This Area of Focus funds projects that provide prevention services to gay and bisexual men. In particular, these funds are targeted for projects providing services to:

   A. Young gay/bisexual men.
   B. Gay/bisexual men of color regardless of age (*i.e.*, African American, Latino, Asian, Pacific Islander, etc.).

2. **Substance Users.** This Area of Focus funds projects that provide prevention services to person using drugs, with special focus on out-of-treatment drug users. In particular, these funds are targeted for projects providing services to:

   A. Injection drug users (IDUs) using opiates and stimulants not currently participating in drug treatment programs. There is special emphasis in funding projects that are providing prevention services to:
      - African-American/Black IDUs in urban areas (inner cities).
      - IDUs in urban areas (inner cities).

   B. Alcohol and other substance users who are not injecting drugs intravenously (*e.g.*, crack and cocaine users).

3. **Other persons at high risk for HIV.** This area of focus funds projects that provide prevention services to other select groups at risk for HIV. In particular, these funds are targeted for programs providing services to:

   A. Sex partners of persons practicing high risk behaviors or HIV negative sex partners of HIV-infected individuals.
   B. Persons engaging in unprotected sex with multiple partners.
   C. Sexually active youth that are in out of mainstream schools.

The prevention strategies funded rely on three major interventions. Most of the local programs have been funded to include the use of these three priority interventions. These interventions are:

1. **Street and community outreach programs.** This includes programs that reach individuals practicing high risk behaviors on the street or in community settings to provide prevention messages, informational materials, referrals and other related services.

2. **Risk reduction programs.** This includes programs that provide persons practicing high risk behaviors for HIV infection with skills to change attitudes and beliefs necessary to change high risk behaviors and/or sustain appropriate safe behaviors (*i.e.*, negotiating safer sex, needle and syringe cleaning, proper condom use).

3. **Community intervention programs.** This includes programs directed at the community, rather than individuals, to influence community norms in support of behaviors known to reduce the risk of HIV infection and transmission. Community level interventions typically target specific racial/ethnic/gender populations whose behaviors place them at high risk for HIV infection.

In addition to these types of projects, Education and Prevention funding is used to fund four other initiatives which are not necessarily focused on the same populations as the three Areas of Focus. These initiatives are:

1. **Rural Initiative.** These are projects funded to provide education and prevention services/activities in rural areas/health jurisdictions. The activities and targeted populations vary by project based on the needs of the community.

2. **Youth in Schools Initiative.** This initiative funds the Department of Education through an interagency agreement to provide prevention and education programs to implement state legislation which requires HIV education to be provided to youth in schools. A formal curriculum is provided at least once in middle school and once in high school prior to the youth's graduation. Programs funded include: training persons with HIV to teach/present in school programs, youth as peer educators, school administrator and teacher training, etc.

3. **Training Initiatives.** Education and Prevention funds are used to support local Education and Prevention projects by providing specialized training for their staffs. Training is provided for community health outreach worker (CHOW) staff conducting street outreach and individual prevention activities. Additionally, the Multicultural AIDS Resource Center (MARC) provides

multicultural training and technical assistance to local project staff providing prevention and education services to ethnic populations.

4. **Other Statewide Projects.** Other statewide projects funded with Education and Prevention funds support prevention activities for Office of AIDS and Education and Prevention projects. These projects include the English and Spanish Hotlines and the California AIDS Clearinghouse.

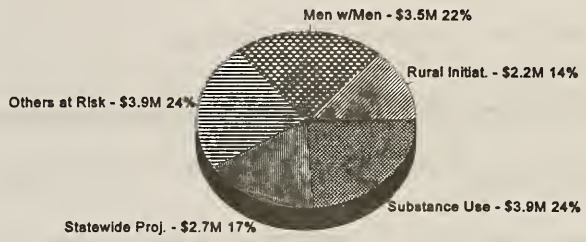
Exhibit 5.5 and Exhibit 5.6 depict the funds allocated for each Area of Focus and the number of projects funded.

Exhibit 5.5
Funding by Area of Focus

1.	Men Having Sex with Men	
	Number of Projects:	34
	Amount Funded:	$3.5 Million
2.	Substance Use	
	Number of Projects:	35
	Amount Funded:	$3.9 Million
3.	Other Persons at Risk for HIV	
	Number of Projects:	43
	Amount Funded:	$3.9 Million
4.	Rural Initiative	
	Number of Projects:	27
	Amount Funded:	$2.2 Million
5.	Statewide Projects	
	Number of Projects:	11
	Amount Funded:	$2.7 Million
Total:	Number of Projects:	150
	Amount Funded:	16.2 Million

Source: California Department of Health Services, Office of AIDS

Exhibit 5.6
Education & Prevention Programs Funds
By Area of Focus for 1994
(Total Education & Prevention Funds = $16.2M)



Source: California Department of Health Services, Office of AIDS

HIV Testing Program

The HIV Testing Program provides funds to local health departments and community clinics to provide HIV testing and counseling services to individuals who are seeking to learn their HIV antibody status. Federal and state funds are granted to the Office of AIDS for allocation to local entities for the provision of these services. A total of $10 million was available in 1994 for HIV counseling and testing services. Approximately $1.6 are federal funds granted through the CDC Cooperative Agreement Prevention Grant; the remaining amount, $8.6 million, are state funds. In 1995, the HIV Testing Program received an additional $1.9 million in state funds for a total of $11.9 million for counseling and testing services.

Funds for this program are allocated through formalized agreement/contracts to local county/city health departments and community clinics, *i.e.*, family planning clinics, rural community health clinics and Indian Health Clinics. The Office of AIDS is currently contracting with 130 entities to provide counseling and testing services throughout California with over 400 test sites. Allocations for local testing programs are derived using utilization and expenditure data from the previous 12 months of services. The allocations are relatively stable with increases in amounts based on demand for services in a given fiscal year.

Funds are provided for a risk assessment session, HIV laboratory test, disclosure session where test results are provided, and referral services. In California, there are primarily two types of testing provided, anonymous testing and confidential testing. For anonymous testing no personal identifiers are provided by the person seeking HIV testing. This type of testing is provided through legislatively mandated Alternative Test Sites (ATS) which are established by county/city health departments. Anonymous testing is also provided at other community clinics where individuals are given an option of having the HIV test either confidentially or anonymously. Confidential testing is provided with personal identifiers where the individual identity is known and individuals must give their written or informed consent to test for presence of HIV antibodies.

Reimbursement for counseling and testing services is provided on a monthly basis in arrears. The reimbursement for the total array of services is as follows:

Risk Assessment Session	$10.00
Laboratory Test	$15.00
Disclosure Session	$10.00
Total reimbursement	$35.00

Reimbursement may occur for the entire array of counseling and testing services or for only a portion of services provided. If only a risk assessment session is provided with an HIV test because the client does not return for the test results, the test site will receive reimbursement for a maximum of $25.00 ($10.00 for the risk assessment session and $15.00 for the HIV laboratory test).

Exhibit 5.7 illustrates the funding and types of testing sites provided through the HIV Testing Program.

Exhibit 5.7
HIV Testing Funding 1994

Funding to Local Health Departments--State Funds	
Alternative Test Sites 38 County/City Health Departments 110 Test Sites	$5,176,000
Primary Care Sites (i.e., STD, FP, etc.) 61 County/City Health Departments	$1,195,000
Total State Funds to Local Health Departments	$6,371,000
Funding to Local Health Departments--Federal Funds	
HIV Counseling and Testing for Out of Treatment IDUs 20 County/City Health Departments	$ 511,210
HIV Counseling and Testing In STD Clinics 36 County/City Health Departments	$1,100,000
Total Federal Funds to Local Health Departments	$1,611,210
Funding to Community Clinics--State Funds	
Family Planning Clinics 42 Agencies/143 Sites	$1,717,720
Rural Primary Health Clinics 11 Agencies/16 Sites	$ 128,826
Indian Health Clinics 12 Agencies/22 Sites	$ 157,454
Total State Funds to Community Clinics	$2,004,000

Source: California Department of Health Services, Office of AIDS

Training Program

The Training Program operates under the Education and Prevention Services Branch. This program provides direct training services to Office of AIDS contractors and other state and local agencies. The program operates with state and federal funds; however, most of the funds are for the administrative functions of the program since staff are hired and operate through the Office of AIDS Training Program to provide training locally. In addition to the administrative costs associated with the staff operating under the Training Program, there is a total of $515,000 state and federal funds that is contracted to agencies to support the HIV Test Counselor Training. This includes $255,000 state funds and $260,000 federal funds. These funds are used to maintain curricula, train trainers and maintain trainers' skills, and pay for costs associated with providing the training locally.

There are three basic types of training the Office of AIDS provides through the Training Program: HIV Test Counselor Training, AIDS/HIV 101 Training, and AIDS In the Workplace Training.

The HIV Test Counselor Training provides training throughout California to Office of AIDS HIV counseling and testing contractors. All HIV test counselors must undergo the required training courses in order to provide the risk assessment counseling session and disclosure counseling sessions to those seeking HIV testing. Training is provided locally and free of charge to any Office of AIDS HIV testing contractor. Training for HIV counselors include several courses. The courses provided are as follows:

1. **Basic Counselor Training.** This is a three day training course required for HIV counselors. It provides counselors with beginning counseling skills, and covers topics such as risk assessment, risk reduction, counseling guidelines, cultural issues, testing procedures and HIV epidemiology. In FY 1993-94, 54 courses were held and approximately 963 counselors were trained.

2. **Enhanced Risk Assessment Training.** This is a required two day course for HIV counselors who have gone through the Basic Training and have three months counseling experience and 75 contact hours working with the public. It provides counselors with enhanced skills on client risk and needs assessment, client centered counseling techniques, emphasis on behavior change model, risk reduction planning and secondary risk factors (*i.e.*, social, cultural, economic and psychological). In FY 1993-94, 35 courses were held and approximately 453 counselors were trained.

3. **Continuing Education Training.** This is a required six hour course designed for experience counselors with at least six months of experience. The course provides three hours of "update" counseling techniques and three hours of

consultation for problem areas as identified by the counselor, and "care for the care giver." In FY 1993-94, 33 continuing education courses were held and approximately 426 counselors were trained.

4. **Supplemental Spanish Training.** This is an optional one and a half day training designed for counselors working with monolingual Spanish speaking individuals. It reviews the basics of counseling in Spanish and the cultural and linguistic needs of Latinos.

The AIDS/HIV 101 Training is provided upon request to any local, department or other state agency requiring HIV training for their staff. The scope of this training may range from an overview of HIV transmission issues to a full eight-hour training tailored to meet the needs of the agency requesting the training. Trainings have been provided to the California Department of Social Services for staff working with foster parents for the placement of children, the Department's Audits and Investigation staff as part of an in-service training and to many local churches, community clinics, and other organizations.

The AIDS In the Workplace Training is the Office of AIDS's newest training program. It will function much like the AIDS/HIV 101 Training in that it will be provided upon request. Office of AIDS trainers are undergoing training through the American Red Cross AIDS In the Workplace Training Curriculum which was developed with funds from CDC. It is the Office of AIDS's intent to use the Red Cross curriculum and provide training upon request to meet the needs of state agencies as well as local programs.

HIV Early Intervention Program

The goals of the Early Intervention Program are:

- To interrupt the transmission of HIV to uninfected persons by focusing HIV transmission risk-reduction, behavior change support, and HIV education on HIV-positive individuals; and

- To improve and prolong the health and productivity of those infected with HIV by providing long-term, managed health care and support services.

To achieve these goals, the program funds and monitors twelve locally operated Early Intervention Projects statewide. The existing Projects are located in major urban areas: the San Francisco Bay area (San Francisco, San Leandro, San Jose, San Mateo, and Sonoma), the greater Los Angeles area (Los Angeles, Long Beach, Santa Ana, San Bernadino, and Riverside), San Diego, and Sacramento. Project staffing includes a project director, a health educator, a social worker, a clinician (nurse, physician's assistant, and/or physician), and a clerical position. Staffing may include other positions, such as nutritionist, phlebotomist, or eligibility clerk) depending on resources and additional program components.

Any person who is HIV-infected is eligible to receive Early Intervention Program services. In addition, when appropriate, the HIV-negative, ongoing partners of HIV-positive Early Intervention Program clients are eligible to receive risk-reduction and other related services. All clients are screened to determine the availability of third-party payers and to determine the client's ability to pay a share-of cost. Services are not denied because of inability to pay.

Early Intervention Program services are provided on an ongoing basis. All clients receive transmission risk, health, psychosocial, and needs assessments approximately every four to six months. Additional or more frequent services are provided on an as-needed basis. Specifically, services provided by Project staff to all HIV-infected Early Intervention Program clients are:

1. **Risk Reduction/Behavior Change Support.** Assessments of HIV transmission risk behaviors at regular intervals, with risk reduction strategies and behavior change support as needed.

2. **Health Education.** HIV and general health education with assessments at regular intervals and health enhancement strategies such as nutrition, exercise, or stress reduction techniques.

3. **Psychosocial Support.** Psychological assessments at regular intervals with short-term counseling and support groups where appropriate.

4. **Medical Monitoring.** Comprehensive medical evaluations and laboratory tests at regular intervals to monitor HIV infection. Prophylactic therapies are prescribed and monitored when appropriate.

5. **Case Management.** Needs assessments at regular intervals with individualized action plans, appropriate referrals, and linkages for future AIDS treatment and support services.

In addition to the required "core" components listed above, some Projects are able to offer additional services such as clinical trials information and referrals, nutrition counseling, benefits counseling, smoking cessation classes, client newsletters, treatment advocacy, dental services, services to the incarcerated, community forums, and specialized services for substance users, women, and non-English speaking, monolingual individuals. The services that are offered vary from project to project depending on available resources, population(s) served, and type of location (*e.g.*, public health clinic versus hospital setting).

The Early Intervention Program was implemented at two locations in 1988 with $600,000 in federal prevention funds. It now operates twelve Early Intervention Projects with a budget of $3.18 million, including the $600,000 in prevention dollars provided by the

Centers for Disease Control and Prevention. The state general fund provides $2.58 million of the total Early Intervention Program funding.

As stated previously, all twelve Projects provide five "core" components. Federal prevention funds of $600,000 support only one of the five components -- risk reduction/behavior change support -- providing approximately $50,000 for the prevention component at each site. State general funds augment client services in all program components.

Total Early Intervention Program local funding is allocated as follows:

Project	Amount
Alameda	$246,595
Long Beach	300,000
Orange	286,595
Riverside	166,595
Sacramento	286,595
San Bernadino	166,595
San Diego	276,595
San Francisco	286,595
San Mateo	238,815
Santa Clara	300,000
Sonoma	277,020

Costs for the Early Intervention Program vary considerably from project to project, depending on the number and types of services offered and the number of clients served. All projects provide the program's core services as required by legislation and program protocols, but many of the projects provide additional services such as nutrition counseling or benefits counseling. To provide more types of services and/or services to more people, many projects supplement their state funding from a number of sources. Total costs from all funding sources to operate a project for fiscal year (FY) 1992-93 ranged from $158,228 to $1,403,354, with a median cost of $522,316. By comparison, expenditures for FY 1991-92 ranged from $152,923 to $1,667,533.

The average total cost for services per client per year also varies substantially from project to project, depending on individual need and services provided. For those projects that provided only the required core services, the cost for services per client in FY 1992-93 ranged from $640 to $1,758 per client, with a median of $1,209 and an average cost of $1,254.

For those projects that provided services beyond the required Early Intervention Program core services, costs were higher. In FY 1992-93, the annual cost per client for all

services provided ranged from $1,100 to $2,479, with a median cost of $1,790 and an average cost of $1,769.

It is important to note that the provision of the above services leads to a reduction of future HIV/AIDS health care costs in the following ways:

- Further HIV transmission by HIV-infected persons is averted or reduced, thus creating cost savings in future HIV/AIDS care and treatment. Prevention dollars are used to their maximum potential by narrowly concentrating prevention activities on and around the HIV-infected persons who can actually transmit the disease rather than on the general population.

- HIV-infected persons whose medical and psychosocial needs are met continue to be productive, wage earning, tax-paying members of society for longer periods of time.

- If the referrals and linkages necessary to provide a person with a comprehensive continuum of care are already in place when the need for AIDS treatment arises, expenses for emergency care and hospitalizations can be avoided or minimized.

- The need for costly, inpatient medical care is delayed, lessened, or avoided as a result of managed health care. When an HIV-infected person's health status is monitored and appropriate prophylactic care is made available, treatment costs for opportunistic infections are decreased.

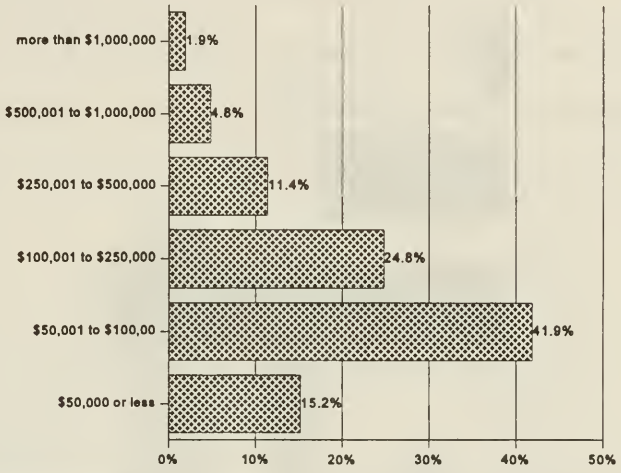
PROFILE OF PROVIDERS AND CLIENTS

The remainder of this chapter profiles the providers and clients of Education and Prevention services. While the Office of AIDS does not maintain a computerized database on its HIV Education and Prevention contractors, limited information on these programs does exist. In 1992, the Institute for Health Policy Studies, through a contract with the Office of AIDS, conducted a survey of all HIV Education and Prevention contractors with contracts in place for fiscal year 1990-91. Contractors responding to this survey supplied information on providers, clients, and services. This information, although not from the most current fiscal year, provides a picture of Office of AIDS-funded HIV prevention.

Providers

Individual Education and Prevention providers range from very small programs with budgets of less than $50,000 and no full time staff, to programs with budgets in excess of a million dollars. The majority of programs are of modest size. As shown in Exhibit 5.8, well over half of Office of AIDS funded Education and Prevention programs have budgets under $100,000, and less than 20% of contractors have programs with budgets that exceed a quarter of million dollars. Only 2% of providers have budgets of one million dollars or more.

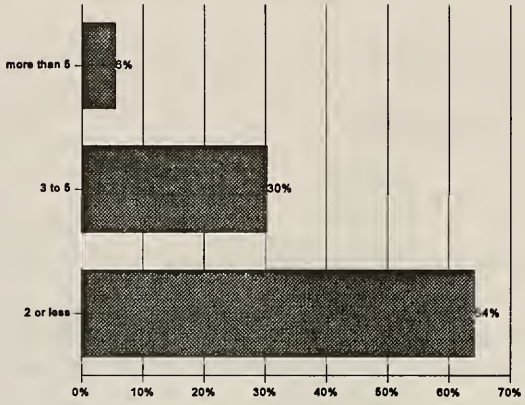
Exhibit 5.8
Total Budget of Education and Prevention Contractors
FY 1990-91



Source: HIV E&P Contractor Survey.
HIV E&P Evaluation, IHPS, UCSF, 1992.

As Exhibit 5.9 shows, staffs of these programs tend to be of modest size, as well. Close to two-thirds of Office of AIDS funded Education and Prevention programs have fewer than three FTE staff persons. Just 6% of programs have five or more persons on staff supporting their Education and Prevention programs.

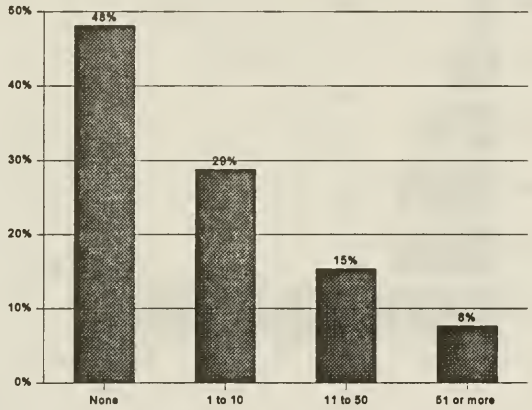
Exhibit 5.9
Number of FTE Staff of Education and Prevention Contractors
FY 1990-91



Source: HIV E&P Contractor Survey.
HIV E&P Evaluation, IHPS, UCSF, 1992.
Office of AIDS, California Department of Health Services

With staff size so small, volunteers make critical contributions to the operation of many Education and Prevention programs. Over half of the programs utilize volunteer support, and almost a quarter of the programs enjoy the benefits of eleven or more volunteers. While approximately 8% of the programs have large numbers of volunteers, (51 volunteers or more), close to half (48%) do not have any volunteer support. (See Exhibit 5.10.)

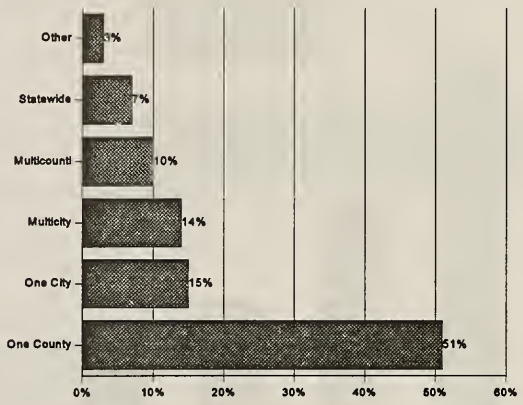
Exhibit 5.10
Number of Volunteers of Education and Prevention Contractors
FY 1990-91



Source: HIV E&P Contractor Survey.
HIV E&P Evaluation, IHPS, UCSF, 1992.

In light of the modest size of most programs, it is not surprising that just over half of Education and Prevention contractors serve a single county, while another 15% operate within a single city. Exhibit 5.11 shows that only 10% of programs serve a multi-county region, not including the 7% of programs that are statewide.

Exhibit 5.11
Service Areas of Education and Prevention Contractors
FY 1990-91



Source: HIV E&P Contractor Survey.
HIV E&P Evaluation, IHPS, UCSF, 1992.

Even with limitations of staff and finances, Education and Prevention contractors reported serving large numbers of people. In FY 1990-91 contractors collectively served almost 80% more individuals than they had projected. "The reason for actual numbers of persons served being higher than projected numbers are:

1. Contractors are serving more people than they anticipated or the demand for services was greater than anticipated;

2. Contractors are reporting repeat encounters with the same individuals;

3. Contractors are serving more people than projected because initial projections were conservative since contractors recognized that these projected numbers were part of their contractual agreement with the Office of AIDS;

4. Contractors are reporting actually serving more people, since they perceive it to be in their best interest to do so, reflecting the bias of self-reported data in an evaluation of their agency's performance that could affect their future funding." (Institute for Health Policy Studies, 1993) (See Exhibit 5.12)

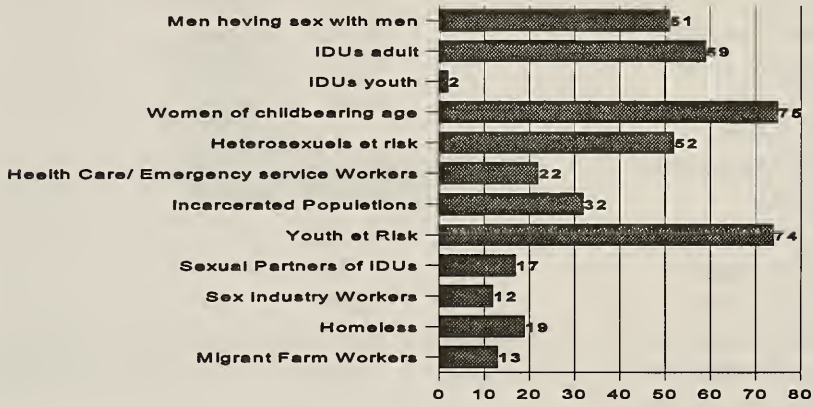
Exhibit 5.12
Projected vs. Actual Numbers of Clients Served by Education and Prevention Contractors, FY 1990-91

Target Groups	Projected Number	Actual Number
Men having sex with men	51,042	84,426
Injection drug users (IDUs)	34,612	65,186
Women of child-bearing age	32,120	75,531
Heterosexuals at risk	45,269	82,072
Health care/emergency services workers	10,015	25,483
Incarcerated populations	16,742	19,421
Youth at risk	47,049	68,728
Sexual partners of IDUs	4,483	4,975
Staff at your agency	203	300
Sex industry workers	10,990	25,646
Homeless	5,378	9,181
People with AIDS/HIV	900	1,592
People who trade sex for food, drugs, or shelter	0	0
Migrant farm workers	10,590	14,243
State office of AIDS E&P contractors	859	1,095
Alternative testing sites	1,600	1,669
Trainers	455	779
Other	37,620	75,437
Total	309,927	555,764

Source: HIV E&P Contractor Survey.
HIV E&P Evaluation, IHPS, UCSF, 1992.

The number of contractors serving particular target groups varied, due in large part to the varied sizes of each population. This is illustrated by Exhibit 5.13. For FY 1991-92, women of childbearing age and youth-at-risk were served by the largest number of contractors--75 and 74 programs, respectively. Injection drug using adults, heterosexuals-at-risk, and men having sex with men were each served by slightly more than 50 contractors. Interestingly, sexual partners of IDUs were served by just 17 contractors, and injection drug using youth were only served by 2. Two groups, health care/ emergency service workers, and the incarcerated were both served by between 20 and 50 service providers. Other groups that were served by fewer than 20 contractors include the homeless, migrant farm workers, and sex industry workers.

Exhibit 5.13
Number of Contractors Serving Target Populations FY 1991-92



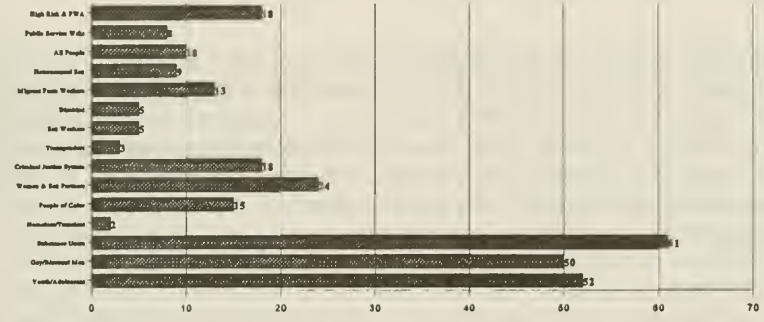
Source: HIV E&P Contractor Survey.
HIV E&P Evaluation, IHPS, UCSF, 1992.
Office of AIDS, California Department of Health Services

To better inform this Plan, the Office of AIDS and the planner analyzed 1994 Education and Prevention contracts with an eye to the Community Planning Working Group's defined target populations and strategies. Since the contracts were issued using a 1993 set of priority populations, information was unavailable in some instances about the CPWG-defined populations being served under these contracts. This proved particularly difficult for the

subvention contracts where many groups were being served under a single contract. The problems of analyzing contracts by differing frameworks applied to the analysis of strategies, as well. Office of AIDS contract managers used their best judgement and knowledge of the Education and Prevention contractors to provide information to the planner. From this information, we were unable to estimate the number of persons served in each target population and with each strategy. Despite the limitations of this analysis, we obtained useful information to contribute to a profile of providers and clients.

Results from an inquiry regarding the target population of programs showed that the three groups targeted by the largest number of contractors were substance abusers, with 61 programs, youth and adolescents, with 52 programs, and gay and bisexual men, with 50 programs. The group targeted by the next largest number of programs was women and their sex partners (24 programs). No other group was targeted by more than 18 programs (Exhibit 5.14).

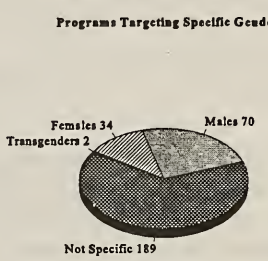
Exhibit 5.14
Programs By Target Population, FY 1993-94

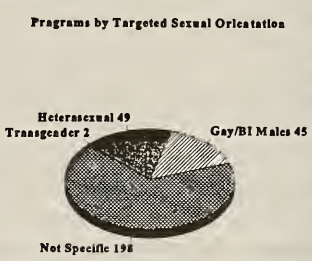


Analysis of OA E&P Contracts
Harder+Kibbe Research
August 1994

The contract analysis also gives a picture of programs by gender and sexual orientation. Exhibit 5.15 shows that almost two-thirds of Education and Prevention programs do not specifically target one gender or another. Almost one-quarter specifically serve males, while 12% direct services toward females. Two programs target transgenders. More than two-thirds of the programs do not specifically serve any sexual orientation, while almost an equal number target heterosexuals as target gay and bisexual men (17% and 15% respectively).

Exhibit 5.15
Programs by Gender and by Sexual Orientation, FY 1993-94

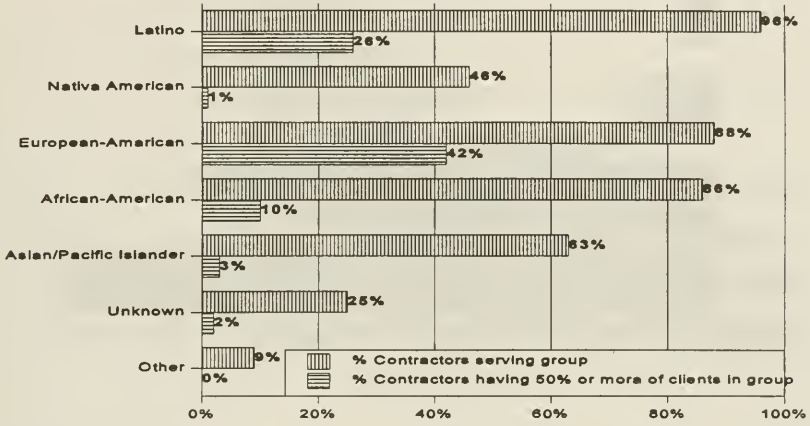




Analysis of OA E&P Contracts
Conducted by Harder+Kibbe Research
August 1994

The clients of Office of AIDS contractors reflect the ethnic diversity of both the state and the epidemic. Exhibit 5.16 shows that most contractors in the state report serving most ethnicities. Twenty-six percent, however, report that at least half of their clients are Latinos; only 1% report that at least half of their clients are American Indian/Alaskan Native; 42% report that at least half of their clients are white; 10% report that at least half of their clients are African-American/Black; and 3% report that at least half of their clients are Asian or Pacific Islander.

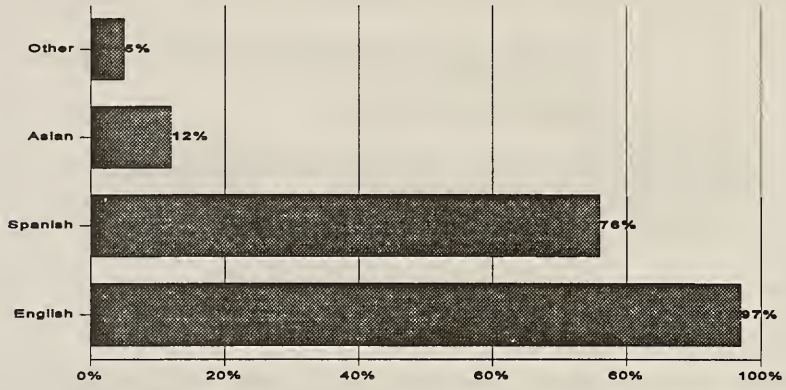
Exhibit 5.16
Racial/Ethnic Composition of Clients
FY 1990-91



Source: HIV E&P Contractor Survey.
HIV E&P Evaluation, IHPS, UCSF, 1992.
Office of AIDS, California Department of Health Services

While English is the most common language used to provide spoken information to the clients of contractors, used by all but three percent of contractors, Spanish is also widely used. As shown in Exhibit 5.17, over three-quarters of contractors use Spanish, either exclusively or together with another language, to communicate with clients. Twelve percent of contractors communicate with clients in an Asian language, and an additional 5% use some other language.

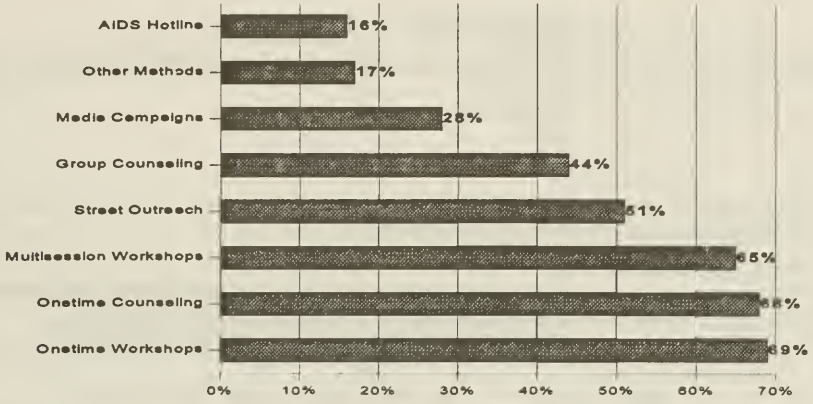
Exhibit 5.17
Languages Used by Contractors to Provide Spoken Information to Clients



Source: HIV E&P Contractor Survey.
HIV E&P Evaluation, IHPS, UCSF, 1992.
Office of AIDS, California Department of Health Services

Just as the clients of Education and Prevention programs are varied and diverse, so too are the types of service contractors provide, illustrated by Exhibit 5.18. The strategy used most commonly by contractors is the one-time workshop, used by almost 70% of contractors. This is followed closely by one-on-one counseling, used by 68% of contractors, and the multi-session workshop, used by 65% of contractors. Only one other method, street outreach, is used by a majority of providers. Fifty-one percent of contractors provide that service.

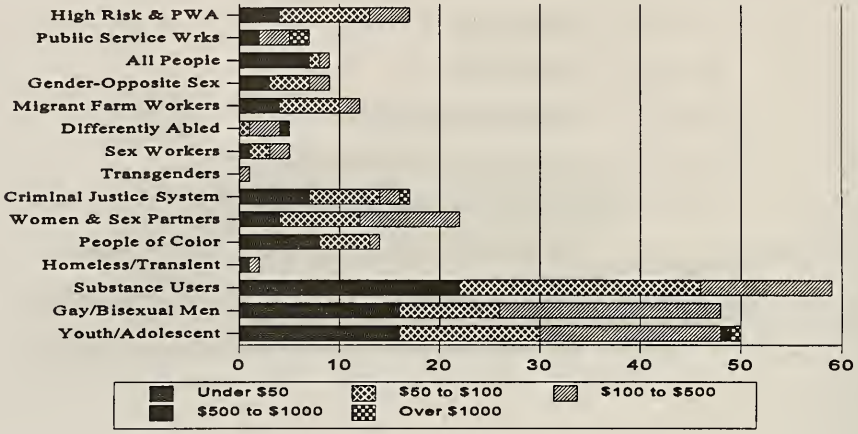
Exhibit 5.18
Methods Used to Provide Services by Education and Prevention Contractors, FY 1990-91



Source: HIV E&P Contractor Survey.
HIV E&P Evaluation, IHPS, UCSF, 1992.
Office of AIDS, California Department of Health Services

The analysis of Office of AIDS Education and Prevention contracts provides information on the cost per client of providing services. As shown in Exhibit 5.19, over two thirds of all programs cost less than $100 per client served; half of these cost less than $50 per client served. The vast majority of the remaining programs (97%) fall between $100 and $500 per client served. Only six programs cost over $500 per client served. Four of these six fall between $500 and $3,000; two target youth and adolescents, one targets people in the criminal justice system, and one targets the disabled. The two most expensive programs, each costing over $3,000 per client served, both target health and human service workers, including emergency service workers and educational service workers.

Exhibit 5.19
Program Cost per Client Served



Analysis of Office of AIDS E&P Contracts
Harder+Kibbe Research
August 1994

SECTION III
RECOMMENDATIONS OF THE CALIFORNIA HIV PREVENTION PLAN

Section III of the California HIV Prevention Plan identifies and describes the recommendations of the Community Planning Working Group. These recommendations were made over the course of the monthly meetings. Each chapter in this section describes one of the recommendations; the discussion includes considerations of the Committee or Community Planning Working Group in developing the recommendations, the recommendation itself, and a brief analysis (as necessary) of the recommendation.

These recommendations and chapters are:

Chapter 6	Priority Goals and Objectives;
Chapter 7	Prioritized Target Populations;
Chapter 8	Prioritized Needs of Defined Populations;
Chapter 9	Prioritized Portfolio of Strategies for Defined Populations;
Chapter 10	Linkages and Coordination Plan;
Chapter 11	Technical Assistance Needs and Plan; and
Chapter 12	Resource Allocation Plan.

A draft of the California HIV Prevention Plan was produced in October and hearings were advertised and held around the State to accept public comment on the plan. The Community Planning Working Group convened in December to consider the public comment. A summary of the public comment is contained in Chapter 13.

CHAPTER 6: PRIORITY GOALS AND OBJECTIVES

INTRODUCTION TO GOALS AND OBJECTIVES

The Community Planning Working Group as a whole developed the HIV prevention goals and objectives through an iterative process of comment and revision. Initially, the Community Planning Working Group separated into five ad hoc groups and each group developed draft objectives for each of the goals. These were integrated into a single text and reissued to the group for written comment. Comments were collected and integrated, and the text reissued for additional rounds of comment. Final changes were made at the Redding (August 31 - September 1) meeting by the full Community Planning Working Group.

The goals address the basic ingredients of a comprehensive HIV prevention program:

- Knowledge and skill development;
- Norm setting among peers, groups and communities;
- Behavior change for those whose HIV status is negative or unknown;
- Behavior change for those whose HIV status is known to be positive;
- Early intervention services for HIV positive persons; and
- Capacity development to ensure the accomplishment of the preceding goals.

Within the framework of these goals, objectives were developed that delineate broad populations (such as sexually active persons), services (such as counseling and testing), or approaches to service delivery (such as cultural competence). In its first year of planning, the Community Planning Working Group did not make the objectives measurable or time-specific. However, the results of the prioritization of target groups, needs, and strategies provide specific information about which objectives should be implemented in the short-term.

Further, at the December meeting, the Community Planning Working Group made provisions for monitoring the implementation of this plan. This implementation includes local health jurisdictions conducting community needs assessment and prioritization on the local level.

GOALS AND OBJECTIVES

GOAL I: TO INCREASE KNOWLEDGE ABOUT HIV AND AIDS AND DEVELOP SKILLS TO PREVENT HIV

Objective 1: All persons living in California who are sexually active should know how HIV is transmitted, be able to assess their personal risk for HIV

infection, and have the skills and tools to protect themselves and others from HIV infection. In particular:

a. All gay and bisexual men, heterosexual men and women, bisexual women and lesbians, transgender persons, children, adolescents, and youth should know the risk of HIV transmission specific to their sexual practices;
b. All persons with sexually transmitted diseases should recognize their increased risks of HIV transmission;
c. All persons should know the increased risks of HIV transmission when under the influence of alcohol or other drugs or emotional states and other mental health challenges that affect judgment;
d. All persons with hemophilia should know the risks of HIV transmission;
e. All women of child-bearing age should know the risks of HIV perinatal transmission and early gynecological manifestations of HIV disease;
f. All persons who have received an HIV negative antibody test result should have the knowledge, skills, and tools to protect themselves from HIV infection;
g. All persons should know the risks of HIV through transfusion of blood and blood products.

Objective 2: All persons living in California who inject drugs should know how HIV is transmitted, should be able to assess their personal risk for HIV infection, and have the skills and tools to protect themselves and others from HIV infection. In particular:

a. All injection drug users should know the risks of HIV transmission specific to their needle using/sharing practices and sexual practices;
b. All injection drug users should know the increased risks of HIV transmission when under the influence of alcohol or other drugs or emotional states and other mental health challenges that affect judgment.

Objective 3: All children and youth living in California should know how HIV is transmitted, should be able to assess their personal risks for HIV infection, and have the skills and tools to protect themselves and others from HIV infection.

Objective 4: All persons living in California should know whether they are at risk for HIV infection and have access to voluntary, free, anonymous and

confidential HIV counseling and testing at appropriate intervals. This is particularly true of those considering parenthood.

Objective 5: All persons living in California should have access to multilingual, culturally sensitive and competent general information about HIV/AIDS (e.g., media campaigns, public education seminars, AIDS in the Workplace training, and Hotlines).

Objective 6: All persons living in California should know that sharing needles to inject any substance, to pierce, tattoo or receive acupuncture or other procedures involving the use of needles can transmit HIV and should know procedures to prevent HIV transmission from these activities.

Objective 7: All persons in California should have access to culturally and linguistically competent and sensitive information, risk assessment, and skills and tools to protect themselves and others from HIV infection. This should include empowerment and safer sex negotiation skills, especially for women.

GOAL II: TO ESTABLISH PEER, GROUP, INSTITUTIONAL, AND COMMUNITY NORMS TO SUPPORT HIV RISK BEHAVIOR CHANGE

Objective 1: All persons living in California should support and expect support from their families, peers, and friends to protect themselves from HIV infection.

Objective 2: All persons living in California should support and expect support from their social/cultural group(s) to protect themselves from HIV infection.

Objective 3: All persons living in California should be assured that health care facilities, health care providers, residential care providers, and blood, tissue, sperm, and breast milk banks practice universal infection control precautions.

Objective 4: All health and human services providers, schools personnel, employers, community leaders, first responders, and correctional and public safety workers in California should be trained and updated to provide HIV prevention information as opportunities arise.

Objective 5: All persons living in California should expect that HIV/AIDS programs and services be culturally and linguistically sensitive.

Objective 6: All persons living in California should expect their geographic community to support HIV prevention efforts/programs with participation by groups such as churches, media organizations, elected officials, government officials, boys and girls clubs, civic groups, local health departments, law enforcement agencies, military establishments and others.

Objective 7: All persons living in California should expect their community to support harm-reduction strategies such as needle exchange programs and condoms in schools, bars, bathhouses, and massage parlors.

GOAL III: TO REDUCE NEW HIV INFECTIONS BY INCREASING THE NUMBER OF PEOPLE PROTECTING THEMSELVES

Objective 1: All persons living in California who are sexually active should protect themselves from the sexual transmission of HIV.

Objective 2: All persons living in California who inject drugs should protect themselves from HIV transmission that can occur through injection drug use.

Objective 3: All youth living in California should receive linguistically and culturally competent age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission.

Objective 4: All persons living in California who have received a negative HIV antibody test result should have easy and affordable access to culturally competent prevention services including counseling, mental health services, addiction prevention and psychosocial support to maintain safe behaviors.

GOAL IV: TO REDUCE NEW HIV INFECTIONS AND REINFECTIONS BY REDUCING THE NUMBER OF HIV POSITIVE PERSONS INFECTING OTHERS

Objective 1: All HIV positive persons living in California who are sexually active should protect their sexual partners from the sexual transmission of HIV and should receive ongoing behavior change education.

Objective 2: All HIV positive persons living in California who inject drugs should protect drug and needle sharing partners from HIV transmission and should receive ongoing behavior change education.

Objective 3: All HIV positive persons living in California should protect others by not donating blood, body tissue, sperm or breast milk.

Objective 4: All HIV positive pregnant women and nursing mothers living in California should know all methods of treatment available and necessary precautions to reduce perinatal transmission.

Objective 5: All persons living in California receiving a positive HIV test result should be counseled about voluntarily disclosing their status to their sexual and/or needle-sharing partners and seek assistance in voluntary partner notification.

GOAL V: TO INCREASE THE NUMBER OF HIV POSITIVE PEOPLE SEEKING EARLY INTERVENTION SERVICES

Objective 1: All HIV positive persons living in California should have information about the range of early intervention services and treatment available, including both traditional and non-traditional modalities, and information about the benefits of potential risks of certain traditional and non-traditional treatments. Information should be both culturally and linguistically sensitive.

Objective 2: All HIV positive persons living in California should receive culturally and linguistically sensitive counseling, referral, and linkage to early intervention programs when they receive their test results.

Objective 3: All HIV positive persons living in California should have easy and affordable access to early intervention programs including medical services, counseling, practical support, and psychosocial support that is culturally and linguistically sensitive.

Objective 4: All HIV positive persons living in California should have the skills to initiate and maintain safer sex behaviors, including self-esteem and life-affirming support.

GOAL VI: TO ENHANCE THE STATE OF CALIFORNIA'S CAPACITY TO ENSURE THE ACCOMPLISHMENTS OF THE PRECEDING HIV PREVENTION GOALS

Objective 1: All local HIV prevention programs should receive the technical assistance needed to provide and maintain quality prevention services. (Examples of technical assistance include fiscal management systems, supervision, board relations, program planning, HIV prevention

methods, cultural competence, program planning and design, quality assurance and community standards of service.)

Objective 2: Training should be available and required as necessary to prevention providers. Examples of training include HIV risk assessment, counseling and testing, and community outreach worker training. Training should be appropriate to the knowledge and needs of the trainee. Further, all local and state HIV prevention program staff should receive appropriate cross-cultural sensitivity training tailored to the populations and residents in their area. Staff should be evaluated for understanding as part of the training.

Objective 3: Evaluations of all prevention programs should be conducted. This should occur through technical assistance rendered to prevention programs; partnerships between prevention programs and academic researchers; or funds to prevention programs to hire professional evaluators. Panels made up of consumers, community members, providers and experts should be used to guide the evaluations. Information from these evaluations should be shared broadly. Consumers and providers should be included in the research and evaluation design.

Objective 4: The functions of the Office of AIDS should be maintained, and improved in collaboration with consumers, providers, experts, and affected communities, including the capacity to award, process, monitor, and reimburse contractors; and the capacity for continued and improved epidemiologic surveillance efforts, including the support of local health department surveillance efforts.

Objective 5: Behavior change studies and prevalence studies in under-reported target populations should be conducted. Information from these studies should be shared broadly among prevention programs and providers.

CHAPTER 7: PRIORITIZED TARGET POPULATIONS

While the Community Planning Working Group as a whole prioritized the target populations, the Other Needs Assessment Committee was charged with the responsibility to develop the unprioritized list of target populations. In conducting this task, the Other Needs Assessment Committee took into consideration several sources of information.

One source of information was work conducted by the entire Community Planning Working Group at the Oakland meeting (April 7 - 8, 1994). This work consisted of a brainstorm session to identify populations which might be at risk but for whom there exists little documented information. These groups included homeless persons, migrant workers, incarcerated persons, young people, people in rural areas, Asians (particularly newly-arrived and monolingual), the hearing impaired, people of color, undocumented immigrants, people with physical disabilities, and transgender persons.

A second source of information that the Other Needs Assessment Committee considered in recommending target groups was the results of five focus groups conducted as part of this planning process. The Community Planning Working Group requested five focus groups around the state to find out about HIV risk behaviors and barriers to prevention education in groups for which little information exists. The groups were Native American Youth (held in Eureka), Latino Migrant Farm workers (held in Calexico), Transgender Persons (held in San Diego), Asian/Pacific Islander Men Who Have Sex With Men (held in Santa Ana), and HIV Positive Women (held in Oakland). Please see Attachment 12 for a summary of the focus groups.

The committee also considered epidemiological information presented by the Office of AIDS Surveillance Branch at the Long Beach meeting (May 5 - 6, 1994) and a summary of the epidemiological information presented by the Epidemiology Committee. Information similar to that presented at the Long Beach meeting is contained in the epidemiology section of this plan.

Further, Other Needs Assessment Committee members received input from all Community Planning Working Group members at the Fresno meeting (June 7 - 8, 1994) during a one hour session, and listened to public comment at each of the meetings.

A packet of information was prepared for the committee by the planner. The packet included a 30 page summary of relevant journal articles and reports on HIV prevention needs cross-indexed by exposure category; a summary of four KABB studies contracted by the Office of AIDS; University of California Abstracts from the 11th Annual AIDS Investigators Meeting prepared by the University-wide AIDS Research Program; a handout prepared by Community Planning Working Group member James Kahn that uses mathematical modeling to estimate the cost-effectiveness of prevention within select populations; and a dense set of

surrogate markers and other statistics supplied by the Surveillance Branch of the Office of AIDS.

During the course of their deliberations, Other Needs Assessment Committee members considered using the standard exposure categories as target populations. However, Community Planning Working Group members believed, and the Other Needs Assessment Committee accepted, that certain groups of people should be highlighted in the California HIV Prevention Plan, even though these groups were not confined to any one exposure category. Members then considered a conceptual framework that was represented by a matrix of risk exposure category by sociological factors such as ethnicity, gender, age. Committee members saw the advantage of this conceptual framework as its inclusiveness: all Californians were included. The weakness to this framework was its impracticality: there are tens of thousands of target groups if one considers combinations of sociological factors (such as age group, gender, ethnicity, housing status and employment status) for each of the exposure categories. The committee sought a framework that contained the inclusiveness of this matrix and the brevity of the exposure categories.

After further consideration and dialog, the committee formed the list that, with few modifications from the floor, was adopted by the Community Planning Working Group. The target groups selected are inclusive of all those living in California. In fact, most persons belong in two or more categories. Yet, the list is short enough to be useful for policy-setting and program implementation.

Upon adopting the list of target populations, the Community Planning Working Group prioritized the lists. To assist with the prioritization process, members were provided with a 45-page packet containing information about each target group. Information in the packets was culled from an extensive search of HIV/AIDS prevention articles in professional journals, a review of the four state-wide KABB studies, a review of local needs assessments, and inquiries from a variety of sources. They also received a summary of findings from the five focus groups conducted as a part of this process, and a summary of information obtained through interviews with representatives of 12 state agencies, such as Department of Education, Department of Corrections, and Office of Family Planning. They were asked to refer to other information available to Community Planning Working Group members such as the Epidemiology Committee's summary of the epidemic; handouts from the Office of AIDS Surveillance Branch presentation on epidemiology; the report, *Frameworks for Change,* by the Multicultural Liaison Board; their recollection of public comment sessions, their personal and professional experiences with HIV and these target groups; and any other sources of information or insight available to them.

Exhibit 7.1
California HIV Prevention Plan Target Populations

1. **Substance Users and Their Sex Partners**
   a. IDUs (sharing needles)
   b. Other drugs/alcohol users
2. **Gay & Bisexual Men of All Ethnicities and Ages**
   a. Gay & bisexual men of all ethnicities (African Americans/Blacks, Latino, Asians, Pacific Islanders, American Indians/Alaskan Natives, whites) and ages
   b. Men having sex with men, who are not identified as gay/bisexual
3. **Sex Industry Workers (Male, Female, Transgender)**
4. **Youth (Ages 17-24)/Adolescents (Ages 12-16)**
5. **People of Color Communities**
   a. African Americans & persons of non-African descent who are black
   b. Latinos/as
   c. Asians
   d. Pacific Islanders
   e. Native Americans (American Indians, Aleutians & Eskimos)
   f. Communities of mixed heritage
6. **Transgender/Transvestite Individuals**
7. **People in the Criminal Justice System**
8. **Homeless/Transient**
   Especially dually & multiple diagnosed (TB, HIV, emotionally or cognitively challenged)
9. **Immigrants and Undocumented Persons** (especially non-English Speaking)
10. **Women & Their Sex Partners**
    a. Heterosexual/Lesbian/Bisexual
    b. Women of Child-bearing Ages
11. **Seasonal/Migrant Farm Workers/Agriculture-related Workers**
12. **Persons Engaging in Heterosexual Sex**
13. **People in Group Living Situations**
14. **The Disabled Community**
    a. Hearing and visually impaired
    b. Physically challenged
    c. People living with hemophilia & their partners
    d. Mentally challenged (emotionally & cognitively)
15. **People Who Pierce or Tattoo**
16. **Children (Ages 0-11)**

Community Planning Working Group members were provided with a summary packet of information and a worksheet to complete. An introductory memorandum accompanying this information confirmed what most members knew: that completing the worksheet would not be easy for many reasons — insufficient information exists about the prevalence or incidence (or even AIDS cases) of many of the target groups; agreement among Community Planning Work Group does not exist about the relative importance of documented evidence versus undocumented evidence gained through talking with or observing behaviors in target groups; many Community Planning Working Group members are in the role of advocates for certain groups which adds an additional biases; some members know more about the risks for some groups than for others; and in each group there are sub-groups at greater risk than other sub-groups. They were asked to use their own judgment and all sources of information and experiences available to them in getting over these hurdles.

The worksheet listed the target populations and asked each Working Group member to rate each population on a scale of 0 to 3 (0= no risk for HIV; 3= high risk for HIV). The results of this decision-making process are dhown in Exhibit 7.1. Members received the information, memorandum of instruction, and worksheet between the Long Beach (July 13 - 15) and Redding (Aug. 30 - Sept. 1) meetings, and 37 members returned the completed worksheets. This constituted 70% of members and established a quorum for decision-making. Responses were tabulated for mean score and standard deviation. Level of agreement was determined by standard deviation scores; standard deviations .67 or higher were construed as a low level of agreement, between .41 and .66 as moderate level of agreement, and .40 or below as a high level of agreement. Please see Exhibit 7.2 for the mean score and levels of agreement.

As this exhibit shows, populations most at risk for HIV as discussed in the Needs Assessment Section of this plan are rated highest by the Community Planning Working Group. It further shows that there is a medium to high level of agreement about the risk for five highest ranked populations. Among the four lowest ranked populations there is a medium level of agreement. There is a low to medium level of agreement about the risk of the populations ranked in the middle. While there are clearly pockets of groups or subgroups whom engage in high risk activities for HIV within the populations of women, seasonal/farm workers/agricultural-related workers, and persons engaging in heterosexual sex, it is unlikely that each of these entire populations is engaging in high risk activities -- hence the mid-level scores and low-level agreement.

It is crucial to bear in mind, when reviewing this list, that people may fall into multiple categories. For example, while seasonal/migrant farm workers are in the bottom half of the list, those that inject drugs or engage in male homosexual sex should be targeted as a high priority. Similarly, women who inject drugs, are partners of injection drug users or work in the sex industry are prioritized high on the list. Therefore, while women as a whole were a mid-level priority, those that inject drugs or are partners of IDUs are a high priority. This approach would apply to other mid- and lower-level priority groups, as well.

Further, a few categories contain multiple and distinct communities, such as People of Color Communities and Disabled Communities. **The intention of the Community Planning Working Group is not to indiscriminately lump distinct communities together in implementing this plan. Programs may target one element within a larger category, such as African Americans, or the Hearing Impaired.**

Exhibit 7.2
Ranking of Target Groups by Community Planning Working Group

Population	Mean Score	Level of Agreement
Substance Users and Their Sex Partners	2.9	High
Gay and Bisexual Men	2.9	High
Sex Industry Workers	2.8	Medium
Youth/Adolescents (12-24 years)	2.6	Medium
People of Color Communities	2.5	Medium
Transgenders & Transvestite Individuals	2.4	Low
People in the Criminal Justice System	2.3	Medium
Homeless & Transient Persons	2.2	Medium
Immigrants & Undocumented Persons	2.2	Medium
Women & Their Sex Partners	2.1	Low
Seasonal/ Farm Workers/Agri-related Workers	2.1	Low
People who Engage in Heterosexual Sex	2.0	Low
Those in Group Living Situations	1.5	Medium
Disabled Communities	1.4	Medium
People who Pierce and/or Tattoo	1.4	Medium
Children (0-11 years)	1.1	Medium

0 = No risk for HIV
1 = Low risk for HIV
2 = Moderate risk for HIV
3 = High risk for HIV

CHAPTER 8: PRIORITIZED NEEDS OF DEFINED POPULATIONS

The Community Planning Working Group as a whole determined the unmet needs of the previously defined populations. They used the goals and objectives as a framework to define "needs" of the populations. Community Planning Working Group members received an 11-page worksheet on which to rate the need of each population for further education/ prevention; as with the Target Population Worksheet, members used a scale of 0 to 3 (0= No Need; 3= Great Need). When members were completing the Needs of Target Populations Worksheet, the goals and objectives were close to their final form, although three additional objectives were subsequently added, and several were slightly re-phrased. The final rounds of wordsmithing of the objectives are unlikely to have affected the scoring since objectives were stated in an abbreviated fashion on the worksheet; the objectives that were subsequently added, however, were not rated. Two of these objectives dealt with providing culturally and linguistically competent services (Goal I Objective 7 and Goal III Objective 7), and one dealt with offering a spectrum of prevention services to those receiving a negative HIV antibody test (Goal III Objective 4)

Community Planning Working Group members received the Needs of Target Populations Worksheet when they received the Target Populations Worksheet; thus, they possessed the packet of information and the introductory memorandum described in the previous chapter.

Thirty-eight members returned the worksheet, representing 73% of the voting membership. Responses were tabulated for mean score and standard deviation. The results of this decision-making task were presented at the Redding (August 31 - September 1) meeting for discussion and adoption.

Exhibit 8.1 presents the moderate to high unmet needs for each population in priority order. The first column notes the goal, the second column identifies the specific need, and the third column lists the mean score. The last column indicates opportunities for collaboration between the Office of AIDS and other state agencies serving the respective populations. Information for this column came from the Needs of Priority Populations Worksheet which Community Planning Working Group members completed. Members were asked to state for each need (objective) whether the Office of AIDS or some other state agency should take the lead responsibility in meeting each need for each population. The far right column contains an asterisk in instances where at least 40% of voters indicated that another state agency should take lead responsibility and a double asterisk in those instances when at least 70% of voters indicated that another state agency should take lead responsibility.

Exhibit 8.1
Prioritized Needs of Target Populations

Rows marked with an asterisk (*) indicate opportunities for increased collaboration between the Office of AIDS and other state agencies serving the respective population.

Goal	Need	Mean	*
Substance Users			
Beh. Change HIV- or Unk.	Young substance users need comprehensive prevention services.	2.9	
Early Interv.	HIV+ substance users need further E/P to initiate and continue safe behavior.	2.9	
Beh. Change HIV- or Unk.	Substance users need further E/P to protect themselves from sexual transmission of HIV.	2.8	
Beh. Change HIV- or Unk.	Substance users need further E/P to protect themselves from transmission through injection drug use.	2.8	
Beh. Change HIV+	HIV+ substance users need further E/P to protect their sexual and/or needle-sharing partners.	2.8	
Beh. Change HIV+	HIV+ substance using pregnant women and nursing mothers need further E/P to reduce perinatal transmission of HIV.	2.8	
Early Interv.	Substance users need information about early intervention services and treatment.	2.8	
Knowledge	Substance users need HIV counseling and testing.	2.7	**
Norm Setting	Substance users need further E/P to help establish peer and group/social norms to support each other.	2.7	*
Norm Setting	Substance users need further E/P to help establish norms in communities that support HIV prevention efforts.	2.7	*
Beh. Change HIV+	HIV+ substance users need counseling about disclosing their status and assistance with partner notification.	2.7	
Early Interv.	Substance users need referral and linkage to early intervention programs.	2.7	
Early Interv.	Substance users need access to early intervention programs.	2.7	
Knowledge	Substance users need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others.	2.6	*
Norm Setting	Providers that serve substance users need training to provide HIV prevention services.	2.6	*
Norm Setting	Institutions that serve substance users need to establish norms to maintain universal precautions.	2.4	*
Knowledge	Substance users need general information about HIV/AIDS.	2.3	
Beh. Change HIV+	HIV+ substance users need further E/P about not donating blood, tissues, sperm or breast milk.	2.2	*

Gay and Bisexual Men			
Beh. Change HIV- or Unk.	Young gay/bisexual men need comprehensive prevention services.	3.0	
Early Interv.	HIV+ gay/bisexual men need further E/P to initiate and continue safe behavior.	2.7	
Norm Setting	Gay/bisexual men need further E/P to help establish peer and group/social norms to support each other.	2.5	
Beh. Change HIV+	HIV+ gay/bisexual men need further E/P to protect their sexual and/or needle-sharing partners.	2.5	
Beh. Change HIV+	HIV+ gay/bisexual men to seek counseling about disclosing their status and assistance with partner notification.	2.4	
Early Interv.	Gay/bisexual men need information about early intervention services and treatment.	2.4	
Early Interv.	Gay/bisexual men need referral and linkage to early intervention programs.	2.4	
Early Interv.	Gay/bisexual men need to have access to early intervention programs.	2.4	
Knowledge	Gay/bisexual men need further E/P to know how HIV is transmitted, to assess their personal risk, and to have skills to protect themselves and others.	2.3	
knowledge	Gay/bisexual men need HIV counseling and testing.	2.3	
Norm Setting	Gay/bisexual men need further E/P to help establish norms in communities that support HIV prevention efforts.	2.3	
Norm Setting	Providers that serve gay/bisexual men need training to provide HIV prevention services.	2.2	
Beh. Change HIV- or Unk.	Gay/bisexual men need further E/P to protect themselves from the sexual transmission of HIV.	2.2	
Beh. Changen HIV- or Unk.	Gay/bisexual men need further E/P to protect themselves from HIV transmission through injection drug use.	2.1	
Norm Setting	Institutions that serve gay/bisexual men need to establish norms to maintain universal precautions.	2.0	

Sex Industry Workers			
Beh. Change HIV- or Unk.	Young sex industry workers need comprehensive prevention services.	2.9	
Beh. Change HIV+	HIV+ sex industry workers need further E/P to protect their sexual and/or needle-sharing partners.	2.7	
Early Interv.	Sex industry workers need information about early intervention services and treatment.	2.7	
Early Interv.	Sex industry workers need referral and linkage to early intervention programs.	2.7	
Early Interv.	Sex industry workers need further E/P to initiate and continue safe behavior.	2.7	
Norm Setting	Sex industry workers need further E/P to help establish peer and group/social norms to support each other.	2.6	
Beh. Change HIV+	HIV+ sex industry workers need counseling about disclosing their status and assistance with partner notification.	2.6	
Early Interv.	Sex industry workers need access to early intention programs.	2.6	
Knowledge	Sex industry workers need to know how HIV is transmitted, to assess their personal risk, and to have skill to protect themselves and others.	2.5	
Knowledge	Sex industry workers need HIV counseling and testing.	2.5	
Norm Setting	Providers that serve sex industry workers need training to provide HIV prevention services.	2.5	
Norm Setting	Sex industry workers need further E/P to help establish norms in communities that support HIV prevention efforts.	2.5	
Beh. Change HIV- or Unk.	Sex industry workers need further E/P to protect themselves from sexual transmission of HIV.	2.5	
Beh. Change HIV- or Unk.	Sex industry workers need further E/P to protect themselves from HIV transmission through injection drug use.	2.5	
Beh. Change HIV+	HIV+ pregnant and nursing sex industry workers need further E/P to reduce perinatal transmission of HIV.	2.5	
Knowledge	Sex industry workers need general information about HIV/AIDS.	2.2	
Norm Setting	Institutions that serve sex industry workers need to establish norms to maintain universal precautions.	2.2	
Beh. Change HIV+	HIV+ sex industry workers need further E/P about not donating blood, tissues, sperm, or breast milk.	2.1	

Youth and Adolescents			
Norm Setting	Youth & adolescents need further E/P to help establish peer and group/social norms to support each other.	2.9	*
Beh. Change HIV- or Unk.	Youth & adolescents need further E/P to protect themselves from sexual transmission of HIV.	2.9	*
Early Interv.	Youth & adolescents need further E/P to initiate and continue safe behavior.	2.9	*
Knowledge	Youth & adolescents need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves & others.	2.8	*
Norm Setting	Providers, schools that serve youth & adolescents need training to provide HIV prevention services.	2.7	*
Norm Setting	Youth & adolescents need further E/P to help establish norms in communities that support HIV prevention efforts.	2.7	**
Beh. Change HIV+	Youth & adolescents need further E/P to protect their sexual and/or needle-sharing partners.	2.7	*
Knowledge	Youth & adolescents need HIV counseling and testing.	2.6	*
Beh. Change HIV- or Unk.	Youth & adolescents need further E/P to protect themselves from transmission through injection drug use.	2.6	*
Beh. Change HIV+	Youth & adolescents need counseling about disclosing their status and assistance with partner notification.	2.5	*
Early Interv.	Youth & adolescents need information about early intervention services and treatment.	2.5	*
Early Interv.	Youth & adolescents need referral and linkage to early intervention programs.	2.5	*
Knowledge	Youth & adolescents need general information about HIV/AIDS.	2.4	*
Beh. Change HIV+	HIV+ young pregnant women and nursing mothers need further E/P to reduce perinatal transmission of HIV.	2.4	*
Early Interv.	Youth & adolescents need access to early intervention programs.	2.4	*
Norm Setting	Institutions that serve youth & adolescents need to establish norms to maintain universal precautions.	2.3	*

People of Color Communities			
Norm Setting	People of Color need further E/P to help establish peer and group/social norms to support each other.	2.8	
Beh. Change HIV- or Unk.	Young people of color need comprehensive prevention services.	2.8	
Norm Setting	Providers, employers and community leaders that serve people of color need training to provide HIV prevention services.	2.7	
Norm Setting	People of color need further E/P to help establish norms in communities that support HIV prevention efforts.	2.7	
Beh. Change HIV- or Unk.	People of color need further E/P to protect themselves from sexual transmission of HIV.	2.7	
Beh. Change HIV+	HIV+ people of color need further E/P to protect their sexual and/or needle-sharing partners.	2.7	
Beh. Change HIV+	HIV+ pregnant women of color and nursing mothers need further E/P to reduce perinatal transmission of HIV.	2.7	
Early Interv.	People of color need information about early intervention services and treatment.	2.7	
Early Interv.	People of color need access to early intervention programs.	2.7	
Early Interv.	HIV+ people of color need further E/P to initiate and continue safe behavior.	2.7	
Knowledge	People of color need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others.	2.6	
Knowledge	People of color need HIV counseling & testing.	2.6	
Knowledge	People of color need general information about HIV/AIDS	2.6	
Beh. Change HIV- or Unk.	People of color need further E/P to protect themselves from transmission through injection drug use.	2.6	
Beh. Change HIV+	HIV+ people of color need counseling about disclosing their status and assistance with partner notification.	2.6	
Early Interv.	People of color need referral and linkage to early intervention programs.	2.6	
Norm Setting	Institutions that serve people of color need to establish norms to maintain universal precautions.	2.2	
Beh. Change HIV+	HIV+ people of color need further E/P about not donating blood, tissues, sperm or breast milk.	2.2	

Transgender and Transvestite Individuals			
Early Interv.	Transgender & transvestite individuals need information about early intervention services and treatment.	2.6	
Early Interv.	Transgender & transvestite individuals need referral and linkage to early intervention programs.	2.6	
Early Interv.	HIV+ transgenders & transvestite individuals need further E/P to initiate and continue safe behavior.	2.6	
Norm Setting	Transgender & transvestite individuals need further E/P to help establish peer and group/social norms to support each other.	2.5	
Norm Setting	Providers, schools, employers & community leaders that serve transgender and transvestite individuals need training to provide HIV prevention services.	2.5	
Beh. Change HIV- or Unk.	Young transgender & transvestite individuals need comprehensive prevention services.	2.5	
Beh. Change HIV+	HIV+ transgender & transvestite individuals need further E/P to protect their sexual and/or needle-sharing partners.	2.5	
Beh. Change HIV+	HIV+ transgender & transvestite individuals need counseling about disclosing their status and assistance with partner notification.	2.5	
Early Interv.	Transgender & transvestite individuals need access to early intervention programs.	2.5	**
Knowledge	Transgender & transvestite individuals need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others.	2.3	
Knowledge	Transgender & transvestite individuals need HIV counseling and testing.	2.3	
Norm Setting	Transgender & transvestite individuals need further E/P to help establish norms in communities that support HIV prevention efforts.	2.3	
Beh. Change HIV- or Unk.	Transgender & transvestite individuals need further E/P to protect themselves from sexual transmission of HIV.	2.3	
Norm Setting	Institutions that serve transgender & transvestite individuals need to establish norms to maintain universal precautions.	2.2	
Beh. Change HIV- or Unk.	Transgender & transvestite individuals need further E/P to protect themselves from transmission through injection drug use.	2.2	
Knowledge	Transgender & transvestite individuals need general information about HIV/AIDS.	2.0	

People in the Criminal Justice System			
Beh. Change HIV- or Unk.	Young people in the criminal justice system need comprehensive prevention services.	2.8	**
Beh. Change HIV- or Unk.	People in the criminal justice system need further E/P to protect themselves from transmission through injection drug use.	2.7	**
Early Interv.	HIV+ people in the criminal justice system need further E/P to initiate and continue safe behavior.	2.7	**
Norm Setting	Providers, schools, employers & community leaders that serve people in the criminal justice system need training to provide HIV prevention services.	2.6	**
Beh. Change HIV+	HIV+ people in the criminal justice system need further E/P to protect their sexual and/or needle-sharing partners.	2.6	*
Knowledge	People in the criminal justice system need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others.	2.5	**
Beh. Change HIV- or Unk.	People in the criminal justice system need further E/P to protect themselves from sexual transmission of HIV.	2.5	**
Early Interv.	People in the criminal justice system need information about early intervention services and treatment.	2.5	**
Early Interv.	People in the criminal justice system need referral and linkage to early intervention programs.	2.5	**
Early Interv.	People in the criminal justice system need access to early intervention programs.	2.5	**
Knowledge	People in the criminal justice system need HIV counseling and testing.	2.4	**
Norm Setting	People in the criminal justice system need further E/P to help establish peer and group/social norms to support each other.	2.4	**
Norm Setting	People in the criminal justice system need further E/P to help establish norms in communities that support HIV prevention efforts.	2.4	**
Beh. Change HIV+	HIV+ people in the criminal justice system need counseling about disclosing their status and assistance with partner notification.	2.4	*
Knowledge	People in the criminal justice system need general information about HIV/AIDS.	2.3	**
Norm Setting	Institutions that serve people in the criminal justice system need to establish norms to maintain universal precautions.	2.3	**
Beh. Change HIV+	HIV+ pregnant women and nursing mothers in the criminal justice system need further E/P to reduce perinatal transmission of HIV.	2.3	*

Homeless and Transient Persons			
Beh. Change HIV- or Unk.	Young homeless & transient persons need comprehensive prevention services.	2.8	
Early Interv.	Homeless & transient persons need information about early intervention services and treatment.	2.7	
Early Interv.	Homeless & transient persons need referral and linkage to early intervention programs.	2.7	
Early Interv.	Homeless & transient persons need access to early intervention programs.	2.7	
Early Interv.	HIV+ homeless & transient persons need further E/P to initiate and continue safe behavior.	2.7	
Knowledge	Homeless & transient persons need HIV counseling and testing.	2.6	
Norm Setting	Providers and community leaders that serve homeless & transient persons need training to provide HIV prevention services.	2.6	
Beh. Change HIV- or Unk.	Homeless & transient persons need further E/P to protect themselves from sexual transmission of HIV.	2.6	
Beh. Change HIV- or Unk.	Homeless & transient persons need further E/P to protect themselves from transmission through injection drug use.	2.6	
Beh. Change HIV+	HIV+ homeless & transient persons need further E/P to protect their sexual and/or needle-sharing partners.	2.6	
Knowledge	Homeless & transient persons need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others.	2.5	
Beh. Change HIV+	HIV+ homeless & transient pregnant women and nursing mothers need further E/P to reduce perinatal transmission of HIV.	2.5	
Beh. Change HIV+	HIV+ homeless & transient persons need counseling about disclosing their status and assistance with partner notification.	2.5	
Norm Setting	Homeless & transient persons need further E/P to help establish peer and group/social norms to support each other.	2.4	*
Norm Setting	Homeless & transient persons need further E/P to help establish norms in communities that support HIV prevention efforts.	2.4	
Knowledge	Homeless & transient persons need general information about HIV/AIDS.	2.3	
Norm Setting	Institutions that serve homeless & transient persons need to establish norms to maintain universal precautions.	2.3	*
Beh. Change HIV+	HIV+ homeless & transient persons need further E/P about not donating blood, tissues, sperm or breast milk.	2.1	

Immigrants and Undocumented Persons			
Norm Setting	Providers, employers and community leaders that serve immigrants and undocumented persons need training to provide HIV prevention services.	2.7	
Norm Setting	Immigrants and undocumented persons need further E/P to help establish peer and group/social norms to support each other.	2.6	
Beh. Change HIV- or Unk.	Immigrants and undocumented persons need further E/P to protect themselves from sexual transmission of HIV.	2.6	
Early Interv.	HIV+ immigrants and undocumented persons need further E/P to initiate and continue safe behavior.	2.6	
Knowledge	Immigrants and undocumented persons need HIV counseling and testing.	2.5	
Knowledge	Immigrants and undocumented persons need general information about HIV/AIDS.	2.5	
Norm Setting	Immigrants and undocumented persons need further E/P to help establish norms in communities that support HIV prevention efforts.	2.5	
Beh. Change HIV- or Unk.	Young immigrants and undocumented persons need comprehensive prevention services.	2.5	
Beh. Change HIV+	HIV+ pregnant women and nursing mother immigrants and undocumented persons need further E/P to reduce perinatal transmission of HIV.	2.5	
Early Interv.	Immigrants and undocumented persons need information about early intervention services and treatment.	2.5	
Early Interv.	Immigrants and undocumented persons need referral and linkage to early intervention programs.	2.5	
Early Interv.	Immigrants and undocumented persons need access to early intervention programs.	2.5	
Knowledge	Immigrants and undocumented persons need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others.	2.4	
Norm Setting	Institutions that serve immigrants and undocumented persons need to establish norms to maintain universal precautions.	2.4	
Beh. Change HIV+	HIV+ immigrants and undocumented persons need further E/P to protect their sexual and/or needle-sharing partners.	2.4	
Beh. Change HIV+	HIV+ immigrants and undocumented persons need counseling about disclosing their status and assistance with partner notification.	2.4	
Beh. Change HIV- or Unk.	Immigrants and undocumented persons need further E/P to protect themselves from transmission through injection drug use.	2.1	
Beh. Change HIV+	HIV+ immigrants and undocumented persons need further E/P about not donating blood, tissues, sperm or breast milk.	2.1	

Women and Their Sex Partners			
Beh. Change HIV+	HIV+ pregnant women and nursing mothers need further E/P to reduce perinatal transmission of HIV.	2.8	
Beh. Change HIV- or Unk.	Women and their sex partners need further E/P to protect themselves from sexual transmission of HIV.	2.7	
Beh. Change HIV- or Unk.	Young women and their sex partners need comprehensive protection services.	2.7	
Early Interv.	HIV+ women and their sex partners need further E/P to initiate and continue safe behavior.	2.7	
Knowledge	Women and their sex partners need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others.	2.6	
Norm Setting	Women and their sex partners need further E/P to help establish peer and group/social norms to support each other.	2.6	
Norm Setting	Providers that serve women and their sex partners need training to provide HIV prevention services.	2.6	
Beh. Change HIV- or Unk.	HIV+ women and their sex partners need further E/P to protect their sexual and/or needle sharing partners.	2.6	
Early Interv.	Women and their sex partners need information about early intervention services and treatment.	2.6	
Knowledge	Women and their sex partners need HIV counseling and testing.	2.5	
Beh. Change HIV+	HIV+ women and their sex partners need counseling about disclosing their status and with partner notification.	2.5	
Early Interv.	Women and their sex partners need referral and linkage to early intervention programs.	2.5	
Early Interv.	Women and their sex partners need access to early intervention programs.	2.5	
Norm Setting	Providers that serve women and their sex partners need training to provide HIV prevention services	2.4	
Knowledge	Women and their sex partners need general information about HIV/AIDS.	2.3	
Beh. Change HIV- or Unk.	Women and their sex partners need further E/P to protect themselves from transmission through injection drug use.	2.3	
Norm Setting	Institutions that serve women and their sex partners need to establish norms to maintain universal precautions.	2.2	
Beh. Change HIV+	HIV+ women and their sex partners need further E/P about not donating blood, tissues, sperm, or breast milk.	2.1	

Seasonal Farm Workers/Agri-related Workers			
Beh. Change HIV- or Unk.	Seasonal farm workers/agri-related workers need further E/P to protect themselves from sexual transmission of HIV.	2.7	
Norm Setting	Seasonal farm workers/agri-related workers need further E/P to help establish peer and group/social norms to support each other.	2.6	
Norm Setting	Providers, schools, employers and community leaaders that serve seasonal farm workers/agri-related workers need training to provide HIV prevention services	2.6	
Early Interv.	HIV+ Seasonal farm workers/agri-related workers need further E/P to initiate and continue safe behavior.	2.6	
Knowledge	Seasonal farm workers/agri-related workers need HIV counseling and testing.	2.5	
Norm Setting	Seasonal farm workers/agri-related workers need further E/P to help establish norms in communities that support HIV prevention efforts.	2.5	
Early Interv.	Seasonal farm workers/agri-related workers need information about early intervention services and treatment.	2.5	
Early Interv.	Seasonal farm workers/agri-related workers need referral and linkage to early intervention programs.	2.5	
Early Interv.	Seasonal farm workers/agri-related workers need access to early intervention programs.	2.5	
Knowledge	Seasonal farm workers/agri-related workers need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others.	2.4	
Knowledge	Seasonal farm workers/agri-related workers need general information about HIV/AIDS.	2.4	
Beh. Change HIV- or Unk.	Young seasonal farm workers/agri-related workers need comprehensive prevention services.	2.4	
Beh. Change HIV+	HIV+ seasonal farm workers/agri-related workers need further E/P to protect their sexual and/or needle sharing partners.	2.4	
Beh. Change HIV+	HIV+ seasonal farm workers/agri-related workers pregnant women and nursing mothers need further E/P to reduce perinatal transmission of HIV.	2.4	
Beh. Change HIV+	HIV+ seasonal farm workers/agri-related workers need counseling about disclosing their status and assistance with partner notification.	2.4	
Norm Setting	Institutions that serve seasonal farm workers/agri-related workers need to establish norms to maintain universal precautions.	2.3	
Beh. Change HIV+	HIV+ seasonal farm workers/agri-related workers need further E/P about not donating blood, tissues, sperm, or breast milk.	2.1	
Beh. Change HIV- or Unk.	Young seasonal farm workers/agri-related workers need comprehensive prevention services.	2.0	

People who Engage in Heterosexual Sex			
Early Interv.	HIV+ people who engage in heterosexual sex need further E/P to initiate and continue safe behavior.	2.4	
Beh. Change HIV- or Unk.	Young people who engage in heterosexual sex need comprehensive prevention services.	2.3	
Early Interv.	People who engage in heterosexual sex need information about early intervention services and treatment.	2.3	
Early Interv.	People who engage in heterosexual sex need access to early intervention programs.	2.3	
Norm Setting	Providers that serve people who engage in heterosexual sex need training to provide HIV prevention services.	2.2	
Beh. Change HIV+	HIV+ people who engage in heterosexual sex need further E/P to protect their sexual and/or needle-sharing partners.	2.2	
Beh. Change HIV+	HIV+ people who engage in heterosexual sex need counseling about disclosing their status and with partner notification.	2.2	
Early Interv.	People who engage in heterosexual sex need referral and linkage to early intervention programs.	2.2	
Knowledge	People who engage in heterosexual sex need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others	2.1	
Beh. Change HIV- or Unk.	People who engage in heterosexual sex need further E/P to protect themselves from sexual transmission of HIV.	2.1	
Beh. Change HIV+	HIV+ pregnant women and nursing mothers need further E/P to reduce perinatal transmission of HIV.	2.1	
Knowledge	People who engage in heterosexual sex need HIV counseling and testing.	2.0	
Knowledge	People who engage in heterosexual sex need general information about HIV/AIDS.	2.0	
Norm Setting	People who engage in heterosexual sex need information about early intervention services and treatments.	2.0	
Norm Setting	People who engage in heterosexual sex need further E/P to help establish norms to support each other.	2.0	

People in Group Living Situations			
Beh. Change HIV- or Unk.	Young people in group living situations need comprehensive prevention services.	2.2	*
Early Interv.	HIV+ people in group living situations need further E/P to initiate and continue safe behavior.	2.2	*
Norm Setting	Providers that serve people in group living situations need training to provide HIV prevention services.	2.1	*
Beh. Change HIV+	HIV+ people in group living situations need counseling about disclosing their status and assistance with partner notification.	2.1	
Early Interv.	People in group living situations need information about early intervention services and treatment.	2.1	*
Early Interv.	People in group living situations need referral and linkage to early intervention programs.	2.1	*
Early Interv.	People in group living situations need access to early intervention programs.	2.0	*

Disabled Communities			
Norm Setting	Providers that serve disabled communities need training to provide HIV prevention services.	2.4	*
Early Interv.	HIV+ disabled people need further E/P to initiate and continue safe behavior.	2.4	*
Norm Setting	Disabled people need further E/P to help establish peer and group/social norms to support each other.	2.2	**
Beh. Change HIV- or Unk.	Disabled people need further E/P to protect themselves from sexual transmission of HIV.	2.2	*
Beh. Change HIV- or Unk.	Disabled young people need comprehensive prevention services.	2.2	*
Early Interv.	Disabled people need referral and linkage to early intervention programs.	2.2	*
Norm Setting	Disabled people need further E/P to help establish norms in communities that support HIV prevention efforts.	2.1	**
Beh. Change HIV+	HIV+ disabled people need further E/P to initiate and continue safe behavior.	2.1	*
Beh. Change HIV+	HIV+ disabled people need counseling about disclosing their status and assistance with partner notification.	2.1	*
Early Interv.	Disabled people need information about early intervention services and treatment.	2.1	*
Early Interv.	Disabled people need access to early intervention programs.	2.1	
Knowledge	Disabled people need further E/P to know how HIV is transmitted, be able to assess their personal risk, and have skills to protect themselves and others.	2.0	*
Knowledge	Disabled people need general information about HIV/AIDS.	2.0	*
Norm Setting	Institutions that serve disabled people need to establish norms to maintain universal precautions.	2.0	*
Beh. Change HIV+	Disabled HIV+ pregnant women and nursing mothers need further E/P to reduce perinatal transmission of HIV.	2.0	*

Persons who Pierce and/or Tattoo			
Beh. Change HIV- or Unk.	Young persons who pierce and/or tattoo need comprehensive prevention services.	2.2	
Early Interv.	HIV+ persons who pierce and/or tattoo need further E/P to initiate and continue safe behavior.	2.2	
Norm Setting	Institutions that serve persons who pierce and/or tattoo need to establish norms to maintain universal precautions.	2.1	
Beh. Change HIV- or Unk.	Persons who pierce and/or tattoo need further E/P to protect themselves from transmission through injection drug use.	2.1	
Early Interv.	Persons who pierce and/or tattoo need information about early intervention services and treatments.	2.1	
Early Interv.	Persons who pierce and/or tattoo need referral and linkage to early intervention programs.	2.1	
Early Interv.	Persons who pierce and/or tattoo need access to early intervention programs.	2	

Children (0 to 11) years of age			
Norm Setting	Providers that serve children 0 to 11 years of age need training to provide HIV prevention services.	2.4	*
Beh. Change HIV- or Unk.	Children 0 to 11 years of age need comprehensive prevention services.	2.2	*
Early Interv.	HIV+ children 0 to 11 years of age need further E/P to initiate and continue safe behavior.	2.1	*
Norm Setting	Institutions that serve children 0 to 11 years of age need to establish norms to maintain universal precautions.	2.0	*

Please refer to attachment 13 for the complete set of needs with relative levels of agreement. Please note that standard deviation scores were arbitrarily clustered to express level of agreement, with standard deviations below .33 construed as a high level of agreement, between .33 and .65 as moderate level of agreement, and .66 or above as a low level of agreement. Generally, the needs of youth were rated high for each of the target populations. For most populations, the needs focused on initiating and maintaining safer sexual behaviors and needle cleaning/sharing behaviors. Referral and access to early intervention services was rated as a high need for many of the groups.

CHAPTER 9: PRIORITIZED PORTFOLIO OF STRATEGIES FOR DEFINED POPULATIONS

While the entire Community Planning Working Group prioritized strategies by target groups, this task could not occur until three committees completed their work:

- The Other Needs Assessment Committee developed an unprioritized list of target groups;
- The Strategies and Interventions Committee developed an unprioritized list of strategies; and
- The Priority-setting Criteria Committee developed a set of weighted criteria to use during the prioritizing task.

The work and results of the Other Needs Assessment Committee was described in Chapter 7. Please refer to that chapter for a discussion and list of prioritized target populations.

The Strategies and Interventions Committee was charged with the responsibility of developing an unprioritized list of strategies. Early in the process, the Strategies and Interventions Committee developed a survey to collect specific information about strategies. The survey was completed by Community Planning Working Group and other prevention providers. The results of this survey were integrated into Chapter 4, the description of existing and potential strategies and interventions. Please refer to Attachment 14 for a summary of the results of this survey.

In developing the framework for strategies and interventions, the Strategies and Interventions Committee members reviewed the requirements set forth in the CDC *Guidance* and a set of materials provided by the planner. These materials included a summary of relevant journal articles and reports about strategies; several articles of importance including a review article by Kyung-Hee Choi and Tom Coates; Donna Higgins' article on the effect of HIV counseling and testing on risk behaviors; a report on the public health impact of needle exchange programs; Richard Stephens' article on effectiveness of NADR interventions; summaries of Centers for Disease Control prevention projects; an article about prevention for women and people of color published by WORLD; a handout prepared by Community Planning Working Group member James Kahn, Ph.D. of UCSF that uses mathematical modeling to estimate the cost-effectiveness of prevention within select populations; and a taxonomy of HIV prevention strategies from a review article by David Holtgrave.

The Strategies and Interventions Committee recommended, and the Community Planning Working Group adopted, the unprioritized list of strategies shown in Exhibit 9.1.

Exhibit 9.1
Prevention Strategies List
(not prioritized)

1. **TESTING (culturally, socially & linguistically competent)**

HIV counseling, testing, referral and partner notification to provide opportunities for individuals to learn their serostatus and to receive prevention counseling and referral to other preventive, medical and social services.

- **Anonymous** (client tests without personal identifiers)
  Information presentation, followed by testing and later, when results are given, individual counseling and referral.
- **Confidential** (patient must give consent to be tested; personal identifier used)
  Individual information/orientation session in context of a clinical exam, followed by testing and later, when results are given, counseling and referral.
- **Partner notification & notification for parents of infants**
  A traditional STD control intervention in which either the patient or public health officials or both take responsibility for locating and notifying sexual partners of people who have tested positive.
- **Referral**
  Individual information about legal, social, psychological, and medical services provided before or after HIV testing for HIV negative and HIV positive individuals.

- Anonymous and Coffidential testing can occur at a variety of sites such as mobile sites (such as a van), off-site settings (such as in parks on the street or in a motel room), free standing test sites, or other clinical settings.

2. **INDIVIDUAL LEVEL INTERVENTIONS (culturally, socially & linguistically competent)**

Provide health education and risk reduction counseling to assist individuals to learn about transmission and risk behaviors, make plans for individual behavior change and ongoing appraisals of their own behaviors, and to facilitate linkages to resources to support behavior change. The common denominator of these strategies is their focus on one-on-one interactions between educator and individual.

a. **Hotlines (education, information & referral)**
Toll-free telephone hotlines which provide information, education, and referrals to callers.

b. **Outreach: Street & Community**
Education and counseling at sites where community members informally congregate such as streets, bars, parks, shooting galleries, bathhouses, beauty parlors, etc.

c. **Peer education (individual)**
Education, counseling, risk assessment, and referrals provided by trained peers of target group members.

d. **On-site risk reduction education and counseling**
Education and counseling at sites where people formally congregate for purposes other than HIV prevention, such as drug treatment centers, work sites or social welfare offices.

e. **Prevention case management**
Identification, coordination and delivery of primary and secondary HIV prevention services. It is an intensive, individualized support to assist persons to remain seronegative or to reduce the risk for HIV transmission to others.

f. **Needle exchange programs**
Distribution of clean needles in exchange for used needles and related supplies and provision of referrals in areas where high-risk people congregate. Limited opportunity for one-on-one health education or risk reduction may be offered.

g. **Bleach & barrier demonstration and distribution/accessibility**
Distribution of bleach and risk reduction barriers and provision of referrals in areas where people congregate. Limited opportunity for one-on-one health education or risk reduction may be offered.

h. **Condom demonstration and distribution**
Demonstration and distribution of condoms and other risk reduction barriers in areas where people congregate.

3. **GROUP-LEVEL INTERVENTIONS (culturally, socially & linguistically competent)**

Provide education and risk reduction support to groups to promote and reinforce safer behaviors, and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change. The common denominator of these strategies is their focus on groups.

a. **Speakers' bureaus**
Presentation by a trained volunteer of a one-time educational seminar at a site where the audience regularly meets, including schools, work sites, clubs, treatment clinics, etc.

b. **Group presentations**
Groups to discuss risk assessment, gain risk reduction skills such as condom usage or condom negotiation, or develop motivation to maintain safer sex practices. Groups may be lead by trained peer facilitators or professional health educators.

c. **Multi-session groups**
Closed structured groups, drop-in groups and support groups held over a period of time to develop risk reduction skills, and receive on-going education and psychosocial support to maintain safer sex practices.

d. **Peer education (group)**
Education, counseling, risk assessment, and referrals provided by trained peers of target group members.

4. **COMMUNITY-LEVEL INTERVENTIONS (culturally, socially & linguistically competent)**

Seek to reduce risk behaviors by changing attitudes, norms and behaviors through health communications, social (prevention) marketing, community mobilization and community-wide events. The common denominator of these strategies is their focus on community/group (we're-in-this-together) identity.

a. **Social marketing**
Advertising using billboards, television, radio, bus placards which seek to increase knowledge or change norms or behaviors.

b. **Media relations**
Activities to gain in-depth media coverage about issues related to HIV prevention or risk reduction.

c. **Public events**
Public meetings or events that offer community booths or other displays where printed information and referrals are offered. Limited opportunity for one-on-one health education or risk reduction may be offered.

d. **Natural opinion leaders**
Using natural opinion leaders, such as celebrities, to heighten people's interest in learning more about HIV transmission.

e. **Community mobilization**
Efforts to motivate a segment of a community or an entire community to engage in prevention activities — the focus is not on the individual members of a community, but those who can influence individual members.

5. **PUBLIC INFORMATION PROGRAMS (statewide, regional, local)**

Provided for the general public to dispel myths about HIV transmission, support volunteerism, reduce discrimination toward individuals with HIV/AIDS, promote support for strategies and interventions that contribute to HIV prevention. The major distinction between public information programs and community level interventions is the extent to which the focus is on risk behavior.

a. **Social marketing**
Advertising using billboards, television, radio, bus placards that seek to dispel myths, support volunteerism, reduce discrimination, or promote programs or strategies that contribute to HIV prevention.

b. **Media relations**
Activities to gain in-depth media coverage about issues such as myths, volunteerism, discrimination, or education programs and strategies that contribute to HIV prevention.

c. **Public events**
Public meetings or events that offer community booths or other displays where printed information and referrals are offered. The focus is on dispelling myths, volunteerism, reducing discrimination, or promoting programs or strategies that contribute to HIV prevention.

The Priority-setting Criteria Committee was given the responsibility of developing a set of weighted criteria by which to prioritize strategies for the defined target groups. The Priority-setting Criteria Committee closely followed the Centers for Disease Control *Guidance*. This *Guidance* listed several criteria such as outcome effectiveness, cost-effectiveness, sound scientific theory, and values/norms/preferences of consumers. The Committee discussed, refined, and described these criteria; they added an additional criterion — "perceived need".

The Priority-setting Criteria Committee was provided with a set of material to begin their task, and collected and reviewed additional material. In addition to the *Guidance*,

committee members received a summary of relevant journal articles and reports about target populations; a summary of relevant journal articles and reports about strategies and interventions; several complete text articles; a supplement to the *Guidance* issued by the Centers for Disease Control and Prevention (CDC) in July 1994; the report of the Multicultural Liaison Board, entitled *Frameworks for Change*; and a handout prepared by Community Planning Working Group member James Kahn, Ph.D. of UCSF that uses mathematical modeling to estimate the cost-effectiveness of prevention within select populations. Additionally, the committee relied heavily on Chapter 6 of *Handbook for HIV Prevention Planning* prepared by the Academy for Educational Development specifically for the Community Planning Process. Committee members sought out additional information about the definition of cultural competency including "Toward a Culturally Competent System of Care," T.L. Cross et. al. (Washington, D.C., 1989); *Frameworks for Change* by the Multicultural Liaison Board; and material from Polaris Institute.

After exhaustive drafts and tele-conferences, the Priority-setting Criteria Committee developed and presented to the Community Planning Working Group a set of criteria and weights. The criteria, contained in Exhibit 9.2, were adopted by the Community Planning Working Group. These criteria were used to prioritize strategies for each target population on a state-wide level.

Exhibit 9.2
Proposed Criteria and Weighing for Priority Setting

20%

(A) Documented HIV prevention needs based on current and projected impact of HIV/AIDS in defined populations in California, primarily by epidemiology and ethnography;

Epidemiology is defined as HIV incidence, HIV prevalence, AIDS cases, and HIV risk behaviors (e.g. KABB studies, surrogate markers). HIV incidence can be measured as part of prospective cohort studies or estimated using other techniques. HIV prevalence can be measured by surveys. AIDS cases and case-rates are available from mandatory reporting systems. Epidemiologic and ethnographic data can help define prevention needs by documenting the level of HIV risk and the specific behaviors that underlie that risk.

Ethnography is the study of a people and culture from the perspectives of that community and its people (clients/consumers) being served. Ethnographic techniques are employed by trained health service providers (ethnographers, community health outreach workers, social workers, etc.) to assess service needs. These data are collected from observation in high risk settings and/or in settings identified as pertinent to the activities and behaviors of groups targeted for risk reduction. Analysis of these data is accomplished when competent cultural translation and literacy is assured.

10%

(B) Outcome effectiveness of proposed strategies and interventions either demonstrated or probable;

Outcome effectiveness is defined as magnitude of reduction in HIV risk behaviors due to a prevention strategy. Quantitative evidence of outcome effectiveness comes from studies and from program evaluations. Such data are currently limited. California needs additional outcome effectiveness data to help organizations that can provide prevention services but that do not have resources to conduct or assess outcome evaluation. These organizations need technical assistance to apply existing outcome effectiveness data and conduct some focused evaluations. Outcome effectiveness will be assessed using studies, ethnographic data, consumer focus groups, program evaluations, and the experience of HIV prevention providers.

Additionally, California needs to recognize and encourage innovative and untried strategies that have not yet been evaluated.

10%

(C) Cost effectiveness of proposed strategies and interventions either demonstrated or probable;

Cost-effectiveness is defined as prevention program cost divided by the number of HIV infections averted. The simplest approximation of the number of infections averted in the HIV incidence multiplied by the number of HIV negative individuals by percent reduction in frequency risk behaviors.

Evidence of cost effectiveness comes from formal analyses that use epidemiological and behavioral data as inputs. Cost-effectiveness data are currently sparse. California needs additional cost-effectiveness data about more interventions in varied populations. Where formal analyses is absent, California recognizes the importance of outcome effectiveness and high HIV incidence.

10%

(D) Sound scientific theory, e.g., behavior change, social change, and social marketing theories;

Sound scientific theory is defined as being based on validated principles of prevention effectiveness. When there is little or no empirical evidence of the effectiveness of specific interventions in specific populations, the likelihood of success of a new intervention can be improved by relying on theories that have explained success for other interventions (HIV-related or not) and other populations. Some of these theories, for example, link the choice of prevention strategy to the stage of behavior change in a population (i.e. pre-contemplation of change or maintenance of change). In general, the mix of HIV prevention strategies in a population is best when it meets three standards: The strategy (1) focuses on behavior change (after assuring knowledge is adequate), considering where in the change process each individual is; (2) is ongoing over time (not just one-shot) to strengthen and maintain behavior change; (3) is intensive and interactive (population is actively involved via discussion, role plays, creative arts, etc.), not just passive education.

15%

(E) Values, norms, and consumer preferences of the communities for whom the services are intended, as described by groups with a demonstrated identification with and/or the ability to work with the target population: cultural competence, linguistic competence and cultural translation;

Cultural Competence varies from community to community and includes:

- Understanding the history of a particular community of color and its relationship to larger communities of color statewide and nationwide;
- Understanding the history and current situation of a particular community of color in relationship to the general community;

- Understanding the oppression faced by the community, and the community's methods for resisting this oppression on personal, familial, and community-wide levels;
- Understanding specific issues of gender, ethnicity, and sexual orientation within the community.

This requires a willingness and ability to draw on community-based values, tradition, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications and other supports.

Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continual expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of diverse populations. Such agencies view diverse populations as distinctly different from one another and as having numerous sub-groups, each with important cultural characteristics.

Culturally competent agencies work to hire unbiased employees, seek advice and consultation from people of color communities and actively decide what they are and are not capable of providing to these communities. Culturally competent agencies seek people of color staff whose self-analysis of their role has left them committed to their community and capable of negotiating in a multi-cultural world. These agencies provide support for staff to become comfortable working in cross-cultural situations. Further, culturally competent agencies understand the interplay between policy and practice, and are committed to policies that enhance services to diverse populations.

It is important to realize that the definition of cultural competence should also apply to other dimensions of diversity such as age, gender, disability, and sexual orientation, as well as race and ethnicity.

Cultural translation is defined as appropriate expression of a concept or idea from one language to another by addressing the unique linguistic, literacy and cultural needs of that community and taking into consideration the characteristics and varied cultural values, experiences and beliefs existing in diverse subgroups within populations. It is not a simplistic word-for-word translation.

If literacy means "the ability to read and write," cultural literacy is defined as the ability to use the social facts of a community to passively understand and actively function in a particular culture. (Cross, et al., 1989, and Multicultural Liaison Board, 1994).

10%

(F) Availability of other resources for HIV prevention, including governmental, non-governmental, and the private sector;

Ideal HIV strategies will avoid duplication of services, integrate into local planning efforts and collaborate and link with other existing services to maximize HIV prevention efforts and available funds.

25%

(G) Perceived HIV prevention needs based on current or projected impact of HIV/AIDS primarily in the following populations in California:

(1) rural and geographically isolated regions;
(2) historically neglected or ignored populations;
(3) unidentified, undocumented and emerging populations;
(4) marginalized and underserved populations.

At the Redding (August 30 - Sept. 1) meeting the Community Planning Working Group prioritized strategies by target populations. Community Planning Working Group members

received a set of materials that included the results of their previous prioritizing activities — Prioritized Target Populations and Prioritized Needs of Target Populations. Members also received a 28 page summary of relevant literature about the specific HIV prevention strategies the CPWG adopted with particular emphasis on the outcome effectiveness, cost effectiveness, scientific theory, and values, norms and preferences of consumers. Community Planning Working Group members were briefed by the planner prior to completing this worksheet. In this briefing, the planner reminded members of how many of their previous tasks came together in this worksheet, provided an illustrative example of how to complete the worksheet, and responded to questions. Members were reminded of and encouraged to use all sources of information available to them, including the sources of information described in the other chapters of Section II.

The worksheet contained 11 pages and 2,352 items for prioritization using a scale of 0 to 3 (0=Does not meet criteria; 3=Meets criteria very well). The length of the worksheet was a result of 16 target populations, 21 strategies and interventions, and 7 criteria. Due to the length of the worksheet and the collaborative nature of the California Community Planning Process, members were encouraged to work in a comfortable fashion — alone, in pairs, or in small groups while completing the worksheet. Community Planning Working Group members were given several hours to complete and return the worksheet.

Thirty-six members completed the worksheet, representing 70% of the Community Planning Working Group. Exhibit 9.3 contains the highest-ranked strategies for each population. Attachment 15 contains the complete results.

Exhibit 9.3
Prioritized Strategies by Defined Populations as Ranked by the CPWG

Substance Users and Their Sex Partners

Priority Strategies	Weighted Mean
Needle Exchange Programs	2.69
Outreach	2.67
Bleach and Barrier Demonstration and Distribution/Accessibility	2.62
Peer Education (individual)	2.53
Condom Demonstration and Distribution	2.50
On-site Risk Reduction, Education, and Counseling	2.44
Prevention Case Management	2.34
Counseling and Testing	2.28

Gay and Bisexual Men

Priority Strategies	Weighted Mean
Condom Demonstration and Distribution	2.67
Peer Education (individual)	2.62
Outreach	2.59
Counseling and Testing	2.59
Community Mobilization	2.46
Prevention Case Management	2.44
On-site Risk Reduction Education and Counseling	2.39
Peer Education (group)	2.36

Sex Industry Workers

Priority Strategies	Weighted Mean
Condom Demonstration and Distribution	2.64
Outreach	2.59
Peer Education (individual)	2.50
Peer Education (group)	2.32
On-site Risk Reduction, Education, and Counseling	2.30
Counseling and Testing	2.28
Prevention Case Management	2.26
Bleach & Barrier Demonstration and Distribution	2.26

Youth and Adolescents	
Priority Strategies	Weighted Mean
Peer Education (individual)	2.68
Outreach	2.61
Condom Demonstration and Distribution	2.58
Peer Education (group)	2.56
Multi Session Groups	2.34
Speakers' Bureaus	2.32
Hotlines	2.30
Community Mobilization	2.25
People of Color Communities	
Priority Strategies	Weighted Mean
Counseling and Testing	2.64
Outreach	2.64
Peer Education (individual)	2.57
Condom Demonstration and Distribution	2.51
Community Mobilization	2.51
Peer Education (group)	2.36
Speakers' Bureaus	2.32
On-site Risk Reduction Education and Counseling	2.28
Transgender and Transvestite Individuals	
Priority Strategies	Weighted Mean
Peer Education (individual)	2.45
Condom Demonstration and Distribution	2.45
Outreach	2.33
Peer Education (group)	2.32
Counseling and Testing	2.15
Community Mobilization	2.14
Bleach & Barrier Demonstration and Distribution	2.10
Prevention Case Management	2.09

People in the Criminal Justice System	
Priority Strategies	Weighted Mean
Peer Education (individual)	2.45
Condom Demonstration and Distribution	2.42
Peer Education (group)	2.24
On-site Risk Reduction, Education, and Counseling	2.22
Multi-Session Groups	2.13
Speakers' Bureaus	2.12
Prevention Case Management	2.00
Group Presentations	1.95

Homeless and Transient Persons	
Priority Strategies	Weighted Mean
Counseling and Testing	2.34
Outreach	2.34
Condom Demonstration and Distribution	2.19
Peer Education (individual)	2.13
Bleach and Barrier Demonstration and Distribution/Accessibility	2.03
On-site Risk Reduction, Education, and Counseling	1.98
Community Mobilization	1.89
Prevention Case Management	1.85

Immigrants and Undocumented Persons	
Priority Strategies	Weighted Mean
Condom Demonstration and Distribution	2.28
Peer Education (individual)	2.16
Outreach	2.15
Community Mobilization	2.01
On-site Risk Reduction, Education, and Counseling	1.94
Counseling and Testing	1.90
Speakers' Bureau	1.85
Prevention Case Management	1.83

Women and Their Sex Partners	
Priority Strategies	Weighted Mean
Condom Demonstration and Distribution	2.42
Peer Education (individual)	2.40
Outreach	2.38
Prevention Case Management	2.27
Speakers' Bureaus	2.24
Community Mobilization	2.17
Peer Education (group)	2.10
Hotlines	2.09

Seasonal Farm Workers/Agricultural Related Workers

Priority Strategies	Weighted Mean
Outreach	2.39
Condom Demonstration and Distribution	2.33
Peer Education (individual)	2.23
Community Mobilization	2.20
Peer Group Education	2.10
Prevention Case Management	1.99
On-site Risk Reduction Education and Counseling	1.93
Public Events	1.93

People Who Engage in Heterosexual Sex

Priority Strategies	Weighted Mean
Condom Demonstration and Distribution	2.23
Speakers' Bureaus	1.90
Hotlines	1.89
Counseling and Testing	1.74
Peer Education (individual)	1.74
Bleach and Barrier Demonstration and Distribution/Accessibility	1.73
On-site Risk Reduction Education and Counseling	1.70
Community Mobilization	1.67

Those in Group Living Situations

Priority Strategies	Weighted Mean
Condom Demonstration and Distribution	2.42
Peer Education (individual)	2.40
Outreach	2.38
Prevention Case Management	2.27
Speakers' Bureaus	2.24
Community Mobilization	2.17
On-site Risk Reduction Education and Counseling	2.10
Peer Education (group)	2.10

Disabled Communities

Priority Strategies	Weighted Mean
Condom Demonstration and Distribution	1.92
Peer Education (individual)	1.90
Outreach	1.82
Speakers' Bureaus	1.80
Peer Education (group)	1.79
Multi-Session Groups	1.78
On-site Risk Reduction Education and Counseling	1.73
Group Presentations	1.73

People Who Pierce or Tattoo	
Priority Strategies	Weighted Mean
Condom Demonstration and Distribuion	1.90
Bleach and Barrier Demonstration and Distribution/Accessibility	1.67
Peer Group Education	1.41
On-site Risk Reduction, Education, and Counseling	1.40
Peer Education (individual)	1.22
Outreach	1.19
Community Mobilization	1.16
Counseling and Testing	1.14
Children	
Priority Strategies	Weighted Mean
Speakers' Bureaus	1.29
Group Presentations	1.28
Outreach	1.11
Peer Education (individual)	1.10
Multi-Session Groups	1.05
Community Media Relations	1.02
On-site Risk Reduction Education and Counseling	1.00
Community Mobilization	0.98

The priority strategies recommend most frequently were: individual peer counseling, condom distribution/demonstration, outreach, on-site risk reduction education and counseling, community mobilization, group peer education, prevention case management, counseling and testing, and speakers' bureaus. Among the five population groups ranked at highest risk for HIV the core set of strategies comprised outreach, peer education, condom distribution/demonstration, and counseling and testing. The portfolio of priority strategies generally reflects the findings contained in the analysis of strategies discussed in Chapter 4. The strategies rated high tended to be those that are highly interactive, approach people where they congregate, are emphasized over time, and focus on behavior change or changes in group/social norms.

Prioritizing the strategies and interventions for the defined populations using this set of criteria was a challenge. During a discussion of the results, Community Planning Working Group members brought out several points. Part of the discussion addressed the reliability of the findings. Community Planning Working Group members felt that three factors significantly impacted the prioritization exercise -- time, expertise, and information. First, Community Planning Working Group members faced severe time constraints in making the multitude of decisions required. Second, while members were chosen for their knowledge of the prevention needs of populations and received much information through reports, public testimony and other sources, each does not possess expert knowledge about all the populations. Third, while the *Guidance* called for the use of criteria such as cost-effectiveness

and outcome effectiveness, no information is available about these elements for many of the strategies. While certain strategies, such as needle exchange programs and counseling and testing, have been the subject of effectiveness studies, most have not.

A second point in the discussion related to condom distribution/demonstration, especially for women. **While condom distribution/demonstration was rated as a priority strategy for all populations except children, this strategy is inefficacious unless combined with other strategies such as peer education, outreach, on-site risk reduction education, or community mobilization, and may, in fact, pose a danger.** Emphasizing condom distribution, without considering specific circumstances of women who may have little control over their male sexual partners, can inadvertently foment a potentially abusive situation. Condom distribution as a stand-alone strategy can send an unfair message to women that HIV prevention is solely their responsibility. The Community Planning Working Group emphasized that prevention strategies should be used in concert with one another to not only transfer the skills and tools necessary for condom negotiation, but to offer other alternatives when condom use is not an option.

Community Planning Working Group members discussed whether to present the weighted mean scores in this presentation of results. They pointed to the general absence of information about certain criteria, such as cost-effectiveness, and the lack of specific information about the effectiveness or appropriateness of certain of the strategies for certain of the populations. **While the weighted mean scores are presented, these should be viewed with caution; the method used to obtain these results is not as precise or reliable as a score to two decimal places might indicate.** While generally the portfolio of strategies for each population is sound, the exact ranking of strategies and the weighted mean score are less significant than the overall cluster of strategies for each population. **Results of the prioritization exercise are a starting point and a guide, and should not be viewed as absolute priorities.** Those reviewing or using the results of this prioritization should focus on the results as a portfolio of strategies -- not a rank order of individual strategies.

CHAPTER 10: COORDINATION AND LINKAGES PLAN

ISSUES OF COORDINATION AND LINKAGES

The overall purpose of coordination and linkage is to facilitate the accomplishment of state and local HIV prevention goals through enhanced communication and planning between regions, agencies, and individuals. California is a large geographic area whose rural and urban communities reflect different needs and resources, and with a population representing diverse cultures and languages. Health jurisdictions and communities throughout the state organize and plan prevention and early intervention activities based on their local resources (including skills, fiscal, and personnel) and culture. Coordination and Linkages recommendations, therefore, are intended to maximize the use of local and state resources in order to strengthen prevention efforts and stop the spread of HIV in California.

Coordination is an active process intended to enhance group efforts toward a common goal or purpose. It blends, integrates, and maximizes resources; it facilitates complementary and supplementary programs; and lastly, leads to a system in which the whole is greater than the sum of its parts. Forming linkages enables coordination and generally relates to sharing information, materials, or referrals.

The benefits of coordination are more compelling and beneficial to the public than the disincentives. The benefits of coordination include, but are not limited to:

- Standardized and consistent prevention and early intervention messages;
- Reduced unnecessary duplication of effort
- Maximized use of often limited resources;
- Increased access to funding opportunities and other resources, because of a growing interest among public and private agencies for collaboration among applicants;
- Increased capacity and improved quality of services to individuals and communities because of shared knowledge and improved planning abilities; and
- Expanded technical assistance opportunities for participating communities, agencies, and individuals through interaction with others who might provide complementary skills, knowledge, or other resources.

Despite all the reasons which promote coordination, many providers experience or perceive disadvantages or threats related to participation. The strongest disincentives to coordination include increased competition for limited dollars or resources, concern by participating individuals or agencies that a coordinated process might result in their loss of control over programs or resources, and a perceived change in equity or standing within the power structure. Another common barrier to coordinated processes is time constraints of participants.

Recognizing that cooperative efforts do not always come naturally or easily, the Coordination and Linkages Committee recommended (and the Community Planning Working Group adopted) the following steps in order to build effective relationships. First, whenever possible, planning bodies should identify and recruit a neutral convener who can facilitate the process. Possible sources for such a facilitator might include a United Way, local foundation, member of a local college or university, or other skilled but disinterested party. Second, prior to conducting business, the planning body should establish and communicate to all members the ground rules for participation. This should include decision-making and conflict management strategies. Conflicts, disputes, or grievances are inevitable in any group process, so creating conflict management or dispute resolution proactively can greatly enhance the group process. Third, the group should define and identify potential conflicts of interest for any potential or existing members, and determine strategies to avoid or resolve related issues. When conflicts or disputes surface, they should be addressed immediately and directly. If the group is convened by a neutral facilitator, that individual can manage this process; if not, it can be helpful to bring in a trained mediator. Finally, each participant should sign Memorandum of Understanding (MOU) delineating what each party agrees to do.

The key findings described below are derived from the following sources:

- *HIV Prevention in California: Final Report HIV Education and Prevention Evaluation*, Institute for Health Policy Studies, UCSF, April 1993.

- *Needs Assessment of California State Office of AIDS Education and Prevention Contractors and Subcontractors*, Multicultural AIDS Resource Center of California at Polaris Research and Development, April 1994.

- Telephone survey of 12 State agencies, conducted by Harder+Kibbe Research & Consulting, August 1994.

- *Frameworks for Change*, a report of the Multicultural Liaison Board of the California State Office of AIDS, July 1994.

- *A Manual for HIV/AIDS Funders, Planners, and Policymakers*, Harder+Kibbe Research & Consulting for the Sierra Health Foundation, August 1993.

- Public testimony provided at State Office of AIDS hearings in San Diego, July 1994.

In its deliberations the committee reviewed a variety of surveys and planning documents, discussed other existing coordinated planning and service models, and considered public testimony. Rationale for the committee recommendations on coordination and linkages are based on these sources, as well as the goals, objectives, and other elements of the California HIV Prevention Plan and discussions of the Community Planning Working Group. Discussions focused on establishing participation requirements for coordinated ventures;

identifying the circumstances which might necessitate distinct coordination and linkage approaches of participants in order to be responsive to particular target populations or prevention strategies; and methods or processes which could improve the effectiveness of coordinated planning and implementation efforts.

One issue of primary concern to the working group was that of representation, or how to maximize inclusion in a cooperative planning process without overwhelming the process with more voices than might be practical. After lengthy discussion, the group decided to create two levels of involvement: the first would be the minimum required representation, and the second would be those that should be strongly encouraged and invited to participate or provide input in some manner. Recommendations were based primarily on *CDC Guidelines* for the HIV Prevention Planning process and modified based on the discussion of the Community Planning Working Group, recommendations regarding target populations and priorities, and the written materials listed above. Furthermore, while the committee believed in the usefulness of a statewide standard, it also recognized the regional differences that exist within the state. Recommendations, therefore, promote a flexibility in structuring local coordinating committees and alternative methods for gathering appropriate input for planning and implementation of HIV prevention and early intervention programs.

Another issue that the committee addressed was how to enhance coordination among state agencies. The Office of AIDS currently convenes an Interagency HIV/AIDS Council which exists to aid in the coordination of HIV/AIDS related policies, problems, and programs. To assess its current usefulness and the concerns of participating agencies, Harder+Kibbe Research & Consulting conducted telephone interviews with 10 of the agencies. Most of the agencies had little to say regarding their experience with the Council, and some did not understand how their agency could contribute to or benefit from participation. Among those agencies who thought that coordinated planning efforts could be useful were Primary Care and Family Health, the Office of Family Planning, the Department of Youth Authority, the California Department of Corrections, and the Department of Education.

A third issue was the coordination and linkages between state agencies and local communities. The committee considered at length the types of interaction that should be expected, and would facilitate continuity of services among multiple jurisdictions. One example might involve an individual who is to be released from a State prison. A linkage system that facilitates consistent HIV prevention and related services at all stages of that individual's return to a local community needs to be developed -- from prevention education in the prison system to making organizational connections at the local community. Other examples where coordination and linkages would be important include the establishment, dissemination, and implementation of policies (as in alcohol and drug programs, education, and others).

COORDINATION AND LINKAGES RECOMMENDATIONS

The committee evaluated coordination and linkage strategies from several points of view: among State agencies and departments, among agencies at a local level, between State and local jurisdictions, and across multiple regions (including those that might cross state or national lines). Recommendations address coordination and provisions for adequate funding of these processes.

1. Participation in the Interagency HIV/AIDS Coordinating Council

The interagency HIV/AIDS Coordinating Council exists to aid in the coordinated efforts of diverse state agencies, many of which are under the Department of Health Services. This Council is facilitated and convened by the State Office of AIDS.

The Interagency HIV/AIDS Coordinating Council facilitated by the Office of AIDS should be continued and expanded to include the following State agencies, departments and organizations:

Existing Members	Proposed Additional Members
Department of Alcohol and Drug Programs	AIDS Education Training Centers
Department of Corrections	Department of Developmental Services
Department of Developmental Services	Department of Corporations
Department of Education	Department of Justice
Department of Insurance	Department of Social Services
Department of Mental Health	Department of Women's Health
Department of Youth Authority	Legislature
Division of Communicable Disease Control	Community and State College System
Food and Drug Branch	
Health and Welfare	
Laboratory Science	
Maternal and Child Health Branch	
Medi-Cal Managed Care	
Medical Care Services	
Office of Border Health	
Office of Family Planning	
Primary Care and Family Health	
STD Control Branch	
TB Control Branch	
University Wide AIDS Research Project	

2. Participation in Local or Regional Planning Groups

While structure and process for coordinated planning and program implementation might be determined at a local level (*e.g.*, committees, subcommittees, or other mechanisms for generating participation or information flow), the following "membership" requirements are recommended. The first membership list represents the minimum required in every community. The second level of participation is to be strongly encouraged and utilized wherever and whenever it is possible and practical. Representatives should be able to adequately represent the populations from which they were selected.

In order to ensure and maximize a fair and representative process, and to be consistent with the CDC *Guidance* for the HIV Prevention Community Planning Process, voting representatives must reflect the population characteristics of the current and projected HIV/AIDS epidemic in the local area (as indicated by the HIV ethnographic and epidemiological data, other relevant surrogate markers, and geographic distribution). These representatives must include, but not be limited to:

- People with HIV;
- Local health departments;
- Agencies or organizations serving individuals at risk for HIV or targeted prevention programs (*e.g.* at-risk populations as identified and prioritized by the Community Planning Working Group);
- Early intervention programs, Alternative Test Sites, and Title IIIB and Title IV;
- Title I Planning Councils and/or Title II Consortia; and
- County or school district agencies, or other local educational agencies (including PTAs).

To ensure effective planning, other representatives should include, but not be limited to:

- Other relevant public agencies such as substance abuse, mental health, and corrections;
- Experts in epidemiology, ethnography, behavioral and evaluation research, social sciences, and health planning;
- Individuals from private organizations providing HIV prevention and related services (*e.g.* TB, STD's substance abuse prevention, mental health, HIV testing, and reproductive health);
- Homeless shelters;
- Regional Centers (developmentally disabled) and agencies representing other disabilities (*e.g.* hemophilia);
- Religious communities;
- Health/community clinics (including Federally Qualified Health Centers);
- Experts in prevention strategies (*e.g.* media, marketing and advertising);
- Other regional organizations or consortia (that target similar populations, geographic areas, United Ways, local HMOs, etc.);

- Private and public funders with related interests; and
- Other privately or publicly funded HIV prevention programs.

3. Planning and Coordination

A. For efforts that target specific populations or cultural groups that either migrate between or reside in multiple geographic areas, coordination and linkages should occur among relevant providers throughout California, and where appropriate, neighboring states or countries. Examples of such populations include migrant farm workers; individuals who live in one county, but work or receive services in another; individuals who live in one community, but travel to another to participate in behaviors which put them at risk for HIV.

B. To enhance coordination among agencies serving the same population groups, the State should facilitate linkages regionally or statewide through (a) dissemination of an agency roster, (b) sponsor, host, or work with the National AIDS Update Conference Committee to implement workshops or meetings for the targeted agencies, © requiring that population-based groups participate in local planning, implementation, and evaluation efforts. Some mechanisms to assist in this include utilizing conference calls or tele-conferencing, particularly for agencies which are dispersed widely throughout California (such as those that serve Native Americans). CAIN, or another information network, could also be used as a vehicle for sharing information or holding on-line "forums" to discuss ideas or concerns of mutual interest to organizations.

C. When requested by a local or regional prevention planning group, or population-based or statewide project, the State and/or federal government should facilitate coordination and linkages with neighboring states and other countries (such as Mexico and Canada).

D. Prevention and early intervention strategies which cross many local and regional boundaries (such as State AIDS Hotlines or media campaigns) should institute representative advisory committees in order to demonstrate coordination and ensure that program implementation is responsive to the target audiences. Advisory committees should be involved in planning and evaluating the hotline and media strategies and campaigns.

E. Regardless of the level of geographic coordination (*e.g.*, state or local), planning bodies should always consult and communicate with neighboring public health jurisdictions, HIV/AIDS consortia, or appropriate agencies to share and develop resources, referrals, and prevention strategies in order to stop the spread of HIV in California.

Geographically determined programs may include: multiple regions in California and other neighboring states who serve a shared population (*e.g.*, communities bordering California/Nevada), or across the national borders (*e.g.*, where individuals cross over from Mexico, the Pacific Rim, and other countries). In addition to being defined by city, county, or state borders, other regions to consider in planning, coordination and building linkages include:

- Standard Metropolitan Statistical Area (SMSA);
- Health Professional Shortage Areas (HPSA) (prioritized for National Health Service Corps);
- Medically Under-served Areas (MUA) and Medically Under-served Populations (identified by the lack of primary care services); and
- Media markets.

4. Funding

In order to obtain state or federal funds, all applicants must demonstrate knowledge of and coordination with other related local programs, agencies and target populations. Evidence of knowledge and coordination might include letters of agreement, or a description of the linkages with other organizations.

COORDINATION BETWEEN COOPERATIVE AGREEMENT JURISDICTIONS

An additional issue was one not addressed by the Coordination and Linkages Committee, but is appropriately discussed in this chapter. This issue is the nature of coordination between the three jurisdictions in California. California is in the unique situation of having three separate HIV Community Planning jurisdictions. The cooperative agreement cities of Los Angeles and San Francisco have been funded by the Centers for Disease Control to conduct HIV Community Prevention Plans, as has been the State of California.

Coordination of these three plans would prove to be complex under the best of conditions. This is the first year of a new process -- a community participatory process in planning HIV prevention programs -- and while the process has been fruitful in all three jurisdictions, it has also presented new and complex challenges. Forming the community planning bodies and conducting the planning process required more time and activity than anticipated. As the jurisdictions gain more experience with this planning process, they will be able to take on additional challenges and refine their planning process. One of these challenges will be to develop more fully a system of coordination among the planning processes in the three jurisdictions.

Each of the three jurisdictions has met the basic requirements of coordination as outlined in the CDC *Guidance* and as described to them by their CDC contact officers. Office of AIDS staff (the Chief of the Office of AIDS and the Chief of the Prevention Branch)

have officially designated seats on the planning bodies of Los Angeles and San Francisco (although conflicting meeting dates have prohibited consistent attendance). Further, a co-chair of the Los Angeles planning body and a staff of the San Francisco AIDS Office who is involved with the San Francisco planning process have designated seats on the State's planning body and both regularly attend meetings. Other representatives from Los Angeles and San Francisco are involved in the state planning process as either members of the Advisory Group or the Working Group. These persons have enabled information sharing to occur. A coordination goal for year two will be to have more consistent and clearly defined representation of the three jurisdictions on each other's planning bodies.

Through discussions among persons involved in two planning processes (including representatives from the AIDS offices) and discussions among the planners, each of the cooperative agreement city jurisdictions gained a general sense of the results of the planning process of the State, and vice versa. However, the results -- recommendations about target populations, strategies, goals and objectives, and so forth -- occurred towards the end of the planning process. As a result, insufficient time was left to evaluate the effects of the cooperative agreement cities plans on the State's plan. Likewise, there was little opportunity to examine the effect of the State's plan on the work of the cooperative agreement cities. (The San Francisco and Los Angeles planning process have little, if any, effect on each other; all discussion in this section refers to the coordination and effects of the cooperative agreement cities on the State and the State on the cooperative agreement cities.) The paramount task of simply completing the plans taxed everyone's time and energy.

Attempts were made, even in this first year, to go beyond the basic requirements of the CDC for jurisdiction coordination. Meetings among the jurisdictions were discussed. One meeting was held on September 7, 1994. Present at that meeting were the co-chairs of the planning bodies of all three jurisdictions, the consultants, and representatives from the AIDS offices. Agreements were reached about how to implement a system of inter-jurisdiction coordination. The agreements are four-fold.

1. A more clearly defined representation will occur among the planning bodies: representation of the cooperative agreement cities planning bodies will act as official liaisons to the state planning body and a representative from the state planning body will act as a liaison to each of the cooperative agreement cities planning bodies. This recommendation will be implemented in year two.

2. The cooperative agreement cities and the State will share their plans to correct any factual misrepresentations contained in the plans. For example, the state's plan describes the epidemic for all of California; the cities may have more recent estimates of, for example, HIV prevalence in specific populations in their areas. This information should be incorporated into the State's description of

the epidemic. This agreement will occur in year one, between October and December.

3. The cooperative agreement cities and the State will review the other's plans to ensure integrity of the plans. Specifically, recommendations of the planning groups about goals and objectives, priority populations, strategies and interventions, and technical assistance will be reviewed to ensure that one group's recommendations do not invalidate another's. Implementing this recommendation will begin in year one with a review of the recommendations. In year two, the agreement will be fully implemented, and discussions will take place to define the method of review and coordination. The intents of this recommendation is not for jurisdictions to place limits or controls on each other, but rather to find ways to ensure that the plans can be implemented successfully.

4. As the jurisdictions begin to implement their plans, information sharing will occur among key staff of the AIDS offices. The purpose of this information sharing is to enable the plans to be implemented as designed. Illustratively, a high priority population in the state's plan may be of medium priority in a city's plan. The city's AIDS officer would need to know the approximate level of state funding for that population, so that the city can ensure that, within the city, a medium level of resources is allocated to that population. The majority of funding for that population in the city may therefore come from the state. This would ensure that the population remains at the priority level for resource allocation determined by each of the jurisdictions. Discussions will occur among the three jurisdictions between October and December to develop methods of implementing this agreement.

A second meeting of the three jurisdictions was held on December 6, 1994. Again, the co-chairs, consultants, and representatives of AIDS offices were present. At that meeting updates were given on each of the planning processes and funding coordination was discussed. A third meeting time and location was established.

At the Palm Springs (December 15-16, 1994) of the Community Planning Working Group, presentations were made by representatives from the Los Angeles and San Francisco planning groups. These presentations enabled the members of the Community Planning Working Group to gain insights about methods and outcomes of the other two planning processes in the state.

CHAPTER 11: TECHNICAL ASSISTANCE NEEDS AND PLAN

TECHNICAL ASSISTANCE NEEDS

The Technical Assistance Committee was charged with the mission of identifying the technical assistance needs of state, county and community HIV prevention agencies, particularly in the area of community prevention planning, and to develop recommendation for how those needs could be met. The audience for a technical assistance plan includes a) Education and Prevention contractors and their subcontractors who are community-based organizations, community clinics or other not-for-profits; b) HIV/AIDS programs and HIV/AIDS-related programs within county health departments or county health jurisdictions; and c) State departments and their programs as they relate to HIV disease (for example, Department of Education or Department of Corrections).

To identify technical assistance priorities in community planning and to develop a plan for implementation, the committee reviewed several source documents. These documents included a three-phase baseline needs assessment of Education and Prevention providers conducted by the Multicultural AIDS Resource Center of California at Polaris Research and Development, a telephone survey by Harder+Kibbe Research of State departments or agencies, and an evaluation of education and prevention services in California conducted by the Institute for Health Policy Studies at the University of California, San Francisco.

Limitations, Constraints, and Results

The Technical Assistance Committee found a number of limitations and constraints in attempting to fulfill its charge. Time, money, staffing support, and the design of the research instruments themselves impacted the ability of the Technical Assistance Committee to fully and comprehensively report on the community planning needs of local communities. However, while the micro perspective of the details of local needs assessments in each of the 58 counties was lacking, on the macro level the committee was able to identify a statewide perspective that established recommendations for initial action. Additionally, the findings of some of the instruments clearly went beyond the focus of community planning and reported an overwhelming need in the area of capacity building and culturally-competent technical assistance for diverse communities and their providers. A summary of the three sources for needs assessment is presented below.

Multicultural AIDS Resource Center of California (At Polaris Research and Development): Needs Assessment of California State Office of AIDS Education and Prevention Contractors and Subcontractors

The Multicultural AIDS Resource Center of California in year one of their contract under Polaris Research and Development designed and implemented a three-phase baseline needs assessment of technical assistance needs of HIV Education and Prevention contractors and sub-contractors funded by the Office of AIDS.

The first phase was a mail survey to over 190 state contractors and subcontractors which rendered a 70% response rate (approximately 131 respondents). The focus of Phase I was to identify utilization rates of three of the seven state-funded agencies that provide technical assistance and to identify the technical assistance needs of state-funded Education and Prevention providers. The seven statewide contractors are the Multicultural AIDS Resource Center (formerly contracted to the Minority Training Resource Center); the California AIDS Clearinghouse (formerly contracted to ETR Associates and now with the Los Angeles Gay and Lesbian Community Services Center); the California AIDS Information Network (CAIN); the California AIDS Intervention Training Center; the California Nurses Association; the California Hemophilia Council); and the Association of Regional Centers.

Phase I results found that the California AIDS Clearinghouse under ETR Associates had the highest utilization rate. The technical assistance resource accessed by the fewest providers was the MARC under the Minority Training Resource Center due to poor name and service recognition and a lack of expertise in rural issues. The greatest challenge to utilizing the California AIDS Information Network, CAIN, was provider computer illiteracy and low "user friendliness" of the network. The principal concern about the California AIDS Clearinghouse was the lack of culturally and linguistically appropriate education and prevention materials in Spanish. These results are summarized in Exhibit 11.1.

Exhibit 11.1 Utilization of State Funded Support Services
MARC, CAIN and the Clearinghouse
N= 131 Respondents to Written Survey
February 1994

Responses	MARC	CAIN	Clearinghouse
% using service	22%	41%	81%
Most frequently used service	Cultural diversity training	AIDS statistics, research data base	Order materials, search for culturally relevant materials
Barriers to service utilization	1) Contractors don't know that what is available, 2) perceived lack of expertise and understanding of rural issues, 3) concerns regarding effectiveness of training	1) Computer network is not user friendly, 2) CAIN staff assume an incorrect level of computer literacy among users, 3) some of the information is outdated or not useful	1) Lack of Spanish language materials, 2) concern that literacy level of materials is too high in English and Spanish, 3) limited materials due to restrictions related to State guidelines
Overall Rating of Service (1=not helpful; 5=very helpful)	3.5	3.4	4.1

Phase II (consisting of six focus groups of 69 providers covering all eight regions of the State) and Phase III (a telephone survey of 115 Education and Prevention practitioners and program managers in all 58 counties) identified overall technical assistance needs, including community planning.

The findings of Phases II and III in the area of capacity building (agency skills development) are summarized below:

a) **culturally competent technical assistance**

- designing culturally-specific materials;
  designing culturally-specific interventions and programs;
- implementing culturally-specific interventions and programs;
- culturally-competent evaluation of culturally-specific interventions and programs; and
- diversity training.

b) **evaluation**

- using qualitative evaluation of state-funded education and prevention contractors to capture the cultural nuances of AIDS prevention programs;
- training in data gathering and community evaluation models for communities who have strong oral traditions; and
- creating and utilizing evaluation tools in community conversational dialects.

c) **burnout**

- providing technical assistance in developing psycho-social support to prevent staff turnover due to overwhelm from overwork and loss; and
- training in conflict mediation to deal with politically-charged environments and cross-cultural conflict.

d) **population groups**

- technical assistance in client recruitment and retention of hard-to-reach populations;
- technical assistance in establishing rural AIDS networks of rural technical assistance practitioners to confront specific issues such as fundraising, communication, and intervention design; and
- technical assistance to the State Office of AIDS in developing recognition of its roles and responsibilities.

Exhibit 11.2
Technical Assistance Needs In Rank Order
Based on February 1994 Survey
Conducted by Multicultural AIDS Resource Center of California

Ranking	Topic	% Identifying Need
1	Finding Culturally Specific Materials	60.3
2	Program Evaluation	53.4
3	Reaching Your Target Population	46.6
4	Needs Assessments	45.8
5	Strategic Planning	42.7
6	Operationalizing Cultural Competence	42.0
7	Documenting What You Do	41.2
8	Media Development	39.7
9	Demystifying Grant Writing	32.1
10	Special Event Fundraising	31.3
11	Client Recruitment and Retention	29.8
12	Marketing/Public Relations	29.0
13	Personnel Issues	24.4
14	Conflict Management A-Z	24.4
15	Fiscal Management for Beginners	19.1
16	Working with Board of Directors	16.0

Phase III: Community Planning

A fundamental charge of the Technical Assistance Committee was to examine technical assistance needs related to community planning. Exhibit 11.3 displays how much technical assistance is needed from a provider perspective by assistance type in the area of community planning. The seven steps of community planning are listed in chronological order of progression. The far right column shows the mean calculation (on a scale of one to five) for the level of technical assistance needed for each step. Technical assistance in evaluating community planning was the top priority concern.

Exhibit 11.3
Technical Assistance Needs for Community Planning
Based on a Survey Conducted by
Multicultural AIDS Resource Center of California

Type of Assistance Needed	Amount of Assistance Needed					
	None	2	3	5	A Lot	Mean
Setting up a planning process	10	24	20	9	8	2.73
Community needs assessment	8	19	11	14	19	3.24
Data analysis	5	12	13	17	24	3.61
Setting priorities	8	11	25	18	9	3.13
Developing ways to distribute funds	7	16	16	16	15	3.23
Monitoring agencies' performance	9	7	17	18	20	3.47
Conducting an evaluation	3	5	15	28	20	3.80

Institute for Health Policy Studies, UCSF: HIV Education and Prevention Evaluation

The Institute for Health Policy Studies conducted a comprehensive assessment of the Office of AIDS Education and Prevention programs in 1992/1993. The evaluation included education and prevention providers, including community-based organizations, local health departments and other contractors. As a part of this evaluation, site visits were conducted in five California counties involving 43 participants in group meetings and 19 providers in individual interviews in October and November 1991. A mail survey was conducted of 139 state-funded prevention providers and 22 sub-contractors with a response rate of 70%. The complete findings of the assessment are described in *HIV Prevention in California* prepared for the Office of AIDS by the Institute for Health Policy Studies, University of California, San Francisco, April 1993. A brief summary of select findings follows.

The highest ranked need among all types of providers was for assistance in conducting evaluation of HIV education and prevention programs. Providers were unclear about what level of evaluation and program monitoring was necessary for their state contracts, and similarly, did not feel that they had adequate evaluation skills or a research base to plan effective education and prevention programs. Another highly ranked technical assistance need for community-based organizations, in particular, was grantsmanship training.

In addition to identifying technical assistance needs, providers were asked to report on technical assistance sources used. Ninety percent of contractors reported using the California AIDS Clearinghouse, less than 50% listed MARC as a resource, and a variety of other agencies were used (with a range of 4% to 28% of contractors using them).

Harder+Kibbe Research: Interviews with State Agencies

Harder+Kibbe Research conducted a series of telephone interviews with State agencies (see Exhibit 11.4 for agencies contacted). The purpose of the interviews was to identify the agencies' interests in participating in coordinated planning efforts (reported in the Coordination and Linkages section of this report), and determine their technical assistance needs. As in the needs assessments described above, the most common concerns (noted by about one-half of the respondents) were data collection and evaluation methodologies, access to evaluations of existing programs, and epidemiologic surveillance data. One provider noted the need for grantsmanship training for community-based organizations.

Exhibit 11.4
State Agencies and Departments Surveyed
Summer 1994

Department of Corrections	Division of Communicable Disease Control
Department of Developmental Services	Maternal and Child Health Branch
Department of Education	Office of Border Health
Department of Mental Health	Office of Family Planning
Department of Youth Authority	Primary Care and Family Health

TECHNICAL ASSISTANCE RECOMMENDATIONS

The guiding principles and recommendations established by the Technical Assistance Committee were formed from the data of the three needs assessment tools described above.

Principles

1. Strengthen the California State Office of AIDS, its contractors and sub-contractors in the non-profit sector, HIV/AIDS programs within county government health jurisdictions, and HIV/AIDS or HIV/AIDS-related programs in state agencies to

design, implement, and evaluate local community planning processes and expand capacity-building technical assistance.

2. Recognize the ever-changing environment and diversity of development and technical assistance needs for the multicultural communities of California.

3. Statewide coordination of all technical assistance between and among providers will be paramount to insure inclusion, parity, and equity in the delivery of service.

4. Networking and collaboration between/among providers should be considered a source of technical assistance support (*e.g.*, sharing of effective materials, provision of advice as needed or requested, and as psychosocial support for workers).

Recommendations

A. Institute a statewide advisory committee of professionals representing diverse areas of expertise (*e.g.*, evaluation, data collection and analysis, cultural competence, epidemiology, planning) to provide guidance and increase coordination, standardization of service, and quality control of the statewide technical assistance support programs, including but not limited to the California AIDS Clearinghouse, California AIDS Information Network (CAIN), California AIDS Intervention Center, Multicultural AIDS Resource Center of California (and possibly the state hotlines or other clearinghouses).

   1. Establish a quality assurance program, identifying and disseminating to all state contractors and other relevant parties and planning bodies, information about a) outreach and education programs with proven effectiveness, b) research regarding client knowledge, and c) high quality, culturally appropriate prevention and early intervention materials.
   2. Establish community standards of services for early intervention and prevention contracts.

B. Establish a neutral, culturally competent, statewide agency or body to act as convener and coordinate the response to identified technical assistance needs (not to provide all technical assistance services).

   1. With the Advisory Committee, create a technical assistance resource directory or network of providers throughout the state that can be coordinated by the neutral convener.

C. Conduct annual technical assistance assessments (*e.g.*, surveys, focus groups) of the State Office of AIDS, and at state and local levels in order to plan and design proactive strategies and enhance provision of technical assistance.

1. Conduct more extensive and in-depth technical assistance needs assessment at local level in order to create an effective plan of action.
2. Coordinate local and statewide technical assistance efforts so they complement each other.

D. Provide training and technical assistance, including but not limited to the following skills, in order to strengthen the planning abilities of community agencies and the State Office of AIDS:

1. Identification of and training in HIV outreach and education techniques which have proven effectiveness;
2. Access to research regarding client knowledge;
3. Access to high-quality and culturally appropriate outreach materials;
4. Training to improve cultural competence;
5. Training in techniques for program evaluation and report-writing;
6. Understanding how to use epidemiological data in program development.

E. Evaluate technical assistance delivery to measure effectiveness, usefulness, and appropriateness of technical assistance.

1. Encourage the use of qualitative and quantitative methods in evaluating programs.

F. Funds should be allocated to enable needs assessment and the implementation of capacity building interventions in the State Office, local health jurisdictions or regional planning bodies.

G. The State Office of AIDS should inform and educate contractors and subcontractors about what it does and does not do (*e.g.*, roles and responsibilities, key staff, expectations), and available technical assistance programs and how to access them.

CHAPTER 12 RESOURCE ALLOCATION PROCESS

This chapter describes the Community Planning Working Group's recommendations for the processes to be used in California to allocate HIV prevention funds. Developing these recommendations was a monumental task. In its guidelines to Community Planning Processes, the Centers for Disease Control did not require that the plan address funding mechanisms/processes for prevention programs. However, the Office of AIDS determined that this issue was essential to participatory community planning, and requested that the Community Planning Working Group address this issue.

The Resource Allocation Process committee was established at the same time as the other committees. This committee reviewed current resource allocation methodologies employed by the Office of AIDS and amount of funds currently available for prevention programs. The Committee made recommendations for future allocation methodologies and amounts to be made available for future prevention activities. The committee presented a set of recommendations to the Community Planning Working Group at the San Mateo (September 22-23, 1994) meeting. The Community Planning Working Group adopted some of these recommendations, and formed an expanded committee consisting of the original members of the Resource Allocation Process committee and members of each of the other committees, as well.

PREVENTION FUNDS RECOMMENDATIONS

The Community Planning Working Group as a whole reviewed the entire $35.2 million currently available for HIV prevention programs. In Exhibit 12.1, Column 3, under FY 1995/96, are displayed the results of the voting by the CPWG for FY 1995/96. This exhibit also displays how prevention funds were used in FY 1993/94 and FY 1994/95 to allow comparative review.

Exhibit 12.1
CPWG Recommendations for Prevention Funds Allocation by Program

(in millions)	FY 1993/94		FY 1994/95		FY 1995/96	
HIV Prevention Program	Amount	Percent	Amount	Percent	Amount	Percent
Counseling & Testing	$10.0	32.9%	$11.2	31.8%	$10.6	30.1%
Counselor Training	$ .5	1.6%	$ .5	1.4%	$ .5	1.5%
Early Intervention Program	$3.2	10.5%	$3.8	10.8%	$4.5	12.8%
Education & Prevention	$16.7	54.9%	$19.7	56.0%	$19.6	55.7%
TOTAL	**$30.4**	**100.0%**	**$35.2**	**100.0%**	**$35.2**	**100.0%**

In summary, the Community Planning Working Group recommended that funds be allocated as follows:

- Counseling and Testing Program funding is recommended to be reduced by $600,000, 1.7%, to $10.6 million.
- Training Program funding is recommended to be maintained at the current level, $500,000.
- Early Intervention Program is recommended to increase by $700,000, a 2% increase.
- Education and Prevention is recommended at a slight decrease to $19.6 million, a 0.4% decrease.

The Resource Allocation Process Committee reviewed the current allocation methods employed by the Office of AIDS to disburse funds and recommended changes for future allocation of prevention funds. The recommendations are displayed in Exhibit 12.2, and further described in the text that follows the exhibit.

Exhibit 12.2
Recommendations for Resource Allocation Processes for Prevention Programs

Program	Current Procedure	Recommendation
Counseling and Testing/Partner Notification	Memoranda of Understanding (MOU's)	Status quo/maintain MOU process. If new sites selected, locate in counties with high incidence of HIV
Counselor Training	State Administered	Evaluation of current program; RFP if not acceptable to outside contractor
Early Intervention	Sole Source	Requests For Proposal (RFP's) with review by culturally competent panel. New sites in rural areas if funds become available.
Education & Prevention	RFP	I. Statewide/regional set asides allocated through RFP II. Local prevention program funded through a local planning group decision making process via formula

Counseling and Testing Program - The current process of allocating funds is recommended to be maintained. Funds are allocated using most recent utilization data. An allocation amount is derived by estimating the number of testing and counseling services to be provided multiplied by the reimbursement rates for these services. These funds are allocated through a Memorandum of Understanding (MOU). Additionally it was recommended that if new testing sites are selected, sites should be located in counties with a high incidence of HIV.

Counselor Training - The current process of allocation of funds is recommended to be maintained. Currently OA uses the training funds to contract with an agency that is responsible for training HIV counselor trainers, providing updates, maintaining the HIV counseling training curricula, and providing continuing trainings to counselor trainers. A portion of these funds are also used to pay for costs associated with conducting the trainings, i.e., travel and per diem for trainers. This is also conducted through a competitive bidding process.

Additionally, it was recommended that an evaluation of the current Office of AIDS administered Training Program be conducted and if the assessment determines that if the program needs to be improved, the program would be contracted to an outside contractor through an RFP competitive process.

Early Intervention Program (EIP) - It is recommended that current funds be placed in a competitive RFP process. Proposals submitted would be reviewed by a culturally competent panel. If any additional funds become available above the FY 1994-95 funding levels, the new funds would be targeted for EIPs in rural areas.

Education and Prevention (E&P) Program - The E&P Program allocation methodologies were recommended to change. The next several pages describe the recommendations regarding the Education and Prevention Program. Distribution of funds are recommended to occur in two tracks, Track I and Track II. Track I funds are the portion of E&P funds for statewide and regional set-asides awarded through a competitive bid process. Track II funds are the portion of E&P funds distributed by formula to local health jurisdictions for local distribution by local planning bodies. Each track is discussed below.

The Expanded Resource Allocation Process Committee conducted additional work in October through December and presented recommendations to the Community Planning Working Group at the Palm Springs (December 15-16, 1994) meeting. After discussion and few revisions, these recommendations were adopted. The mission of the Expanded Resource Allocation Committee was to make recommendations to the Community Planning Working Group about the following:

- Percent of Total E&P funds to go to:
  - Track I: State RFP Process
    - a) Statewide mandated programs
    - b) Statewide/regional set-asides
  - Track II: Local Planning Groups
    - a) Local Projects/Assistance
- Establish statewide/regional set asides
- Develop and approve HIV prevention Request for Proposal (RFP) criteria
- Provide written input for developing an HIV Prevention RFP
- Develop selection criteria for review process and evaluation of proposals
- Develop list of interested parties for HIV prevention RFPs
- Develop formula for allocation of local assistance funds

- Develop criteria for local planning groups
  Including the process for compliance with State Plan

- Develop process for ongoing community input and evaluation of resource allocation process implementation

Percentage of Education and Prevention Funds by Track

Track I Statewide and Regional Set asides:
$5.88 million (30% of E & P funds)

Track II Local Planning Groups:
$13.72 million (70% of E & P funds)

Track I is a portion of the funds allocated through a request for proposal (RFP) competitive bidding process. This will include funds for state mandated programs such as the Computerized AIDS Information Network (CAIN) and the California AIDS Clearinghouse (CAC). Also included in Track I are funds for statewide/regional set-asides for target populations.

Categories for Statewide and Regional Set Asides (Track I)

A. Legislatively mandated programs:
   1) Statewide HIV/AIDS electronic information network
   2) Statewide education information and material distribution center

B. Technical Assistance, and/or Training (train-the-trainer), and/or Telephonic Information Access Network

C. Statewide/regional education and prevention projects targeting specific populations

Allocations for Statewide and Regional Set-Aside Funds

Category	Dollars	% of E&P Funds
Legislatively mandated programs	$0 .78 million	4%
Technical Assistance	1.96 million	10%
Target Pop. Set-asides	2.94 million	15%
OA Emerging Issues*	0.20 million	1%
Total	$5.88 million	30%

*Held aside by OA annually; not allocated through RFP

The Resource Allocation Process Committee recognized the need for the State to provide an effective level of set-aside funding to serve target populations identified by the Community Planning Working Group. The intent of the statewide and regional set-asides for target populations is to insure the development, implementation, and maintenance of a safety net of education and prevention services for the historically un/underserved. Populations (documented and undocumented) exist in California that remain unrepresented and un/underserved at the local and regional level. There are local entities that remain unresponsive and/or unwilling to address the needs and concerns of these communities. Statewide and regional set-asides are an effective means of insuring representation and program delivery for these identified populations.

Fund Allocation Method for Statewide/Regional Set-asides for Target Populations

These funds will be awarded through a competitive bid process. Proposals for statewide and regional projects must demonstrate all of the following:

a) Target populations are consistent with the California HIV Prevention Plan and reside in geographic areas which extend beyond county/health jurisdiction boundaries;
b) The project addresses unmet needs or gaps in service or emergency issues;
c) The project provides a means of establishing or maintaining linkages and cooperative efforts;
d) A statewide/regional project assures economy of effort and/or increased cost effectiveness; and
e) Proposed strategies and methods are consistent with the California HIV Prevention Plan.

Applicants for the Statewide and Regional Set-asides for Target Populations will respond to a Request for Concept Paper (RFCP) process initiated by the Office of AIDS.

In order to apply for Statewide/Regional Set-asides for Target Populations, a local HIV prevention plan must be in place. Local planning is discussed under Track II funds; however, the local planning process will conduct local needs assessments that include forming local focus groups to gather information about local needs.

In order to enable Local Planning Groups to conduct a planning process, the CPWG recommends that funding be extended to all existing contractors through June 30, 1996. Additionally, it was recommended that if funds are available, a 5% COLA is to be extended to existing contractors. This extension will allow 12 months to develop local plans and six months to allocate funds by Local Planning Groups through a competitive bidding process.

This will enable interested parties to more effectively develop requests for Statewide/Regional Set-asides.

To assist interested providers in applying for Statewide/Regional Set-asides, the CPWG recommends that Office of AIDS contract with an agency to provide technical assistance to develop RFCPs (approximately $250,000 - $300,000 from new CDC funds or OA emerging issues funds is recommended to provide this technical assistance).

The CPWG will add new organizations to the Request for Concept Papers (RFCP) distribution list. The CPWG recommends retaining the current RFP review criteria, and adding non-governmental members to the current group of reviewers of proposals.

Local Planning Groups (Track II)

The Community Planning Working Group recommends that a portion of the Education and Prevention funds used for local education and prevention projects be allocated to all health jurisdictions through a local assistance formula (described below). This track would require that local planning groups be established to decide how the funds would be used and distributed locally. However, of the funds received, Local Planning Groups will be mandated to set aside 15% of local funds to assure the development, implementation and maintenance of a safety net of education and prevention services for the historically un/underserved. Populations (documented and undocumented) remain unrepresented and un/underserved in some local areas. Local set asides will be a means of assuring representation and program delivery for these identified populations. (These are in addition to the Statewide/Regional Set-asides described above.) The remaining funds will be distributed locally through a local RFP process.

The planning bodies established at the local level are to adopt the following principles:

- CPWG is committed to the concept that all persons living in California should have access to HIV prevention education.
- Under the guidance of OA, local planning groups shall be constituted per the CDC HIV prevention community planning process guidance and the California HIV Prevention Plan.
- Local planning bodies shall use RFP process to allocate funds, setting aside some portion for historically un/underserved groups in the jurisdiction.
- Every county (as a geographical area) shall receive some funding according to an established formula.

Health jurisdictions (health departments in 58 counties and 3 cities) shall receive their prescribed level of funding according to a statewide formula. Should jurisdictions decide to form one Local Planning Group (LPG), the combined group will receive all prescribed funds.

By the end of January 1995, the Office of AIDS will develop criteria to determine under what conditions jurisdictions can combine to form one LPG.

The formula used to allocate Track II funds from State to each local health jurisdiction the will be based on total population of the jurisdiction and total population of the State.

Formula Element	Weight
Incidence of recent AIDS cases (1990 to the present total cases for the period divided by the mid-point population):	40%
Percent of population from communities of Color:	25%
Percent of population below poverty level:	15%
Percent of population living in rural areas:	15%
Percent rate of neonatal surveillance:	5%

In the future, the Community Planning Working Group will explore the issue of a criteria for floor and/or ceiling funding for each local health jurisdiction.

The Local Health Department (LHD)/or its designee in each health jurisdiction will be the fiscal agent. This entity will form an advisory committee of HIV/AIDS affected communities and education and prevention service providers. The advisory committee will select the members of the LPG. Decision-making authority is shared between the fiscal agent and the local planning group, modeled on the State process and CDC guidelines.

Health jurisdictions within each geographical county area are encouraged to work together during their planning and implementation of HIV prevention services to efficiently and effectively provide HIV prevention services.

All LPGs must comply with the requirements that the composition of the local planning group must reflect the HIV/AIDS affected populations and communities residing within the jurisdiction of the planning group in compliance with CDC guidelines, and the cluster-concept criteria established in the State plan by the Community Planning Working Group.

The Office of AIDS will ensure the development of mediation process to resolve conflicts and community concerns of LPGs at the local level, beginning with the selection of LPG members and continuing through implementation of services at the local level.

RECOMMENDATIONS ABOUT THE CONTINUANCE OF STATE HIV PLANNING AND IMPLEMENTATION

The following set of recommendations deal with issues of new funding, and the continuation of the Community Planning Process at the state level.

If any new HIV Prevention and Education state or federal funds become available, priority in allocating these funds will be given to local planning, capacity building, and evaluation.

The Community Planning Working Group accepted the recommendations of the Expanded Resource Allocation Process Committee about the continuation of state HIV prevention planning. These are as follows:

Composition of the Community Planning Working Group

- Empower an ongoing 55 member CPWG with the charge of working in collaboration and partnership with the State Office of AIDS (OA).

- Existing Community Planning Advisory Group (CPAG) Membership Selection Committee is charged with filling vacancies to bring membership to 55 members. Selection of new members shall be made using the cluster criteria established by the CPAG and OA in selecting the current CPWG and will also take into account input from the current CPWG and other sources of public comment. There will be term limits established.

- This CPAG Membership Selection Committee will be ongoing and asked to establish "milestones" for when and how vacancies in the CPWG will be filled. They should also consider varied term lengths to accommodate persons with health or other concerns which could limit their ability to serve to extended periods. The use of staggered terms should also be considered to ensure continuity of the group and process.

- Members on current CPWG who wish to will have their terms extended for one year.

- OA shall distribute a survey to all current CPWG members to determine the following:
  a) Do you wish to remain on the CPWG?
  b) What groups do you believe are currently under/unrepresented on the CPWG?
  c) What expertise do you believe we need on the ongoing CPWG?
  d) List all the communities you represent and your areas of expertise.

Tasks Identified for Continuing CPWG Planning

- A major priority of the CPWG in the next planning year should be to establish a timeline for the implementation of the goals and objectives of the plan as well as do any refinements required.

- Work in collaboration with OA to ensure the implementation of the plan. Update the plan periodically.

- Review and integrate public comment from CPWG meetings and the public hearings where appropriate.

- Develop by-laws which address:
  a) Participation in the CPWG (e.g., permitted absences);
  b) Role definition (e.g., working group and leadership roles);
  c) Rules of respectful engagement;
  d) Alternates for CPWG members and their participation in the process;
  e) Leadership (i.e., co-chairs, committee co-chairs);
  f) Community representation; and
  g) Approval of minutes and agendas

- Determine the relationship between the CPWG and other HIV/AIDS Advisory groups such as (but not limited to):
  a) Multicultural Liaison Board
  b) Interagency HIV/AIDS Coordinating Council
  c) Other HIV/AIDS advisory bodies to other State departments
  d) Regional and statewide advocacy and professional associations
  e) Local planning groups

- Define what is meant by a collaborative relationship with the Office of AIDS including a definition of communications, accountability, shared decision-making, monitoring, and evaluation.

- Identify and implement a model for public input which meets the needs of diverse cultural and geographic groups in the state.

- Review the Evaluation chapter of the plan in a self-reflective manner so as to enhance the CPWG's future work by building on what did work in year one and changing what didn't.

Final Year One Planning Issues:

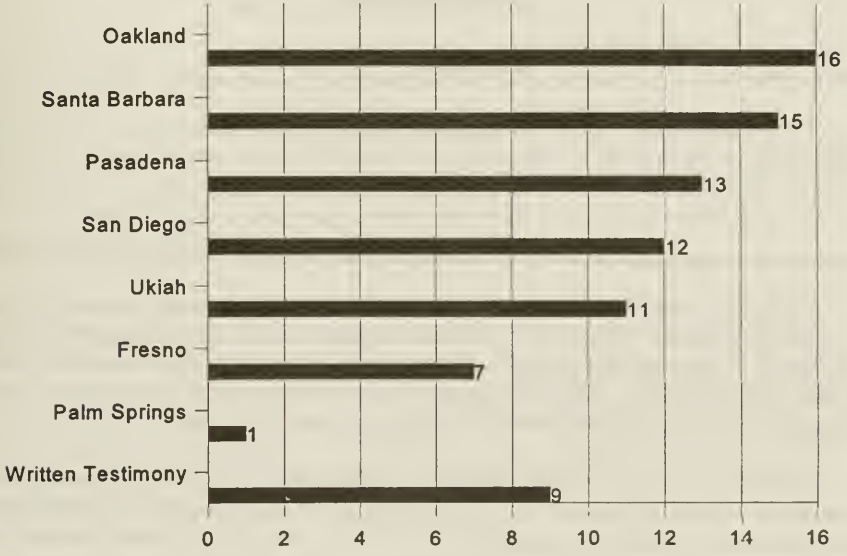
- A group of consultants/advisors to the OA, which includes the planner, evaluator, CPAG, consultant, and facilitators will assess the current committee structure of the CPWG and mechanisms used for decision making. This group should also consider and assess the usefulness of a task force model to address issues identified in the plan and public comment (e.g., development of a technical assistance plan and quality assurance issues and mechanisms used to make decisions and recommendations.) From this discussion, the groups will make recommendations to be acted upon by the CPWG.

- The final recommendations of the Resource Allocation and Expanded Resource Allocation Committees should be included as a Resource Allocation Process chapter in the final draft of the plan submitted to the CDC in January 1995.

CHAPTER 13 SUMMARY OF PUBLIC TESTIMONY

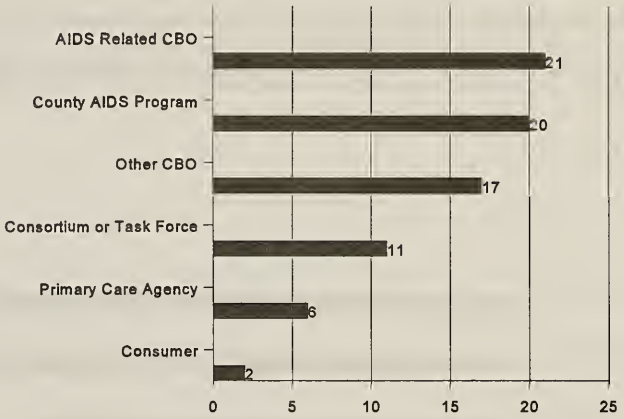
A draft of the California HIV Prevention Plan was produced in October and over 1,000 copies were distributed throughout the state. To obtain public comment on the plan, eight Public Testimony hearings were held in different parts of the state. At each hearing a court reporter was present to record comment. One of the hearings was canceled due to weather conditions and impassable roads. Agencies in that area were contacted by the Office of AIDS and asked to encourage interested parties to submit written comment. Written comment was also solicited from other parts of the state. The number of persons providing public testimony is displayed in Exhibit 13.1.

Exhibit 13.1
Number of Persons Providing Public Testimony at Each Hearing



Almost all persons offering public testimony were service providers or members of Consortia or Task Forces. ("Consumers" of prevention services had made comments during the development of the plan during the public comment section of the planning meetings.) The affiliation of persons providing public testimony is presented in Exhibit 13.2

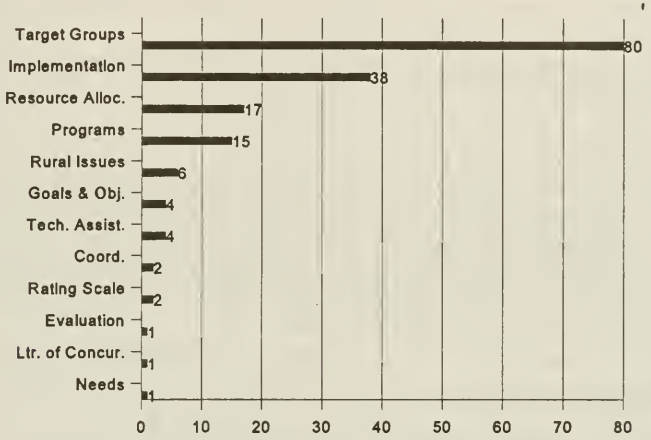
Exhibit 13.2
Affiliation of Persons Providing Public Testimony



Most people who provided public testimony addressed issues related to specific target populations, as shown in Exhibit 13.3. Of the 84 public testimonies, 80 dealt with target populations. Often, issues addressed were agreement with or criticism of the plan's discussion of and/or decisions about specific target populations. Other comments were simply advocacy for higher levels of funding to serve specific target populations.

Another topic which elicited much public comment was the implementation of the plan/ methods of resource allocation. The overall sense gained from the public testimony hearings was that the plan is generally acceptable, and providers want to know more about the "next steps" and how the plan will impact their agencies or counties.

Exhibit 13.3
Issues Presented at Public Testimony Hearings



Many persons providing public testimony praised the plan and the planning process. While some of these comments were introductory to criticisms or critiques of elements of the plan, others were strongly stated praise for the process. These comments of praise were not included in the above exhibits, and only a few representative ones are provided in the summary of public testimony below.

Using court-reporter transcripts, the planner summarized all public testimony and grouped comments by issue. This summary was presented to the Community Planning Working Group at the December 14-15, 1994 meeting, and each comment was reviewed briefly. In many instances, revision of the plan was recommended, especially to the needs assessment section contained in Chapters 3 and 4. Other comments were simply noted. The summary of public comment follows. After each comment, a response is placed in brackets. The responses were composed by the planner with general guidance from the Community Planning Working Group.

Summary of Public Testimony

Letter of Concurrence

In its vision statement and letter of concurrence, under the list of policies, add: Sex education and HIV prevention education in the schools should openly discuss homosexuality and promote the psychological well-being of all students by addressing homophobia and providing support for gay, lesbian, bisexual and questioning youth.

[The CPWG recommended that this sentiment be included in the section on youths and adolescents in Chapter 3]

Goals and Objectives

Goal 2 Objective 7: harm reduction: incorporate into other goals by adding a Goal I Objective 2c: IDUs have access to needle exchange and drug treatment on demand; add Goal I Objective 1 - sexually active people should have access to condoms and know how to use them. Add to Goal III HIV negative people have skills to initiate and maintain safer sexual behavior including self-esteem and life affirming support. Also all (maybe to Goal III Objective 1) empowerment and safer sex negotiation skills, particularly for women.

[The CPWG recommended that language regarding negotiations skills with condoms be added to the goals and objectives. The other issues are covered in the existing document.]

Under Goal V, To increase the number of HIV positive people seeking early intervention services, I would like to see added under Objective 1 the following: support and funding for Intervention Case Workers who would work with counseling and testing programs to pick a HIV positive person up upon them receiving their results. This person then would be responsible for ensuring the HIV positive persons having information about early intervention and other HIV-related services available in the community.

[This is a program-specific issue rather than a broad statewide goal. Local programs may wish to develop positions to serve this need.]

Make goals and objectives specific and measurable; for example: how many people in California regularly use needle exchange and project where we want to be in 1 year, 2 years. Or new number of infections.

[For Year 1, the CPWG were unable to attempt this. The Year 2 planning process will emphasize specific measurable goals and objectives.]

Throw out the goals and objectives and start new. Make them time based and feasible: measure degree of change.

[For year 1, we were unable to accomplish this. The Year 2 planning process will emphasize specific measurable goals and objectives.]

Needs
Prevention dictates that all obstacles, including homelessness and hunger must be eliminated...Beyond condoms and clean needles, let us also find how to produce blankets, food, shelter and jobs.
[The preamble (Letter of Concurrence) discusses these issues.]

Target Groups

Target Groups
I think the money should be going into prevention and behavior change. Public awareness campaigns are not a priority in 1994. We have seen that 70% to 80% of our AIDS cases are among gay and bisexual men. Another 15% are among injection drug users and their partners. We need to start with that epidemiology. The laundry list of 16 target populations in the state plan is useless. I appreciate all the work that went into them, but they look like a piece of political work. I would suggest it start in terms of risk behaviors rather than target populations. It's probably too late to look at that, but it certainly would make a lot more sense.
[Not all contracts will address all 16 target groups. Target groups were prioritized as a guide to focus on groups in real need of E&P. A future planning process may want to use a different framework for target groups.]

Epidemiology inaccurately reports HIV infection in minority communities by misidentifying people's ethnicity. Asian/Pacific Islanders, American Indians and Hispanics are often mistaken for white or African American. Women to women transmission is still not listed as a category. There is no category for transgenders. There is a need for prevention case management for Asian women and transgenders in massage parlors. These are two groups that are very stigmatized and have very little legal recourse, especially in instances of sexual abuse.
[The CPWG requested that the OA make a presentation at the next available opportunity on how HIV testing data can become more useful in planning and on what special studies of incidence or prevalence are occurring.]

People have a matrix of identities. Many people we see don't fit under one category, but fit under many categories.
[Chapters 3 and 7 were revised to incorporate this concept.]

It is difficult to determine how much to base E&P programs on epidemiological data. By relying on epidemiological data too much we may miss groups such as migrant workers, sex industry workers, minority groups and the homeless. It is difficult to grasp how many women are being infected because of the current reporting system. A new reporting system needs to identify lesbian and bisexual women.
[Noted.]

There is a lack of material in Asian languages. There is a lack of group specific materials for Native Americans, people on probation, parolees, students in special school programs, including

special education and continuation schools and any kid outside the mainstream. My biggest concern is the low priority given to women and Latinos, and I would encourage the committee to consider raising the priority of women.

[The issue of women as a priority population was a frequent comment. Currently there is not a high degree of agreement about this. Most people believe that there are pockets of epidemic in the female population. Whether the entire female population is at high risk is controversial. The CPWG recommended that gathering more information on women be a priority task in Year 2 planning.]

Reemphasize the two biggest groups where there is new infection: gay and bisexual youth under age 25 and injection drug users. Both of these groups have either been lumped or ignored into larger categories. We really need to emphasize real HIV epidemics, not potential ones.

[The text in both chapters 3 and 7 was revised to clarify that gay and bisexual youth can be targeted under either gay males or youth, and that the priority of the Substance Abusers and Their Sexual Partners target group be IDUs. The text was changed to clarify that gay and bisexual youth are a priority group.]

There is some question as to the accuracy of existing reports in depicting a genuine picture of who is actually infected by HIV, particularly African-Americans, Latinos, people currently using substances. We know that unless that individual has a desire to interface with the system they would not be tracked and therefore have no way of being identified for HIV seroprevalence reports. Efforts must be developed to access at-risk populations for the purposes of generating information that accurately depicts the effects of this pandemic.

[The CPWG requested that the OA make a presentation at the next available opportunity on how HIV testing data can become more useful in planning and on what special studies of incidence or prevalence are occurring.]

The first three target groups are very specific: substance abusers, their partners, gay and bisexual men, sex industry workers. When you get to number 4, youth and adolescence, it's very broad. If we are talking about those youth who are mostly getting infected, that would probably be substance-using youth and gay/bisexual youth. So I think that definitely needs to be more specific as far as youth. We really need to focus on those who are becoming infected, but not the mainstream youth.

[In developing local plans, communities will need to specify who will be targeted in that area. The State-wide document is, by its nature, broad. The Plan was, however, changed to emphasize in Chapters 3 and 7 that gay and bisexual youth are a priority group.]

We ask and encourage the committee to consider the following areas to be those of our greatest concerns: 1) Men with men, bisexuals and Lesbians engaged in high risk behaviors. 2) Injection Drug Users, addicts, alcoholics and substance abusers. 3) Sex workers who are for the most part driven by drug/alcohol addictions/homelessness and mental health disorders. 4) People of Color in general and those included in the other three categories, emphasizing language, cultural uniqueness and sensitivity. As a health care provider it is our mission to provide needed services

to all people in our community without exception (nor immigration status). We know that limited funding is available. Therefore, wise and informed decisions are imperative.
[Noted]

Targeted educational efforts shouldn't be based solely on epidemiological data. We need to also include populations in denial that do not get tested. We cannot only focus on the people who get tested; they already have a level of awareness.
[The CPWG members used various sources of information to develop their list of prioritized target groups. Epi data was only one source.]

I am not aware of any transgender or transvestite individuals in my rural county who have AIDS or who are HIV positive. And I have to confess total ignorance about how to do any outreach to those individuals if they exist in my county. We have a number of homeless and transient individuals how are HIV positive; a significant number of our small county immigrants and the undocumented persons. We also have a concern in our county for seasonal and migrant farm workers. In our county they have a higher priority than some other individuals on the list.

[Each county will need to conduct a local needs assessment to determine what groups are a priority. Transgenders may not be a priority in every county.]

Drug Users
In serving injection drug users, it is imperative that we acknowledge the barriers to effective prevention are real life crises such as primary addiction, compromised immune systems, physical health, homelessness, joblessness, and a variety of other psychosocial stressors. The most effective prevention strategies are going to be those services that are aligned through memorandums of understanding or community linkages or other kinds of agreements with established community resources that can help IDUs with many areas of their lives.
[Noted]

We need to particularly emphasize needle exchange programs, even though they are not politically popular.
[The Plan does this.]

We need to support needle exchange and needle exchange legislation. People will share if they don't have a clean needle. Needle exchange allows people to do something for themselves. It may be the first step on getting them to take care of themselves.
[The Plan does this.]

A need we encounter in doing outreach is immediate treatment services for I.V. drug users. Also, we've encountered clients seeking HIV testing. Our recommendation would be that the be money allocated for a mobile testing unit in the community. And our concern is also Proposition 187 and if it is implemented how will that affect our delivery of service. We would like to know how the plan would be affected if we were told that we had to implement Proposition 187.

[Treatment on demand is addressed in the preamble. Mobile testing is discussed in the Strategies section and nothing in the Plan would prohibit mobile testing. Prop. 187 was discussed at this meeting December meeting of the CPWG. At this time, it is still unclear how the proposition would affect the Plan.]

Drug treatment programs in our county are inadequate to the scope of the job they're required to perform. Amphetamine usage is epidemic in our county. We are in desperate need of strong help to develop educational and support services that can function in spite of the county's lassitude.
[Noted]

Gay/Bisexual Men
Concerned about low level of agreement of needs of gay men -- feels left out in the cold.
[Gay men were ranked as a high priority.]

I don't think the issue of relapse was adequately addressed in the plan. This is an issue that goes to the heart of the difference between urban and non-urban settings. There is more internalized homophobia in non-urban areas. There is no community for them to connect with and they go to those old behaviors, those self-destructive, shame-based behaviors.
[Chapter 3 was revised to address the issue of relapse.]

I would like to stress the importance of continuing education to gay and bisexual men. People are still having high risk sex. They know the facts, but they are still not protecting themselves. Programs need to address the reasons behind unsafe sex such as having see all their friends die and the guilt of surviving. Repeated contact with outreach workers is one way to reach gay/bi men. Programs need to be sex positive. We need media attention to reach closeted men who have sex with men. The message needs to be explicit.
[Noted]

The California HIV Prevention Plan should address the use of nitrite inhalants ("poppers") as a risk factor for unsafe sex among gay and bisexual men. Prevention workers should be alerted to this reemerging behavior. There is a current lack of educational efforts addressing the hazards of using poppers. This gap is important in the context of recent upsurge in popper use and its relationship to unsafe sex. We recommend that one agency be designated to take the lead and distribute and develop information/materials on the popper issue. [Information is enclosed for inclusion into the Needs Assessment section.]
[Chapter 3 was revised to discuss poppers.]

Gay and bisexual men still represent the largest group of reported AIDS cases. Are we to be assured that this information will affect the distribution of funds for prevention education targeted at this group? In San Diego County, gay and bisexual men are still at the greatest risk for HIV infection. We currently only have one program that targets this entire county. Are we getting more funding?

[Gay and bisexual men are a high priority in the Plan. The resource allocation formula was discussed at the December meeting.]

The goals of the comprehensive prevention system must include relapse prevention issues and goals for high-risk groups like gay and bisexual men. Basic HIV information is not enough. We cannot sit back and assume that if we have told people how HIV is transmitted and hand them a condom, that we have prevented them from exposure. Further, grief issues and support for people affected, but not infected, must be included.

[Chapter 3 was revised to include relapse issues. Many elements of the Plan discuss the issue of interactive education strategies.]

We need to support behavior change over time for men who have sex with men. Stress the separation between messages that are for HIV negative men and HIV positive men.

[Specific messages are developed on a program level. The Plan, by its nature is a broad statewide guidance.]

I am concerned that with all the energy that is devoted to being really culturally sensitive, we lose sight of the fact that MSM is the primary group that is affected by HIV and AIDS. The education is not completed in this group. Handing out pamphlets or condoms is not effective. We are beyond the need to raise awareness. We need to change people's behaviors. It requires peer education.

[MSM and peer educators are addressed in the Plan.]

Gay men, young and old, are reporting choices other than condom use to reduce their risk, and we need to find ways to support those choices.

[Noted]

On page 264, Exhibit 5.5, the fewest number of projects and the fewest dollars of all target groups are specified for men who have sex with men [in current funding].

[The table describes funding prior to the implementation of this Plan.]

Just a few notes on the Coachella Valley (Palm Springs). It's a resort area known to gay men all over the world as one of the top five tourist destinations; and those visitors may, in fact, leave their learned safer sex behaviors behind when they're here on vacation and wanting to forget all about the other pressures of daily life. It's also the last place, oftentimes, where HIV impacts one's life. By that, I mean that people with the disability, people on fixed incomes and people whose mobility has been impaired and whose support systems may have deteriorated, often relocate to the Coachella Valley because of the lower cost of living and higher quality of life and a large support system. So in many senses, we see people at the beginning of contact with HIV and at the end of their personal contact with HIV. The uniqueness of an area such as this has, to this point, not be referenced in the Prevention Plan; and that would be the primary recommendation that I would make.

[Chapter 3 was revised to include information about issues of gay male resort areas.]

I have a fear that the gay and bisexual men will not get the focus they deserve because of the comprehensiveness of the plan. The people being infected are much poorer people than in the past. They tend to be more Latino and more often they are young men. But gay and bisexual men are still a sizable chunk of those we see in our ATS.
[Gay men are a priority population in the Plan.]

The plan mentioned that gay and bisexual men of color believed that the most effective HIV prevention programs were run specifically by and for men of color. I agree. But current reality is that there is still a lack of significant attention to the prevention needs of these groups. I am sure that the organizations that we work with would agree with me that in order for them to successfully impact members of their respective communities, they need adequate funding. In order to continue doing our work, we need your continued attention and support.
[The Plan addresses these issues. Funding was addressed in the Resource Allocation chapter.]

Young Gay Men
We are not going to reach young men who have sex with men through our schools systems as they're currently set up. You really need to make some recommendations that programs within schools cannot make because of censorship, like allowing outside presenters to come in and use the language of prevention that teachers are denied the access to use. Refill the shelves with books that talk about gay and lesbian sexuality and youth. These books are going to be stolen over and over again rather than checked out because it's too embarrassing for young people.

[Chapter 3 and 7 were revised to emphasize that gay youth are a priority group. This Plan has no jurisdiction over the purchase of school library books.]

One correction to the young men's study: there are two sites in Alameda County, namely, the City of Berkeley and the City of Oakland.
[Chapter 2 was corrected.]

Include gay and bisexual youth as a specific target population, prioritize this new population among the other targeted populations and include a discussion of the prioritized needs and strategies for this new target population. Some example issues to address are self-esteem, social isolation, relationship skills, and internalized homophobia. These are some of the barriers to HIV prevention within this particular population that can't be addressed by discussing youth and adolescence as a whole.
[Chapters 3 and 7 were revised to emphasize that gay youth are a priority group. A discussion of the needs of gay youth was added to Chapter 3.]

The California AIDS Clearinghouse needs to develop materials for teens that address homosexuality.
[Noted]

Youth and adolescents are an important and, thankfully, included target audience, but gay and bisexual youth have a whole set of different needs and concerns, and I don't see them represented in this list. Gay and bi youth have more needs regarding support, self-esteem, education, and family issues than do mainstream youth.

[A discussion of the needs of gay youth was added to Chapter 3.]

The committee should recommend funding for programs that serve gay and bisexual youth out of school.

[Chapters 3 and 7 were revised to emphasize that gay youth are a priority group. The resource allocation process determines funding.]

At this late stage, I don't expect that the committee will want to abolish the entire foundation of target populations upon which the rest of the plan is based. Therefore, I encourage the committee to simply include gay and bisexual youth as a defined target population.

[Chapters 3 and 7 were revised to emphasize that gay youth are a priority group.]

We need to create a sense of community for our young gay men. Here in Santa Barbara, they go to the bigger cities on the weekends, but don't feel that they are part of any community. Our program, Pride Mission, did that. But because we couldn't show the kinds of statistics that the sate office needed to see, we lost our funding. There should be more local control over state money.

[Local control is addressed through the resource allocation process.]

Youth

California Department of Education should be less censorial and allow presentations to include words such as condoms, vagina, testes, etc

[Local school boards have jurisdiction over the presentation of this information.]

I have a concern regarding the absence of linkage with the State Department of Education and the mandated HIV/AIDS education, A.B.11 programs in the public schools. I suggest that the HIV Prevention Plan list, as one of its goals, that the Office of AIDS work with the State Office of Education to ensure that effective AIDS education is being provided in the public schools and that adequate funds are being provided to implement that objective. While it is not within the scope of the Office of AIDS to provide direct services to this population, it is morally and logically sound for the HIV Prevention Plan and the Office of AIDS to support and promote uniform and effective HIV education in our public schools.

[The Coordination and Linkages chapter encourages the OA in work with the Department of Education through the Interagency Coordinating Council.]

The HIV Prevention Plan clearly identifies youth as one of the target populations most critically in need of education and prevention programs and notes that homeless and runaway youths are particularly hard to reach. The plan further notes that peer education and support is particularly

important for adolescents. Peer education is even more critical for high-risk youth than youth in general. Homeless and runaway youth have a profound distrust of adults. In addition, adults have a tendency to be in denial about the risks these young people take, or have a tendency to judge and lecture them. Finally, there is no point in using young people to reach out to young people if we don't also use young people to design the outreach programs.

[Noted]

Educate with the truth! Stop deceiving young people about "Safe Sex." Present "Abstinence" as a viable alternative. We know that AIDS is behavioral spread. Attack the behaviors! Viruses don't care about peoples personal freedoms, wishes or urges. They spread in the right environment. Hold alcoholic beverage companies responsible for promoting irresponsible sex among youth through advertising.

[By law, abstinence must be taught in public schools.]

Empower high school peer educators to lead programs. In Santa Barbara they have come up with innovative ideas, including a "Safer and Sober Prom Night". We need to emphasize self-esteem and communication skills -- communication skills between teens and their families, and among peers, especially around the topic of abstinence. There should be funding for these types of programs.

[Peer education is addressed in the Plan. Local planning bodies will conduct needs assessments and use the Plan's guidance on strategies.]

Information regarding HIV infection can be difficult to disseminate to youth. Adolescents are typically short-term thinkers and the abstract idea of the incubation of HIV may be difficult for them to comprehend. Adolescence is a time for sexual exploration and experimentation with drugs and alcohol. Youth often have feelings of immortality. These barriers, many of which are identified in the plan, can provide significant challenges. As noted in the Plan, it is imperative that HIV prevention education be integrated into a broad continuum of services and skill development for youth. We support the plan's acknowledgment of the positive results of peer involvement in youth programs.

[Noted]

I want to reiterate the need for AIDS-appropriate HIV education and prevention that's focused not solely on knowledge but on skill building. Lots of young people are not interested in participating in groups and really respond better to one-to-one tailored educational strategies. Education and prevention must be provided in locations where youth are already seeking services. I'd also like to stress the importance of youth-appropriate HIV counseling and testing services. There was some disagreement in the plan about how important that is. The plan also does not address the need for media campaigns that address youth and speak to youth about their risk for HIV.

[The priority strategies for target groups will serve as a guide to local planning bodies but do not prohibit the use of strategies, such as CT and media for youth.]

People of Color

After more than a decade of AIDS, communities of color continue to be severely impacted by an alarming trend of disproportionate growth in cases of this devastating disease. Although racial and ethnic minorities comprise less than 20% of the total U.S. population, 49% of reported cases of AIDS are African-American, Hispanic/Latina/o, Asian, Pacific Islander, American Indian, Alaska Native or Caribbean American individuals. Under-reporting is also considered to be a significant issue in getting accurate count of diagnosed cases in the Asian/Pacific Islander and Native American communities.

[The CPWG requested that the OA make a presentation at the next available opportunity on how HIV testing data can become more useful in planning and on what special studies of incidence or prevalence are occurring.]

African Americans

Our concern is that all the ethnic groups are lumped together. We should single African-Americans out and have it as a separate group to address the needs of our community.

[Chapter 7 was revised to clarify that each community of color would be targeted as a separate group.]

Latinos

We need to be focused on the Latino community. The focus we have been giving them has been received extremely well and we see a huge increasing in testing. We need support to do it more widely and with greater impact.

[Local planning bodies will conduct a needs assessment and may focus on Latinos, as needed.]

Native Americans

The glaring lack of risk data from the State of California on Native Americans should immediate suggest one direction for the future of HIV prevention efforts in our population. It is difficult to make an effective determination of resource allocation of HIV prevention in the Native American population if we don't have accurate or at least somewhat representative data on such items as STD rates. Place a high priority on the improvement of epidemiological reporting for the Native American population.

[The CPWG requested that the OA make a presentation at the next available opportunity on how HIV testing data can become more useful in planning and on what special studies of incidence or prevalence are occurring.]

It is imperative that the diverse voices of American Indian and Alaskan Native residents of California be heard. Since a lack of information about the health status of AI/AN in California exists, the CPWG must include all available data that shows this population is at risk for HIV infection, and support the development of new and better data. Nationwide infection rates of syphilis and gonorrhea are nearly twice as high for AI/AN than non-Natives. Military seroprevalence rates for AI/AN are twice that of whites. The percentage of pregnancies among

AI/AN under 21 is the highest of all minority groups. A state task for AI/AN on HIV/AIDS issues needs to be created. The task force would be multidimensional and involve both federal and state agencies.

[Year 2 CPWG should have formal linkage to the Multi-cultural Liaison Board. The OA encourages recommendations on the collection of epidemiological data. The CPWG planning group in year 2 may want to consider the idea of a Native American Task Force.]

In the epidemiology section it would be more effective to separate epidemiology trend charts by ethnic groups, placing charts side by side and in a smaller format rather than on one chart.

[Information was unavailable from the OA to do this.]

We appreciate the efforts to do justice to a description of the needs of Native American population in California, but too little substantive information is provided in the plan to do so. We strongly recommend that a statewide task force be formed to look specifically at the needs of the Native American population. Native Americans have a unique legal status as citizens of a First Nation of North America; tribal governments have a government-to-government relationships to the Untied States and are not under state jurisdiction. Since California has the second largest Native American population in the country and the least studied in terms of health a task force should develop a section of the plan to address both an evaluation of risk, available resources, gaps, and community needs. It should be viewed as a subcommittee of the Statewide Planning Committee.

[The CPWG Planning Group in Year 2 may want to consider forming a sub-committee for Native American issues. The CPWG planning group in year 2 may want to consider the idea of a Native American Task Force.]

Asians and Pacific Islanders

It's been really difficult for the Asian/Pacific Islander community-based organizations to start an AIDS service organization, and we seem not to get enough support, either from funding, technical assistance, or whatever from the community. We have to compete with the bigger organizations and the mainstream organizations. Asian/Pacific Islanders have one of the highest-growing rates for AIDS cases. We have to emphasize prevention education to keep this number low, and in order to do that, we have to put more money into prevention education. We are dealing with 29 Asian populations and 22 Pacific Islander populations. It is difficult to outreach into each community, so we need more funding for outreach into the different communities.

[Local planning groups will conduct a local needs assessment to determine need.]

Strategies designed for, say, Japanese-American or Chinese-Americans are going to be different from what is needed in the Filipino community. Sexual mores, language used around sexuality, disease, and AIDS is very specific. It's different than other Asians and Pacific Islanders. We need to focus more on the specificity of the different cultures.

[Local planning groups will conduct needs assessments to determine local needs]

There has been a recent and dramatic rise in HIV infection among API women infected through heterosexual contact. We do not know the exact number of API women AIDS cases due to a problem of under-reporting. The stigma of contracting AIDS insinuates infidelity and brings shame and dishonor. API women are not in a position to negotiate safe sex. If an API women asks her male partner to wear a condom, the male may feel the woman has been unfaithful. There is still the belief that only promiscuous women use condoms. Many immigrants are pushed into sex work where they have little power to protect themselves. API communities are blind to the need of women-specific services. In Orange County, which has the greatest number of Vietnamese population in California, there is no HIV/AIDS program for women.
[Noted]

There wasn't a lot said in the plan about Pacific Islander communities in Los Angeles. Samoan, Tongan, Hawaiians, Guamanians are communities that need education funds. Most of the Asian people with HIV in this country are Filipino. Most Filipinos with HIV are immigrants. We need to provide prevention information in Tagalog, as well as Ilcano and Banget. Regardless of prop. 187, we should still serve the undocumented residents of California.
[The Plan did not address issues in specific counties; it maintains a Statewide view. The plan encourages services to the undocumented.]

I have a contract reaching out to Samoan communities, specifically youth. And I feel that even though I may have a contract, I feel it's ineffective because it's too small considering that it's the only contract directly aimed at Pacific Islanders. Men sleeping with men in these communities really don't associate themselves with West Hollywood gays or men sleeping with men. They're not like this wild crowd; these people are very closeted. It's because these communities are in denial that their people even have HIV at all. I feel there should be more attention and understanding of these communities.
[Noted]

The majority of APIs are foreign-born and do not speak English as a primary language. APIs come from over 43 countries and speak over 100 languages and dialects. There is a strong tendency to lump all Asians in one category without being sensitive to different needs, particularly linguistically. We need more culturally appropriate prevention services for the AIDS youth and families here in Los Angeles. County statistics and epidemiology do not adequately reflect the growing needs of the Asian communities. Due to stigma, shame and denial, APIs do not receive assistance until later stages of their illness. There is a strong cultural resistance to getting tested. Planning and priorities for APIs should not be geographically based. APIs are scattered across the county, and if services are geographically based and left to the local community to provide, APIs will be left out.
[The Coordination chapter encourages coordination across county lines to target specific populations.]

People in the Criminal Justice System

I know that the document refers primarily to the State Justice system. But we need to have a lot more access into the county jail system. The Humboldt county jail is definitely under-funded, understaffed, and overpopulated. We need a concentrated effort from the Office of AIDS to enable local education prevention programs greater access to county detention systems.

[Noted]

The programs that work for the incarcerated that are presented by state officials simply do not work. Education for this population needs to be very interactive and personalized. Showing a video to a large group is not effective AIDS education. The Incarcerated Task Force should be more involved in the planning of programs for this population. The Incarcerated Task force has a process for bringing inmates, the CDC, and CBOs together to identify and implement solutions. It has taken us three and a half to four years to put this process in place. We ask that you continue to support us in the work that we are doing.

[The CPWG Year 2 group may want a representative from the Incarcerated Task Force on the CPWG, or a CPWG member on the Task Force.]

People in prisons are having sex. You rated gay men very high and drug users, too, then when it came to the incarcerated population, you rated them quite a bit lower. People in prison have sex with each other. Their risk should be rated higher.

[Gay men are ranked high and the Plan does not prohibit targeting gay men who are incarcerated.]

The Prevention Plan is impossible to implement in the criminal justice system without changes in CDC policy. Condoms have to be allowed, and the policy of quarantine has to be abandoned. This point has been left out of the plan. The CDC has a very bad record on health care, and resources are stretched already. CBOs are the answer. As many inmates do not trust anybody involved with their incarceration, a peer delivery system is needed. This would also train inmates for community work, and allow them to contribute. Policies must be included to sensitive correctional and correctional medical personnel about HIV education. The issue of tattoos needs to be addressed. People in prisons often tattoo themselves.

[Noted.]

The California Department of Corrections (CDC) is concerned about the general lack of recognition or acknowledgment in the document of many positive and progressive approaches to HIV prevention, education and treatment undertaken by the CDC. In addition, the language used in the document describing correctional HIV prevention and education appears to diminish the efforts and achievements of the many caring and dedicated professionals working for the CDC in education, prevention and treatment areas. I am attaching specific comments regarding this use of language and opinion [comments received]. [Comments concern emotionally charged words and essentially editorial statements without supporting documentation.]

[Chapter 3 was revised to remove unnecessarily emotionally charged words and to document statements.]

Women

Specifically, strategies are needed that take into account family roles, negotiating with a partner, the impact of domestic violence, substance use, and survival sex as well as the sex work industry.

[The plan addresses these issues.]

I noticed that women and their sex partners were ranked 10th out of 16 groups. I feel that documented and undocumented numbers of women as a whole being diagnosed are by far increasing in numbers and should be a higher priority for education and prevention services than for target groups ranked above women.

[The low level of agreement and mid-range ranking of women by the CPWG reflects the lack of agreement in the prevention field about the risk for women. Most agree that there is an epidemic in pockets or sub-groups of women. It is controversial whether all women are at high risk. Local planning bodies will conduct needs assessments to determine local priorities.]

Women receiving prenatal education are among the least educated about HIV prevention. They show up at our clinics are in complete denial. Women, particularly Spanish-speaking monolingual women, should be given high priority. They need culturally sensitive education. My main plea is that women be the highest priority, especially if they are monolingual, Spanish speakers.

[See above comment.]

The entire education plan is based on epidemiology of AIDS cases. AIDS case epidemiology does not document new infections. It does not accurately reflect infection in females. We must use risk behaviors, not AIDS cases, to determine target populations. If we continue to use epidemiology as the basis for determining target populations, than we must enhance the categories to include lesbians, bisexuals and heterosexuals separately. Lesbians can engage in high risk activities during sex, yet there is no category to track infection between women. Given that women are poorer than men, they should have access to open ended supplies of condoms and lubricants, so that socioeconomic status is not a barrier to protecting lives. Female condoms should also be provided, because their cost is prohibitive for many women. Negotiation skills should be incorporated into education programs, in order to assist behavior change. Sex workers need support for the use of condoms. There needs to be education of the trick through the media and advertising in men's magazines promoting condom use with prostitutes.

[The CPWG used various sources of information to rank target populations, not only AIDS cases. The CPWG requested that the OA make a presentation at the next available opportunity on how HIV testing data can become more useful in planning and on what special studies of incidence or prevalence are occurring. Specific program designs such as negotiation skills and condom distribution are programmatic issues.]

Transgenders and transvestite individuals being a higher priority than women and their sex partners doesn't make any sense to me. There's got to be 6,000 of them, possibly, versus all the women. It's not a fair ranking for the number of people that are truly affected.

[The low level of agreement and mid-range ranking of women by the CPWG reflects the lack of agreement in the prevention field about the risk for women. Most agree that there is an epidemic in pockets or sub-groups of women. It is controversial whether all women are at high risk. Local planning bodies will conduct needs assessments to determine local priorities.]

Lesbians

Lesbians need to be included in a specific category for reporting and statistical purposes.

[The CPWG requested that the OA make a presentation at the next available opportunity on how HIV testing data can become more useful in planning and on what special studies of incidence or prevalence are occurring.]

Farm Workers

The health care needs of farm workers and their families in San Benito County are indeed great. For instance, Latinos in this county have a life expectancy of only 59.9 years, compared to the Anglo population of 75.5 years. Hispanic farm workers are at an increased risk for contracting HIV. Inadequate health knowledge, poor accessibility to health care, a mobile life-style, limited case finding of follow-up, lack of and discomfort with the use of condoms, language barriers and myths of health and illness all contribute to this increased risk. The majority of farm workers seek care for acute problems rather than for preventive services. Symptoms such as weight loss, fatigue, swollen hands, recurrent skin rashes, and fungus infections may be attributed to pesticides or toxic chemicals instead of HIV/STDs. Such misdiagnosis can hasten death from AIDS-related illnesses.

[Noted]

Santa Barbara has a large Hispanic migrant population. This population are not easily accessed with education because of lifestyle, language, and literacy. Prostitution is a common practice among this group of men, and it's speculated that unsafe sex is common.

[Noted]

ESL students, especially those in the migrant education program, are not getting AIDS education. Migrant workers themselves are not getting any education. They tend to use sex workers, so the risk is very high.

[Noted]

We need more relevant AIDS education literature and videos in Spanish. Material that is too racy will turn off a Latino audience. We need more Spanish speaking health educators. We need more programs that meet the needs of migrant farm workers. They are out in the fields, and not always accessible to outreach workers.

[Noted]

Persons Engaging in Heterosexual Sex

The target population of people who engage in heterosexual sex needs more emphasis than the plan gives it, as well as an increased emphasis of projected impact of HIV in rural and

geographically isolated areas. These populations do not perceive themselves at risk. They're not necessarily presently living in a highly HIV-impacted community. Prevention education must be a priority in these populations. Putting it bluntly, rednecks do not feel they're at risk, and they're a difficult population to work with.

[While there are pockets of an epidemic among heterosexuals, it is not clear that all heterosexual are at high risk for HIV. Local planning bodies will conduct a local needs assessment to determine local priories.]

The Disabled

The sexual abuse of developmentally disabled persons occurs, sometimes by people who are charged with the responsibility of serving these persons. Separate the category of developmentally disabled from physically disabled because agencies providing services to the two are often pitted against one another in competition for money.

[Chapter 7 was revised to clarify that the disabled category includes several very different populations and local planning bodies should conduct local needs assessments to determine which groups of disabled persons are in need of E&P in their area.]

As a "differently-abled" person, I ask myself where did they come up with this label? The Americans with Disabilities Act provides federal definitions which are uniformly recognized. I recommend using the A.D.A. definition in this document, and I am happy to be referred to as a Person with a Disability or as a member of the Disability Community. The HIV Reporting Form should contain a question which asks for disabling conditions, and data be collected the State can estimate the numbers of HIV infected disabled persons.

[The Plan was revised to use the phrase Persons with a disability or member of the disability community.]

In keeping with the ADA, I would encourage the use of the term "People with disabilities", rather than the "differently-abled". Along with information in Braille, you should consider using audio-tapes, and large-print material. For the hearing impaired, consider open and closed -captioned video material. It would be wise to utilize Independent Living Resource Centers to reach people with disabilities.

[Local planning bodies should investigate issues of the disability community through the needs assessment process.]

As more of the developmentally disabled move into less restrictive settings in the community, there will be more possibility for sexual exploitation. The developmentally disabled are amenable to the right kind of training specific to their needs. I urge you to remember the developmentally disabled.

[Noted]

People who Pierce and Tattoo
The issue of concern around piercing and tattoo is not with professionals, but with gang identification, blood rights, incarceration, and fetish sexuality. The way we need to address this is through outreach, not through compliance of professionals.
[Chapter 3 was revised to reflect this comment.]

Rating Scale
The range for the mean score, I feel, is inappropriate. Using a range from zero to three I feel isn't enough to determine a low-to-high-risk group. I'd like to suggest that the Working Group recognize a range from zero to ten which would allow for the target groups to be more easily determined to be a low risk or a high risk
[There was variability in the rating scores -- 2.8, 2.1, 1.1, etc. A broader range would probably not have altered the order of the target groups.]

I think that the scale of zero to three didn't give enough range. I think if we took the time to go back and prioritize all the target groups again using the fax. Not the strategies, that was a huge project and I think that needs to stay the way it is.
[See above comment.]

Programs

Counseling and Testing
Get testing funded elsewhere so primary prevention monies doesn't have to pick up the tab.

[Noted.]

In the provision of counseling and testing services to participants of alcohol and drug treatment /recovery programs, it has become evident that a person who tests HIV positive is in need of a lot of support. Their first response is generally to consider relapse in their recovery. Our program has developed an Intervention Case Worker position to provide support, advocacy, and referral assistance immediately upon a person testing HIV positive. This Case Worker follows the person for 3 months until they get linked into early intervention, case management, or other HIV-related services. This position provides a smooth transition of the HIV positive person from counseling and testing into early intervention services.
[Noted]

The list of testing as "mobile, anonymous, and confidential" is both limited and inaccurately defined. There are two types of testing: anonymous and confidential. These types of testing are provided through a number of settings including: mobile, off-site, free-standing test sites, and other clinical settings. [definitions provided] The definition of partner notification offers only one of three methods. The other two include Self-referral which involves the person testing positive notifying their partners and referring them in for counseling and testing and contact referral which involves the patient taking primary responsibility of contacting partners

and the public health worker contacting those the patient is not able or does not want to contact.
[The text was revised to include these definitions.]

A study is cited (Berrios 1992) from which you draw the conclusions that programs providing CT services have been successful in reaching the gay/bisexual community. I believe this is not a valid conclusion to be drawn from this study. It might speak to the fact that a significant proportion of those who reported a risk factor were homosexual men. In the information we have gathered from test sites and early intervention programs we have found that we are missing a number of gay men at highest risk and are not reaching large numbers of bisexual males.
[This study was examined and the text revised.]

On page 221, it is stated that, "The central question pertains to the usefulness of HIV testing in maintaining safer sexual and needle-related behaviors." The Centers for Disease Control clearly states that one of the goals of HIV counseling is to help INITIATE behavior change, which is clearly different from "maintaining" behavior change. It is interesting that the report relies so heavily on the Higgins article. A recent article in *AIDS Care* by Susan Beardsell questions some assumptions in this article. In addition, most of the studies cited in Higgins do not examine the effect of counseling but examine the effect of "HIV testing" or "knowledge of serostatus" and make no reference to whether the individuals received any counseling or if they did, what was the extent of the counseling. A more thorough examination of the studies cited reveal that even those studies that did provide counseling vary from viewing a video to a didactic lecture format to extensive counseling. When the studies are viewed in this context, it becomes clear that when HIV counseling and testing affects behavior change it is because it is provided in a manner consistent with the recommendations provided by the CDC on "appropriate" counseling.
[These articles were examined and the text revised.]

Under the description of HIV antibody testing and counseling strategies delivered include mobile testing. However, there is no mention of on-site HIV testing, which is the primary focus of current SMAHSA set-aside testing dollars targeting alcohol and drug users in treatment. As stated in the document, "Extended counseling and education interventions appear to provide substantial benefits in most settings." I would like to echo this statement. Providing services to alcohol and drug-using persons oftentimes requires more counselor time and attention due to mistrust and reluctance to self-identify the behaviors that might have put them at risk for HIV. As a result, additional time needs to be spent to develop the trust and rapport in order to conduct a valid behavioral assessment. Also, additional time spent in a pre-test counseling session might be studied to see if it impacts on an increased number of person returning for their post-test results.
[On-site testing was included in the revision of the text.]

In the document the training program is described, along with the funds designated. However, it does not include that currently all DADP-contracted program staffs are charged for all the courses conducted. Where is this revenue reflected? The department has not conducted any type of needs assessment of counseling and testing programs as to their identified training needs. The topics and content are decisions made by the Education and Prevention branch level. I would like to recommend not only reassessment of this contract, but also that a training assessment be done of programs to solicit the actual needs of the frontline counselors.
[Noted.]

It is unclear how out-of-treatment substance abusers will be reached for HIV counseling and testing. While ATS sites receive federal funds for out-of-treatment IDUs, I am concerned about the degree of alcohol and drug training provided to ATS counselors and how effective this program is in reaching and impacting this population.
[Noted.]

Being in a small area, a lot of people don't want to be seen in the health department because everybody makes assumptions of why they're there. We need to expand testing; we need to be able to take our testing into the field and hit some of our target groups for education and prevention money.
[Noted.]

Separate testing, which is often a placebo for safe sex, from prevention plans.
[Counseling and testing is within the jurisdiction of this plan.]

Early Intervention
The CPWG should consider carefully any change to the current procedure that will impact the services that people with HIV are receiving. A review of current projects for cost effectiveness and cultural competence, among other variables, would provide information to assess the needs of the program overall. From that needs assessment a plan could be developed to improve and enhance the current program. It seems reasonable to target new dollars for Early Intervention in rural areas which do not receive funding.
[The CPWG recommended that any new funds for Early Intervention services go to rural areas.]

Street Outreach
The California HIV Prevention Plan corroborates much of what I have known regarding prevention education for street populations. The plan acknowledges field staff as trusted health care professionals, and rightly so. The plan recognizes the need for a consistent presence of outreach workers on the street and in communities where high-risk activities are prevalent and where individuals get their basic human needs met within the context of their environment.
[Noted.]

AIDS in the Workplace
Money needs to be allocated for HIV/AIDS education in businesses or in the workplace. There is not a whole lot of funding out there right now for workplace education. Businesses are very uneducated as to what they can be doing for people who are HIV positive or who have AIDS. If we can make businesses and corporations aware of what is going on in HIV, maybe they will become more supportive of our activities in the HIV community.
[Local planning groups will conduct a local needs assessment to determine local need and may fund AIDS in the Workplace under several target populations, such as Persons Engaging in Heterosexual Sex. Further the Office of AIDS conducts an AIDS in the Workplace program.]

Materials
We need culturally appropriate materials that reflect the actual makeup of our county's population. For example, Humboldt County has a strong Hmong community that is in transition. The elders are observing traditional lifestyles and cultural strictures, while the teens are becoming more Americanized. The situation is difficult for us to deal with because we have almost no translation facilities to provide materials to the teens.
[Noted.]

Technical Assistance
Rethink and reframe technical assistance. Four hours are not enough to train people on the multitude of education, management, budget tasks. Provide real training. Seek linkages with universities to do education and theory and planning and evaluation.
[Noted.]

Smaller cities and rural areas desperately need technical assistance in designing effective programs.
[Noted.]

The vast majorities of people who are involved in prevention work are in dire need of more training, particularly with respect to ethnic groups, with respect to sexual diversity, and even with respect to sensitivity to HIV and AIDS related issues. Sometimes it seems as though those persons who are involved and engaged in the work are the ones that are least sensitive.
[Noted.]

The functions of coordination and linkage and technical assistance will be crucial in the next few years. Rural areas have strong links between agencies and resources within the county. These are in strong need of more strength and information from Sacramento out to rural areas.
[Noted.]

Coordination
Broaden the scope of prevention services via community collaboration and interagency linkages. In our experience, several organizations would like to provide services to a vast majority of people. Those particular interventions are the least effective simply because they

don't have the knowledge or the skill to meet the needs of specific populations. We suggest a greater emphasis be placed on community linkages, memorandums of understanding, on working together, and using what might be considered non-conventional agencies, such as church, school district, criminal justice system, et cetera.
[The Plan supports coordination and linkages.]

Evaluation
Resources are going to be diminishing in the days to come; we need to be smart about where sw spend our monies. We are gravely concerned about deciding which prevention strategies are proving to have the most impact with what population. There needs to be a greater emphasis placed on evaluation within the full context of program development, program design, as well as anything associated with prevention.
[The Technical Assistance Plan address the need for evaluation skills for contractors.]

Rural Issues
During 1993, 175 cases of chlamydia were reported in our rural county. 57% of these cases were in young men and women under the age of 21 years. 51 young women, 17 years and under had positive pregnancy tests. Of the 48 of these pregnancies that were unplanned, 71% had attempted no method of birth control, including condoms. This is also true of the adult unplanned pregnancies. We have also noted an alarming increase over the last few years in young women with venereal warts. These statistics indicate that although we have not yet had an alarming rate of HIV infection, our population is not protecting itself from HIV. Our rural population may be small, but the behaviors that leave people at risk for HIV infection are here. We must have the funds to continue our education and prevention efforts.
[Noted.]

There hasn't been much thought put into the rural area people's problems. There's some different cultures involved, some of the plan talks more about urban type things. And rural type culture is not exactly discussed. We have a high number of illiterate people. We like having the HIV Clearinghouse information, but we hope that they could expand and get a lot more handouts, especially in Spanish that are more culturally relevant to rural areas.
[The CPWG considered rural issues and reflected these issues in the funding allocation formula. Local planning groups in rural areas will develop rural-specific E&P programs.]

I think that some regulation needs to be made for the fact that in rural areas the efforts to do adequate outreach for education and prevention to the entire population require more of an investment in terms of time for travel and staff and building an infrastructure which in the largest metropolitan areas where there has been more adequate funding there are already institutions in place that can carry on education efforts.
[The CPWG considered rural issues and reflected these issues in the funding allocation formula.]

We need to increase funding to second wave or semi-rural or rural communities like Santa Barbara County. We do not have the large economies that large cities have, yet education is just as critical.
[The CPWG considered rural issues and reflected these issues in the funding allocation formula.]

San Diego
Nowhere did this document address, unfortunately, the specific needs and challenges of San Diego, with its unique relationship with our international border and Mexico. Our challenges in offering services and culturally-specific education to undocumented individuals are not addressed in this plan. Ignoring our neighbors to the south simply because they are living across an increasingly vague and false border is not going to effect much change.
[The Plan addressed border issues in the Coordination and Linkages chapter. Immigrants were discussed in the plan. These issues will may need further discussion in Year 2.]

Implementation

Future of State Planning
Provide CPWG members with training in planning, evaluation, and epidemiology necessary to make informed choices rather than just advocate for our population. Epidemiology should not be confused with democracy. We are all created equal but not all of us are at equal risk.
[The Year 2 Planning process may want to consider receiving training.]

We would like to see people with disabilities included on your planning committees so that when something comes up that sounds like a great idea to those of us who don't have overt barriers, they can give you feedback whether they work or not.
[The Year 2 Planning process may want to consider including more people with disabilities.]

I have concerns about the role of the working groups once the HIV Prevention Plan has been implemented statewide. Whatever plan is finally adopted by the Office of AIDS, will the Working Group or representative part of it still exist to monitor and evaluate the final working of the plan, the initiation of a plan in all areas of the state and monitoring the success and shortcomings of both contractors and the Office of AIDS in reaching at-risk populations? I suggest that some kind of permanent working group infrastructure remain after the implementation of the plan.
[Continuation of the Working Group is discussed in the Resource Allocation chapter.]

I have one big question: Is this it? Not that this is bad, but it's nothing new. We've all known for a long time that almost every one of the target populations included in the plan was at risk for HIV. And we've all more or less agreed that the core set of strategies in the plan are indeed the most effective. The process of Working Group was an exemplary democratic approach. But that endless debate robs activists of precious energy needed in this struggle. Many of the members came from rural areas where the E&P programs consist of 2 or 3

people. The continual, chronic absence of between 30% and 100% of the program's staff can have a debilitating effect on the program's effectiveness. I thank all the members of the working group for their time spent, and I know it was sincere. But next time I suggest instead that you just go have a die-in on the state capitol steps, ACT-Up style. Or maybe even better, a good-old homestyle revolution.
[Noted.]

Rural Local Planning Issues
Our concern is the problems of the Consortia itself [in a rural county] with the limited number of people that we operate with. We see problems with technical assistance. We now get it form the State Office of AIDS, but it takes people away for a day or two at a time and it's very difficult for the people we have to get this time off to go and do it. Developing a plan by July 1 would be a problem [because of the few people in the consortium]. It is a great deal of effort for the group to come up with a needs assessment plan each year. Our concern is the management of this new function and the funds and the timing that will be given to us so we can develop plans, find people and get the entire function going. It will represent an additional chore for a very small organization.
[The CPWG recommended a 12 month planning opportunity with an additional six months to implement it.]

The education money we receive is a very small amount and it's spent through our health department in the format of one person and one very part-time person doing education to the county. If we change anything and the health department didn't want to do the education program any more there's no other community-based organization in our county that does health education, so they would have to start up a new agency.
[Noted.]

Since we're small and there's only a few people wearing hats that have anything to do with HIV. We work well together, there is coordination and linkage all set there. But the same people are wearing too many hats so when we have to take on another function, you just start stretching people very, very thin and we're running out of talent here.
[Noted.]

Other Implementation Issues
I am concerned whether the plan provides DHS with a clear framework to ensure its implementation.
[Implementation with involve the on-going participation of the CPWG.]

I am interested in seeing what the next step is -- how the Office of AIDS prevention working group will begin working with local communities to identify how the local education should take place and what the time frame for that will be and what is anticipated for the role of involvement of the local public health agencies in the process.

[Implementation of the plan was discussed at the December meeting, and addressed in Chapter 12.]

The State HIV Prevention Plan should make a stronger statement regarding prioritization of target populations so that the Plan can be adequately used by local communities in their planning process. But local communities need to have the final say in what populations are targeted and how they are prioritized, what strategies are most effective and how resources should be allocated to best meet the needs of those populations.
[The plan supports local communities in determining effective use of resources.]

We should not have to accept this document as a whole; it is too diverse. The problems of urban centers are radically different from more rural areas. I think we need to consider non-urban centers differently from urban centers if we develop a prevention plan in the future.
[The Plan can serve as a guide. Local planning groups will conduct a local needs assessment to determine need.]

We in San Diego are committed to the next step of this statewide process. We want collaborative and inclusive local planning, funding and implementation of the HIV prevention activities.
[Noted]

I would like the Working Group to allow counties to join together so that multi-county funding could become a possibility. By joining together they would be able to have a m ore effective program than if each county stood alone. We're only a small county; we have close to 60 documented AIDS cases right now. Most of the counties don't have a lot of cash to subsidize AIDS programs. We'd certainly like to have some more money.
[The coordination and linkages section specifically encourages this type of multi-county funding.]

A trend lately is to use a client services care delivery system to either oversee or house or administer prevention education programs. The skills are not the same and the clients of a successful prevention project are precisely the people we do not want to become the clients of a client services care project. Keep prevention projects out of agencies that provide care.
[Local communities will determine which agencies provide E&P.]

We should not be too rigid in the kind of service that an agency must provide in order to receive funding. You need flexibility to allow an agency to develop programs and services appropriate for that particular community.
[Noted]

The CDC should not funnel funding through the state. Smaller agencies will lose funding that way. We would like to see the funding come straight from the CDC and be more competitive.
[This is out of the jurisdiction of the CPWG.]

Nowhere in the plan can I find specific reference to precisely how the Office of AIDS will use, implement, and execute the Working Group's plan. Will this plan constitute the basic framework for the next funding year, or is this plan going to be used only as suggestions or reference information for another plan that the Office of AIDS will formulate?
[Implementation of the plan was discussed at the December meeting and discussed in Chapter 12.]

When developing our local E&P plan, we should be able to use local information gathered in needs assessments versus basing our plan only on statistics. Our local plans should reflect our local prevention needs and utilize the information that is gathered by the outreach workers and focus groups.
[The Plan requires local needs assessments of this type.]

In the document, it states that "to ensure effective planning, other representatives should include, but not be limited to..." I would like to add to this list consumers of HIV services, mental health services, alcohol and drug services, disability services, etc.
[The Plan lists people with HIV as required representatives. If the CPWG would like, consumers could also be added to the list.]

I would like to see how the community planning process for prevention will be folded into the community planning for Title I and Title II services. There needs to be some plan that goes one step further. This document addressed prevention, counseling and testing, and early intervention. The next step would be integrate direct services for the continuum of HIV-related services from early intervention to end care.
[Integration of direct services was beyond the scope of this year's activities.]

I recommend that the state fund 1-3 year projects which will identify and develop model projects that can be replicated throughout the state. This funding should be community-controlled and be in the form of community-based contracts. Projects funded should be geographic, culturally, and population-specific. Organizations need to be able to demonstrate private and public linkages; mechanisms for decreasing duplication of effort, and collaboration across the entire spectrum of services.
[Noted]

Another concern is the requirement for the constitution of a local Planning Group. We already have in place something that we call the Rural Health Outreach Consortium. If the proposed local Planning Group is similar to ours, we don't see the need for forming another group with the same characteristics and same objectives.
[A community may use an existing local planning body if that is appropriate for that community.]

I believe that there would be a need for fairly strong guidance from the Office of AIDS to insure that local working groups use and follow through on the recommendations put forward.

I believe that the funding for the planning groups should be fairly low and minimal as compared to the actual dollars for real HIV prevention, direct costs for those targeted groups. I don't think that the bureaucracy should become high.
[The OA will provide guidance in how to use the Plan.]

The Community Planning Group concept is excellent and it can actually work quite well in areas that have had some problems in the past. But what target populations are going to be targeted for education and prevention? Is the list going to be left up to the local group? If the pot of money is small, can we choose only Number 15 and 16 if that/s what the group decides, or is the State going to say you need to focus on high priority populations? The State has to have really strong guidelines in regards to this.
[Implementation of the plan was discussed at the December meeting and is discussed in Chapter 12.]

Who will make up the local decision-making group, and how will that be decided? What is the expected timeline for the RFP process? How narrow will the target populations be; can a target population cross categories? Will a separate application be required for each target group? Will the RFP and allocation process be completed by July 1, 1995, so that there is no break in services? If it is anticipated that the process may not be completed by July 1st, is there any plan for extension of existing contracts until the anticipated completion date?
[Implementation of the plan was discussed at the December meeting and discussed in Chapter 12.]

Education and prevention programs will be dealing with issues that do not necessarily reflect the "community norms" in a rural community. There is no way that we will be able to comply with community norms and meet the goals and objectives stated in the plan. It's essential that the process be kept independent from the mainstream political process within the county. The community planning process needs to have clearly defined areas of fiscal responsibility to maintain its independence. And the suggested list of members of groups who represent it needs to be adapted to reflect that groups of minorities and actions list within the county itself.
["Community norms" refers to the norms of the group being targeted, not of the overall community.]

Would the State consider funding by health districts rather than by Counties to insure that independent cities, such as Pasadena, don't get lost in the cracks? If funding comes from the state rather than the County, and the State cycle starts in July, but the County starts in January, who will pick up the slack for those six months?
[Funding will go to local health jurisdictions, of which 3, including Pasadena, are cities.]

I am concerned that there is not time to formulate a planning prevention group to be prepared for next fiscal year, especially in rural communities. In rural communities, leaders are overextended, and it takes time to recruit appropriate people for the planning group. Also concerned that people do not understand what the planning group is supposed to look like.

Would like to recommend that existing contractors be extended for one more year, to give time for communities to develop their planning groups.
[Chapter 12 describes the resource allocation process, including the recommendation that in the first year, 18 months be allotted for planning locally.]

Contracts should be awarded on a multi-year basis. It would make for better service delivery and is more cost-efficient.
[Noted.]

Each county should be given as much latitude as possible to identify the needs within its own jurisdiction. The needs of the Imperial County are as different from Sacramento and LA as Santa Barbara is from the Bay Area, or Marin for that matter.
[The Plan encourages local needs assessment to determine local needs.]

Existing Ryan White groups should be given authority over E&P money rather than reinvent the wheel because the infrastructure is already in place. There would be no lag time in recruiting or forming the group.
[In some counties, using existing planning groups is appropriate; in other counties it is not.]

We are delighted that the State Office of AIDS is supporting more local control. In the past, we have been told which target groups to reach. Once we got an entry into the group which often took up to a year, we had to change focus and abandon those we've established a relationship with to go on to another group.
[Noted]

Our county has been able to do successful, unmet needs assessment for educational purposes. The planning group as proposed could do that for their own communities throughout the state. But it is very difficult for us to have good representation of all the groups that might be affected.
[Noted]

What are the specifics of the local RFP and set-aside process that will determine future funding, and what system of checks and balances will ensure that they are fair and are not subject to local political pressures? What system will be used to weight those populations that fall into more than one target group? For example, a gay male youth substance abusing sex worker has a risk far higher than the maximum 3.0.
[Implementation of the plan is discussed in Chapter 12. The system to "weigh populations" will be based on local needs assessments.]

The members of the Los Angeles Prevention Planning Committee have reviewed the plan document and have concerns about portions of the State's proposed plan, most specifically its funding implementation and potential impact on Los Angeles County. As stated in the plan, Los Angeles County accounts for the highest number of diagnosed AIDS cases in the State.

The County currently has 35% of all AIDS cases reported throughout California. What is the proposed implementation date of the prevention plan? The State's Prevention Plan does not provide a clear outline of how the proposed plan and its changes will impact current State funded prevention contracts for contractors in Los Angeles County ending as of June 30, 1995. The Plan does not clearly detail the impact of proposed revisions to the funding formula and its impact on Los Angeles County. This proposed Plan addresses basic funding issues for 1994 and 1995, but does not clearly discuss any of the variables which the State would consider important in overall allocation of prevention dollars in Los Angeles County. The Los Angeles Prevention Planning Committee is at the beginning of reformulating its target populations, goals and objectives, and strategic priorities for HIV Prevention in the County. As it works to further formulate its plan, the Committee will take into consideration the overall strategic direction and objectives by the State in its Prevention Plan.
[These issues are discussed in Chapter 12.]

There are two areas of concern regarding the local planning process: 1) being able to identify community members who are willing to participate and who don't already participate in other planning bodies, and 2) the increase in competition locally for the limited dollars that will be available. Adding another group will mean expanded commitments from the limited pool of people willing to participate in the planning process.
[A separate planning body is not required; some counties may use an existing body.]

I am concerned about the formula that will be used to allocate funds to each county. How will the OA monitor these grants, and what guidelines will be set forth for setting up local structures? How will diversity be assured?
[These issues are discussed in Chapter 12.]

Coordination and Linkages
The advisory board [CPWG?] should be on the California Department of Corrections' HIV Advisory Group. The OA and the California Department of Corrections must work together. Programs are not coordinated.
[Noted.]

Resource Allocation
In Mendocino County we have a very ambitious and efficient system for education prevention around HIV. I think the system we have serves both those folks that are at risk and the general public and agencies and providers of services. I'm concerned about not trying to fix what ain't broke. So I would like to maintain the system we have in place. I think the concerns really more are around long-term stable funding and I would recommend something like a five-year funding cycle that includes technical assistance. Concerns of my colleagues and other public health departments are that we get off this roller coaster of uncertain funding and get onto some sort of stable path.
[Noted.]

Our main concern is in regards to the local assistance formula. We in San Benito County are adversely affected by the parameters considered for this formula. Our county, being so rural, cannot compete against the number of HIV positive clients generated in larger counties. Many people who suspect they might have the disease go out of the area for diagnosis. Since 1985 five county residents have dies from AIDS.
[Resource allocation is discussed in Chapter 12.]

In looking at the allocation format, the first question that comes to mind is how the recent manual surveillance data would impact funding for our county. I think in terms of looking at the number of AIDS cases, population from communities of color, population below the poverty level, population in rural areas, we have ways of identifying how we fit into all those aspects of the formula. But I'm not sure how manual surveillance data for our county would be identified because I'm not aware that hospitals in our area are part of the targeted group of hospitals that are participating in that surveillance.
[Some information may not be available in every county. Local planning bodies will conduct needs assessments using various sources of information.]

As the allocation process is not final, I encourage the Office of AIDS to give us a chance to make additional review of whatever final allocation proposal emerges. We are very concerned that solid epidemiological data be used to calculate local allocations. We believe that total AIDS cases must be used to influence the formula. Where there are many cases, there will be lots of new infections. Using only recent AIDS cases as a data element will shortchange the high-impact areas still reeling from 12 years of AIDS. I would also like to recommend adding to the data elements the percent of population residing in urban areas, including even those who are diagnosed elsewhere and have migrated to the urban areas. Isn't it obvious that AIDS is predominantly an urban scourge? Aren't 91% of cases in urban areas? Why are we using percent population in rural areas?
[Resource allocation was discussed at the December meeting and discussed in Chapter 12. Several of the formula specifically benefit large counties and counties with high prevalence of AIDS cases.]

The suggestions you have made are certainly important factors, however these alone may not give us a clear picture of the areas that need prevention services. Activities that put people at risk such as teen pregnancy, sexually transmitted diseases, and needle use should be included in that formula.
[Variables in the resource allocation formula need to be available for every county; data on needle use is not widely available.]

All this good information and recommendations do not seem to be reflected in the formula for resource allocation. The five elements in the funding formula seem somewhat illogical based on some of the information that was presented in the plan. The first element gives preference to recent AIDS cases but the formula ignores HIV seroprevalence rates, STD rates, syphilis rates, gonorrhea rates, substance abuse data. The Plan describes a study by the SF

Department of Public Health showing that 34% of young homosexual/bisexual men had unprotected intercourse. Yet, this would not be taken into consideration in the formula. The Plan shows that HIV is a disease that occurs mainly in metropolitan areas. So I take issues with one of the five elements for funding would be the percent of population residing in rural areas. I don't mean that rural areas shouldn't be taken into account. But 20% of the funding allocation based on being in rural areas is too much.
[Resource allocation was discussed at the December meeting and discussed in Chapter 12. Several of the formula specifically benefit large counties and counties with high prevalence of AIDS cases. Variables in the resource allocation formula need to be available for every county; data on needle use is not widely available.]

There needs to be a balanced priority given to the percentage of the population that is gay. I agree that the communities of color should have one of the priorities, but we do know that a big segment of the population affected by HIV is white gay men, and I think that should be balanced in there, somehow. I also think, from looking at all the data, that there should be some kind of priority given to programs targeting African-Americans, because all the data shows the risk to the African-American community. The funding formula should be really looked at more closely; it does not reflect the very information that is in the plan to the point where it almost seems anti-scientific.
[Resource allocation is discussed in Chapter 12. It includes rate of AIDS cases, and percent population that is people of color.]

I'd like a greater emphasis placed in HIV incidence and seroprevalence data.
[HIV incidence and seroprevalence data are not available for every health jurisdiction.]

Looking at the elements to be considered in the infra-state allocation formula, there are concerns about the absence of epidemiological data and risk indicators such as teen pregnancy and STD rates. When making plans to support prevention activities, it seems likely that there needs to be some look at behaviors we know exist. An effort should be made to tie prevention dollars to behaviors that put people at risk.
[Noted.]

I was just kind of hoping that when it was through the funding would have already been decided, so we would have been able to take a look at that and comment on that.
[Noted]

When the state decides how to allocate monies to the counties, they should look at what other funds a county receives. Some counties, especially smaller ones, do not have other resources.
[Other funds a county receives are difficult to determine in many cases.]

Is it necessary to increase the allocation for Early Intervention services at the expense of our education and prevention programs, our primary line of defense against the incidence of new HIV infection?

[The percent allocated to E&P decreased by only 0.4%.]

We support local control for the planning of community HIV and AIDS education and prevention programs and for formula allocation of resources. Long Beach is one of three city health departments. The other two are Berkeley and Pasadena. For true local planning and allocation control to occur, division of resources must occur throughout the 61 health jurisdictions in California. Local area issues will be inadequately represented if the formula is divided by the 58 counties. We support the continued allocation of resources for HIV testing. We also welcome the opportunity to go through the competitive bid process for early intervention.
[Local funding will go to the 61 health jurisdictions.]

I urge you to fund a statewide or several regional education projects for the incarcerated. If you give monies to the counties, there is only a slim chance that they are going to make prisons a priority. I urge you to include strong advocates for prisoners on your working group.
[Noted.]

My only real concern is in how the allocation process outlined in the plan will be implemented. It is extremely unclear what the precise formula will be for distributing funds to the local jurisdictions. Until that formula is in place, we cannot be certain what level of funding will be possible.
[Resource allocation was discussed at the December meeting and is described in Chapter 12.]

It is unclear exactly how the plan will affect Riverside County HIV prevention programs. Since Riverside County receives a limited amount of dollars for education and prevention, the proposal for local planning will probably have a positive impact on the education and prevention program. While it is important to take into consideration other elements of the proposed formula, recent case data will give the most accurate picture of the problem of HIV in a given area. The elements of AIDS cases and the population from communities of color will identify the areas of greatest impact.
[Resource allocation was discussed at the December meeting and is described in Chapter 12.]

SECTION IV
EVALUATION OF THE COMMUNITY PLANNING PROCESS

This section contains a single chapter that describes the methods and results of a comprehensive evaluation of the California Community Planning Process. The evaluation design included process, outcome, and impact questions.

CHAPTER 14: EVALUATION OF THE COMMUNITY PLANNING PROCESS

Evaluation of the Community Planning Process occurred over the 12 month period, December 1993 - December 1994. This chapter presents process, outcome, and impact evaluation results.

Purpose

The purpose of this evaluation was to document and describe the process, outcomes, and impact of California's HIV Prevention Community Planning Process (CPP). The evaluation was designed to identify what worked well in this process and to identify things that might be improved in future community planning efforts. The unit of analysis was the entire Community Planning Process. The report was prepared for the Office of AIDS.

Evaluation Goals and Objectives

The overall goal of the evaluation was to determine whether or not the Community Planning Process (CPP) improved the decision-making process for HIV/AIDS prevention programs in the state of California. Per CDC guidance, the evaluation was designed to:

1. Document that the Community Planning Process actually took place.

2. Determine whether or not the short-term program goals (outcomes) of community planning were met.

3. Identify strengths and weaknesses of the planning process The evaluation was intended to document the activities and dynamics of the Community Planning Process; explore selected issues raised by the challenges inherent in inclusive and participatory public policy group decision-making, and identify those skills, resources, and structures that had the greatest impact on California's ability to develop a prevention plan through a community planning process.

Strategy and Methods

The evaluation was designed to be collaborative, supportive of community planning, and respectful of all planning participants. It was conducted as a systems analysis, analyzing the context, components, process, strengths, and challenges of participatory community planning for HIV prevention. Data was collected from multiple sources in order to construct

as complete and useful a picture of the community planning process as possible within the established parameters.

The evaluation was conducted in three phases:

Phase 1: Planning and organization

Phase 1 occurred between December 1993 and July 1994. During this eight month period, an Evaluation Committee of the Community Planning Advisory Group was formed. This group had oversight responsibility for ensuring that appropriate process documentation was created and preserved, that Working Group meetings were evaluated by participants, and that evaluation summaries were prepared and distributed to all Community Planning participants in a timely fashion. The Evaluation Committee, along with Office of AIDS staff, was also responsible for monitoring the goals and objectives of the planning process.

Phase 2: Preliminary evaluation of CDC Core Objectives

As the Community Planning process got underway, the Evaluation Committee recommended working with an independent evaluator for the rest of the project period. Once the Evaluator was hired, specific evaluation objectives were developed. It was decided by the Evaluator, in conjunction OA staff and the Advisory Group, that Phase 2 (July - September 1994) would focus on the core process objectives specified in the CDC *Guidance* and required for the October 4 Cooperative Agreement application.

Phase 3: Expanded evaluation of the CPP process, outcomes, and impact

The three month period between October and December 1994 was devoted to a broader evaluation of the Community Planning Process. During this period, the full process and selected outcomes and impact of the planning process were explored and the final report written.

Process Evaluation Questions

The process evaluation was designed to monitor and describe the way in which California's community planning experience developed. This part of the evaluation was guided by 10 specific objectives, which were framed as evaluation questions. Four of the objectives (indicated by *) were specified by CDC in the *Guidance* and the *Handbook for HIV Community Planning*. The remaining six objectives were developed as the Community Planning Process unfolded.

The ten process evaluation questions were:

1. What was the context within which California undertook the HIV Prevention Community Planning Process?

2. What were the key components of California's community planning structure?

3.* Was the nomination of members for the HIV Prevention Planning Group was an open process?

4.* Was the composition of the HIV Prevention Community Planning Group reflective of the characteristics of the current and projected epidemic in California?

5. Did planning participants have clear roles and responsibilities?

6. Was a group process developed for operating the planning group?

7. Was a common baseline established for planning participants?

8.* Was the prioritization of needs based on an epidemiologic profile, resource inventory, gap analysis, and research on target populations?

9.* Was the prioritization of interventions based on a list of unmet needs, effectiveness, cost-effectiveness, theory, and community norms and values?

10. How were the group deliberations transformed into a written prevention plan?

Evaluation of the five core process objectives provides an indication of the degree to which the planning process was orderly, systematic, and evidence-based.

Outcome Evaluation Questions

The outcome evaluation centered on six specific objectives, framed as evaluation questions:

11. Did the Planning Group coalesce into a productive working unit?

12. Was the Planning Group able to develop a Prevention Plan?

13.* Was the HIV prevention funding application based on the Prevention Plan?

14. Is the Plan a useful document?

15. Is the public aware of the plan?

16. Are there plans for implementing the HIV Prevention Plan in California?

As this report is being finalized as the first planning year comes to a close, this part of the analysis necessarily focuses on short term outcomes.

Impact Evaluation Questions

The impact evaluation centered on four impact objectives:

17.* What were the costs of the community planning process?

18. Did the planning process result in a more participatory process for the Office of AIDS in its decision-making and resource allocation?

19. Did the planning process change the way in which the Office of AIDS and community stakeholders relate to each other?

20. What was the impact of participation on individuals involved in the planning process?

Evaluation of impact at this point is preliminary and suggestive. However, specific indicators of potential impact are identified and can be followed in future analyses.

Methods

This evaluation is based on data collected, interpreted, and validated from multiple perspectives. Data collection methods included archival review of CPP documents (i.e., meeting records, committee reports, feedback surveys, transcripts of public comment, correspondence); participant observation at Working Group meetings, Committee meetings, Advisory Group meetings, public hearings, and OA staff offices; written questionnaires, short answer question sheets, group discussion, individual interviews, small group interviews, and many conversations about the Community Planning Process. Data were shared and validated through many of the same methods, in addition to periodic presentation of formative results to the Working Group, Advisory Group, and OA staff. The final report was written by the Evaluator.

Assumptions

This evaluation was designed and carried out with the following assumptions on the part of the evaluator regarding the Community Planning Process:

1. Participatory community planning is possible.

2. Community planning is a good thing.

3. A wide variety of perspectives, styles, and interests is both necessary to the creation of a diverse and representative planning body, and catalyst to deeply felt group dynamics.

4. The combination of time pressures, historical relationships, vested and passionate commitments, and the diversity of the group will inevitably lead to conflict throughout the planning process.

5. Respectful engagement is possible between adults of goodwill.

6. California's planning process would be exciting, serious, and cutting edge.

7. The searing impact of the AIDS epidemic in the lives of all planning participants would be a unifying commonalty to which participants could return during unsettling and divisive periods.

8. The impact of participation in the community planning process will be felt in many areas of participants' personal and professional lives.

9. The Community Planning Process will enhance the leadership and organization of HIV prevention education in California.

The Evaluator also held certain assumptions about the nature and process of collaborative evaluation. These principles were shared with the Working Group early on.

1. Evaluation is first and foremost a process for improving our capacity to engage in meaningful and productive community planning.

2. Evaluation should always be done with people and not to them. Evaluation should be approached as a respectful collaboration.

3. The evaluation process should be open and clear to everyone. Evaluation should never be mysterious.

4. The goals, methods, and findings of this evaluation will be explicit and available to everyone involved in the community planning process.

5. This evaluation will protect the confidentiality of all participants. Participation must always be informed and should always be voluntary. Participation by planning partners in evaluation activities is critical to the success of the evaluation.

6. Evaluation should bring forward the voices and experiences of all who are involved with the Community Planning Process. It will respect the dignity and validity of multiple perspectives.

7. The ultimate goal of this evaluation is to contribute to stopping the spread of HIV/AIDS in California and around the world.

These assumptions about community planning and evaluation principles shaped the design, conduct, and dissemination of this evaluation.

Interweaving Issues

This analysis of the Community Planning Process found ten issues interweaving through the structure and dynamics of the group and the experience of participants.

These issues are:

1. The excitement and uncertainty of doing something for the first time;

2. The heavy workload and short time frame;

3. Different ways of understanding evidence, each other, and the AIDS epidemic;

4. The search for common ground;

5. The difficulties of sharing power;

6. Establishing boundaries and relinquishing control;

7. The risks of engaging in a new process with players with past history;

8. Learning to live respectful engagement;

9. Representation, advocacy, and conflict of interest;

10. Constraining political realities amidst the compelling personal and social realities of the HIV epidemic.

The issues will reappear and interweave throughout the following report. Many were predictable given the challenges of participatory community planning and the context within which it was undertaken in California. Others were unique to the mix of individuals, expertise, and perspectives assembled for the Community Planning Process. Some of the issues were resolved, others remain problematic at the conclusion of the first planning year. However, planning participants' response to these ten interweaving issues generated both the turbulence and the grace with which California developed its first HIV prevention plan.

PROCESS EVALUATION FINDINGS

What was the context within which California undertook the HIV Prevention Community Planning Process?

Many of the conditions that led the Office of AIDS to embark on the community planning process were described in two important documents published and widely disseminated in early 1993. *HIV Prevention in California: HIV Education and Prevention Evaluation Final Report* was the result of a collaborative external evaluation, commissioned by the Office of AIDS and conducted by the Institute for Health Policy Studies, University of California, San Francisco. The report created a framework for understanding what was working well, and what was not, in the state's HIV prevention efforts. Issued in March 1993, the evaluators concluded that "HIV prevention efforts are at a watershed in California...[with] major challenges to meet if the state and localities are to move forward, rather than lose ground, in HIV prevention in the 1990s". The second document, *California and the HIV/AIDS Epidemic: A State of the State Report*, provided a summary of current epidemiologic data on HIV/AIDS in California and a programmatic overview of California's response to the epidemic to date. This report, prepared by the Office of AIDS, was released by the Department of Health Services in August 1993.

The evaluation of the Community Planning Process (CPP) began with construction of a logic model for the entire planning effort. Thus, one of the first process evaluation findings was the description of the context, or conditions, under which the Office of AIDS responded to the CDC planning requirement. These conditions are described as they were evident as of December 1993.

The ten salient conditions described below were derived from review of the two previous evaluation reports, interviews with OA staff, consultants, and selected Advisory and Working Group members. These conditions were perceived as significant influences on the way in which participants approached the California HIV Community Planning Process.

1. California had experienced 12 years of a devastating AIDS epidemic.

California ranked second among states in the number of reported AIDS cases. As of December 1993, nearly 20% of all AIDS cases in the U.S. were reported from California.

The number of new cases in California was increasing faster than the number of new cases reported nationwide.

By the end of 1993, it was estimated that 69,000 AIDS cases would have been diagnosed in the state, more than double the 32,000 cases diagnosed through 1989.

The face of the HIV/AIDS epidemic in California was different from the profile of the epidemic nationwide, as were the major modes of transmission.

AIDS case projections were influenced by the slowing of the rapid upward trend in new AIDS cases among men having sex with other men in San Francisco and Los Angeles, and steadily increasing incidence related to injection drug use and heterosexual contact.

The recent impact of the epidemic was becoming apparent in metropolitan areas outside the original epicenters.

Approximately 146,000 Californians - 1 in 200 - were estimated to be living with HIV infection at the start of 1990.

Transmission of HIV infection was continuing in California, chiefly through unprotected sexual activity, sharing of injection drug use equipment, and from infected mother to infant.

2. California had a long history of significant leadership in HIV prevention efforts.

Efforts in HIV prevention had begun early in the epidemic and had expanded greatly.

California was at the forefront among states in efforts to respond to the HIV/AIDS epidemic.

California ranked second after New York in the amount of state general fund dollars earmarked for prevention.

State funding from the Office of AIDS had provided critical support to local health departments and community based organizations, both to seed local prevention activities and to sustain grassroots efforts.

Comprehensive, community-wide approaches to HIV prevention had emerged in California, particularly in major urban areas.

3. The state's HIV prevention efforts encompassed a broad range of target populations and activities.

Key state legislation throughout the period 1983 - 1991 had established a focus and framework for HIV prevention activities.

Mandated target populations included the general public, high-risk populations, health care and public safety workers, teachers in schools, and school-aged youth. State legislation specified that HIV education and prevention materials be culturally relevant, and that special efforts be made to reach racial and ethnic minorities.

In addition to local contracts, the Office of AIDS provided support for several statewide programs, including the California AIDS Clearinghouse and the Multicultural AIDS Resource Center.

A wide number of prevention and education models were in use in different settings and at different sites throughout the state.

There was an acknowledged need for effective prevention models in suburban/small urban and rural areas, as well as a need for models in all geographic areas to reach high-risk youth, women, and all racial and ethnic groups, particularly men having sex with men.

4. State resources for HIV prevention and education were limited and decreasing.

State legislation continued to mandate new target populations, interventions, and settings without increased funding to expand prevention efforts.

The state budget crisis had resulted in decreasing funds to the Office of AIDS. As funding decreased, funding shares for mandated target populations had become smaller, as dollars were being used to reach a larger number of populations.

While some target populations (i.e., men having sex with men) were consistently funded, other populations were not, due to fluctuating program, legislative, and political priorities.

5. There was no comprehensive plan to guide efforts in HIV prevention and to maximize the impact of federal, state, and local funding.

No plan existed for coordinating federal, state, and local funding to maximize prevention program impact at the community level.

Both state and local decision-making about resource allocation for HIV prevention was highly politicized, without a shared framework to guide priority setting.

In an effort to bring consistency to prevention efforts, OA's latest Request for Proposals (RFP) was based on a three year program cycle.

6. State level HIV prevention efforts were based on epidemiologic data.

California had an extensive HIV/AIDS surveillance system, based on a network of local surveillance efforts throughout the state.

The Office of AIDS used Block Grant funds to create and sustain the local surveillance efforts.

OA had received a 1991-92 Commendation from the Legislative Analyst's Office (LAO) for using epidemiologic information in establishing program priorities.

Although local data were used to guide statewide prevention efforts, those same data sometimes were not shared or used at the local level.

7. There was growing community interest in, and demand for, an enhanced role in the statewide planning and decision-making process for prevention priorities and resource allocation.

There was a widespread distrust of bureaucracy, including the Office of AIDS, among many of California's HIV/AIDS community service and program providers.

Program contractors, previously extremely dissatisfied with the request for proposal (RFP) process, evaluation requirements, contract monitoring, and technical assistance from the Office of AIDS, had repeatedly expressed interest in a more participatory role in establishing state-level HIV prevention priorities and procedures.

There was increasing activism at public hearings, enhanced legislative advocacy, and active networking and organizing among grassroots organizers, program contractors, and researchers in order to shape HIV/AIDS funding and priorities for state prevention resources.

Several groups had recently participated in the HIV Prevention and Education Evaluation, including a 15-member Evaluation Planning Group and a 50-member statewide HIV Education and Prevention Working Group.

8. The State Office of AIDS had made a strong commitment to strengthen community involvement and develop a coordinated, effective statewide prevention and education system.

The Office of AIDS had commissioned, supported, and disseminated the independent HIV Prevention and Education Evaluation Report.

In response to the report's recommendations, the Office of AIDS had made a formal commitment to invest in an expanded community planning and participation process.

9. The state had developed an effective participatory planning process in response to the Ryan White CARE Act, Title II legislation.

The Office of AIDS had been involved in community planning for AIDS care and treatment for three years.

Many of the participants in the Title II planning process were also key stakeholders in prevention and education.

10. California had been instrumental in establishing the CDC community planning initiative.

Several of the people closely involved in CDC's movement towards community planning for HIV prevention had long been closely involved with the Office of AIDS.

These ten conditions characterize an environment that welcomed federal guidance for community planning from a number of perspectives. They also anticipate some of the political and affective undercurrents that would rock California's HIV Prevention Planning Process throughout the planning period. The conditions also suggest the considerable strength, expertise, and commitment with which many participants would approach the opportunity to participate in developing California's first statewide HIV prevention plan.

What were the key components of California's community planning structure?

The HIV Prevention Community Planning structure was modeled after California's Ryan White CARE Act, Title II process, which had effectively involved community representation and the Office of AIDS in planning and allocation of care and treatment funds. Staff and informal advisors felt that a similar planning structure would be appropriate for the prevention planning initiative.

Office of AIDS staff gave considerable thought to the best structure and staffing of a community prevention planning process. Among the factors they considered were a) current staffing levels, b) state and federal resources, c) the short time frame for implementation of the planning process, d) the state of relations with community stakeholders, e) the scope and diversity of the state of California, and f) the opportunity to act on their expressed commitment to increasing community participation in statewide prevention and education decision-making. In consultation with an informal group of local and national leaders, OA staff made several philosophical and administrative decisions regarding the key components of the community planning structure early in the "planning for planning" period. These decisions established a framework which would significantly shape the form and dynamics of the Community Planning Process.

Philosophical decisions

1. **Staff committed to the basic principles of community planning,** releasing ultimate control of the content of the final prevention plan. Some OA staff members were very comfortable with this commitment, others who were less comfortable understood it to be necessary given the state of prevention planning in California and the CDC mandate. The Chief of the Office of AIDS particularly welcomed the community planning process, seeing it as an opportunity to bring new and diverse voices to the policy arena. The success of the CARE Act Title II process reassured OA staff that a similar process could work in prevention and education.

2. **Staff committed to careful management of the planning process.** OA staff understood that it was their responsibility to guarantee that all planning objectives be fulfilled, all deadlines met, and all final products be of the highest quality. The staff were keenly aware of California's high visibility and leadership in community planning at the federal level. All key staff members had a deep sense of pride in their professional work. For some, anxiety caused by previous community criticism, community planning time pressures, and the broad guidance early on led to an even more deeply felt need to "do everything right". Indeed, managing the Community Planning Process became the highest priority and most time-intensive activity of the Education and Prevention Section during the planning year.

Administrative decisions

3. **The initial organization of the Community Planning Process was designed as a two-tier structure involving a smaller group of Advisors and a larger Working Group.** Advisors would advise both the Office of AIDS and the Working Group members. Of all planning participants, only the members of the Working Group would have voting privileges. Per CDC requirement, the Chief of the Office of AIDS would be a voting Co-Chair. The staff planned that another Co-Chair would be elected from the Working Group at its first meeting.

4. **Consultants would be used for specific tasks** such as writing the plan, group facilitation, planning guidance, and evaluation. The Advisory Group was instrumental in developing job specifications, recruiting or nominating potential consultants, and assisting in final member selection. Consultants were to be as much a part of the planning process as the budget would allow.

5. **Additional resources were secured to support the planning process.** Office of AIDS staff knew that participatory planning in a state as large and diverse as California would need additional resources. They also knew that the complexity of prevention issues in a state as hard hit by the AIDS epidemic as California would require both time and space for resolution and consensus. The non-competing HIV Prevention Community Planning component of the CDC Cooperative Agreement provided a base of $350,000. However, anticipating the need for additional resources, OA supplemented the base with an initial $150,000 in state discretionary funds at the beginning of the planning process. Later on, OA would add an additional $150,000 of federal prevention funds to support the latter phase of the Community Planning Process.

6. **Management of all logistics and resources were subcontracted to a small independent business.** All of the CDC supplemental planning funds and the additional state and federal allocations were subcontracted to a third party. The woman-owned small business that was selected handled all meeting logistics, subcontracts with consultants, and numerous other tasks. This arrangement freed OA staff from the plethora of logistical details involved in statewide community planning. It also allowed for more efficient and flexible resource flow than if all subcontracting had been conducted through the state bureaucracy.

7. **Selected OA staff were redirected from other prevention assignments to provide fulltime staff support to the Community Planning Process.** As specified by CDC, the Chief of the Office of AIDS was a Co-Chair of the Community Planning Working Group. Within the Office, responsibility for a successful community planning process was assigned to the Education and Prevention Chief. A new organizational configuration was established within E&P to allow two staff members to report directly to her and to work almost exclusively on the Community Planning Process. Over the planning year, nearly all of the Education and

Prevention (E&P) staff would have the opportunity to observe at least some part of the planning process.

8. **A timeline for the planning process was established.** Although some of the particulars would change based on planning group needs and dynamics, the initial timeline provided the structure necessary to quickly mobilize the planning process.

These early decisions had profound influence on the tone and capacities of the planning effort. Definite strengths and challenges to the planning process were introduced as a result.

The planning process was enhanced by:

1. **The availability of significant funding to support the planning process.**

The existence of state funds and federal planning dollars were equally instrumental in realizing a participatory planning process. Over time, it would be clear that the Working Group needed to meet several times, in different parts of the state, and for at least two days at a time. This would not have been possible without significant state and federal resources dedicated to the process.

2. **The early guidance and encouragement provided by participants working closely with CDC.**

The California Prevention Planning Process was fortunate to have close ties with CDC. The Chief of the Office of AIDS had a leadership role with the National Association of AIDS Directors. In addition, one of the advisors to the Office of AIDS was closely involved in the development of the community planning concept at the federal level. These relationships enabled OA staff to anticipate what was coming and to quickly grasp the scope and intent of the final planning requirements. The Co-Chairs' participation in a national meeting of CPP Co-Chairs brought increased enthusiasm and perspective to the California planning process. Encouraging feedback through these and other channels fueled a sense of pride and leadership among many planning participants.

The decision and resources to hire a policy and planning consultant added tremendously to the process, particularly in the early months. The consultant assisted in developing the CPP initiative through CDC and was very familiar with California's Education and Prevention programs. Her ongoing involvement with CDC in the Community Planning Process brought information, clarification, and encouragement to the California staff and Working Group at several key junctures.

3. **The expertise and leadership within the Advisory Group.**

The two-tier planning structure was enhanced by the expertise and leadership within the Advisory Group. From an initial group of 32, the ten individuals who would emerge as "core" Advisors brought a rare mix of experience and skills. The Advisory Group was empowered to make key decisions and recommendations to the Office of AIDS regarding the Community Planning Process. Their mission was 1) to assume and share responsibility with the Working Group for the planning process to ensure the prevention of HIV infection in California, and 2) to develop and coordinate the HIV Prevention Community Planning Process. By February 1994, the Advisory Group had adopted 11 specific objectives, including Working Group member selection, developing a plan for public input into the planning process; developing goals, objectives, and plans for Working Group meetings, and proposing plans for the process evaluation.

At key points throughout the process, Advisory Group members offered guidance, clarification, technical assistance, constructive criticism, and emotional support both to the Office of AIDS and to Working Group members. For example, Advisory Group members helped the Office of AIDS with selection of the Working Group membership, coordination of public hearings, and with numerous problem-solving conversations regarding the logistics and dynamics of the planning process. Advisory Group members called each Working Group member for a personal "check-in" after the first Community Planning meeting. Later on, many advisors worked closely with Working Group members on some of the particularly difficult decision-making worksheets. Working without specific training or outside facilitation, the Advisory Group quickly emerged as a serious and productive group whose influence was widely felt and appreciated, particularly at the beginning.

4. **The expertise and commitment of the Working Group members.**

The heart of the Community Planning process was the Working Group. This group of 55 individuals committed to a group process about which little was known except that it would be challenging, labor-intensive, and, whatever the outcome, could be extremely important to HIV prevention in the state of California. Selected for their expertise and inside knowledge of the AIDS epidemic, the group discussions and ultimate decisions were in their hands. Their individual and group leadership was both essential and reliable.

5. **The availability and expertise of a range of consultants.**

The Community Planning Process was able to draw from a group of consultants in filling key technical and advisory roles. California is rich with experienced planning, facilitation, and evaluation consultants, many of whom have been involved with previous OA projects. Staff and Advisors agreed on the importance of selecting consultants they knew and who had experience in various aspects of HIV/AIDS prevention. For example, the firm hired to write the plan was well known for its planning and research accomplishments. The

principal planner assigned to the project had over 10 years experience in HIV policy and prevention. Equally familiar with research and grassroots organizations, she was able to link the language and thinking of both perspectives with sensitivity and skill. The individuals selected to facilitate the Working Group meetings also were highly accomplished. Well known to many Advisors and the OA staff, the two facilitators brought substantial experience with multicultural group dynamics, AIDS education, and technical assistance to state and grassroots groups. These and the other consultants brought outside skills and perspective that were accepted, in part, because the individuals were known and trusted by many group members.

6. **The inclusion of Advisors and consultants in many aspects of the planning process.**

The Office of AIDS decided to involve Advisors and consultants in many aspects of the planning process. For example, the planner attended all Advisory Group and Working Group meetings in addition to meeting with OA staff and the other consultants. The logistics coordinator attended all Advisory Group meetings. Advisory Group members met monthly and were encouraged to attend all Working Group meetings. While adding to the overall costs, this decision significantly enhanced the process and products of community planning. Participants became known to each other, enhancing trust and credibility, while increasing opportunities for reflection and adjustment in the process. To the degree that they were included in planning and problem-solving, consultants were better informed and better able to provide their contracted services.

7. **The neutrality of the logistics contractor.**

The neutrality of the small company that handled meeting logistics, reimbursement, special needs, and site coordination was an asset throughout the planning process. The state bureaucracy was well known for its slow and cumbersome reimbursement procedures; the contractor's personal attention and fast turnaround time removed a potentially troublesome dynamic from the planning process. The company had handled logistics for a few small contracts with the Department of Health Services but was new to most planning participants. The contractor's consistent efforts to make things work smoothly, while maintaining a clear separation from the content or emotions of the planning process, were appreciated by many planning participants.

8. **Staff abilities in skill areas necessary to mobilize state bureaucracy in support of community planning.**

The Office of AIDS staff brought many management skills to the planning process. In addition, the public health training of the Education and Prevention Chief provided a theoretical framework for community planning that would guide the planning process. OA staff assigned to the community planning process were able to mobilize and manage resources, secure additional funding, prepare and coordinate correspondence, answer questions, and generally weave together the disparate planning components. The staff worked extremely hard

in order to meet all institutional responsibilities and ensure that all deadlines were met. This dedication to administering the community planning process allowed maximum flexibility and resources to consultants, Advisors, and Working Group members.

The structure selected for California's Community Planning Process provided resources, expertise, guidance, and administrative support for a truly participatory experience. The success of this structure is reflected in participants' responses to an evaluation question which asked respondents for five words to describe the statewide planning process. Among the most frequently mentioned responses were *inclusive, empowering, important, exciting, and educational.*

The chosen structure and administration also established dynamics that would challenge planning participants, particularly given the already politicized context into which community planning was introduced. Evidence of these dynamics is found in other frequently reported descriptions of the process: *difficult, controlled, threatening, frustrating,* and *painful.* Four key challenges of the selected planning structure and administration are described below. Each of these issues is explored for its insight into participatory planning within a state bureaucracy and for a region as diverse and large as California.

1. **A persistent tension between managing the process but not controlling the product.**

The Office of AIDS was often perceived by other planning participants (including many Working Group members, Advisors, and consultants) as attempting to control both process and product. Indeed, OA staff seemed to struggle with the boundaries of their oversight responsibility. Staff were in an awkward position: designated as lead agency with sole responsibility for ensuring a complete planning process, but, with the exception of the Co-Chair, without a voting role. The root of the problem may lie in the tension inherent in community planning within a bureaucracy, which is then played out at the local level through individual personalities and administrative styles.

In California, there was often a strong undercurrent of concern among planning participants that, despite its inclusive intentions, the Office of AIDS was controlling the process and even attempting to manipulate the outcome. This concern, voiced by many and emerging at various flashpoints in the planning process, both generated and was met with deeply felt emotions. Planning participants expressed anger and frustration at the reoccurrence of these issues; staff, in turn, felt misunderstood and attacked. The group would struggle with this tension throughout the planning process.

2. **Inexperience of assigned OA staff with community organization and community-based planning.**

Community planning is complex and challenging. Smooth guidance of a participatory planning process requires skill and sophistication in community organization, group dynamics, and leadership. The Chief of the Office of AIDS brought significant leadership experience and a deeply felt commitment to participatory planning. His leadership, particularly in the early months of the planning year, was crucial to the success of the process.

The Education and Prevention staff assigned to the Community Planning Process brought many technical skills to their new assignment. However, they had not yet had experience with community planning of this magnitude. E&P staff approached the mandate with determination and admirable professionalism, assuming that community planning would unfold much like other education and prevention activities (i.e., subvention assistance, contract monitoring, conference coordination). They quickly learned that an entirely different set of skills and group dynamics was needed. Despite their significant learning curve, E&P staff had to learn community planning on the job.

3. **Intense pressure felt by the small OA staff unit.**

The decision to assign responsibility for the planning process to the Education and Prevention Chief and two of her staff created a flexible and organized unit for the complex staffing job ahead. There were many benefits to this decision. However, the staff configuration also served to locate all functional responsibility for the planning process with very few individuals. The intense pressure created by the short timeline, the daunting task, and the sense that this was going to "make or break" the Office of AIDS were evident in staff demeanor and interactions throughout the planning process. Exacerbated by their own high professional standards, discomfort with their own lack of experience in this type of planning, and their growing uncertainty about what the emerging plan would mean for future roles and responsibilities within the Office of AIDS contributed to a very tense and guarded stance by most participating OA staff members.

4. **Tension inherent in community participation in state planning.**

The goals of community participation in state planning were enthusiastically embraced by many involved in HIV prevention and education in California. However, these goals introduced a tension regarding the reach and scope, and ultimate power, of a community planning process within a state bureaucracy. The tension centered around the following fundamental question about the purpose and endpoint of community planning: Is the planning group empowered to *make decisions* about prevention programs, or is its mission only to *make recommendations* to the State Office of AIDS? OA always felt that the planning process was

designed to provide input only to statewide policy. Many other planning participants interpreted the intent and the opportunity of participatory planning quite differently.

The difficulty begins with rather ambiguous wording and the nuances of interpretation depending on point of view. The CDC *Guidance* states that the broad goals of CPP are "to secure a broad range of perspectives, build consensus, and mobilize resources *to make decisions* about HIV prevention programs". This suggests empowerment of the planning group to actually make public policy decisions. However, the mission statement for the California CPP states that the process would lead to "a statewide master plan that will be submitted to CDC as part of the Office of AIDS' continuation application for its Prevention Cooperative Agreement", focusing more on the document to be produced rather than authority to set the policy. These differences suggest a subtle but important shift as federal goals were articulated at the state level.

The planning model developed for the CARE Act, Title II planning had supported OA's role as lead agency while providing a vehicle by which community and local government groups could be involved in planning. The Office of AIDS welcomed a similar process for Education and Prevention. However, the wording in the *Guidance* suggested a broader role for the planning body in ultimate decision-making. Many in the prevention and education community were eager for just such a role. Reading the same words, but with an entirely different emphasis, participants came to the planning process with widely different expectations. The degree of distance would become clearer, and increasingly problematic, as the Working Group extended its deliberations beyond the CDC mandate and moved into areas of resource allocation, implementation, and continuation of statewide community planning.

The challenges described above re-emerge in later sections of this report. However, it should be noted that as difficult as these tensions were for individuals and the group, and as potentially threatening as they might have been to the integrity or productivity of the process, they remained only tensions. At no time did any of the above dynamics destroy or permanently disable the community planning process. Indeed, the underlying goodwill and professionalism of OA staff, and the expertise and commitment of planning participants helped shape a planning group that was capable of learning from its inexperience and mistakes, and rose to the challenge of creating California's first comprehensive HIV prevention plan.

Was the nomination of members for the HIV Prevention Planning Group an open process?

Both the archival record and participant accounts reflect the open process used to nominate Working Group members. As early as August 1993, OA staff sent a letter to all AIDS Education and Prevention contractors, local health departments, and community groups (a mailing list of over 200), alerting them to the upcoming statewide planning initiative. The August 2, 1993 letter stated that "We are interested in having input from community-based organizations, local health departments, or individuals who may have an interest in serving in

the planning process". This pre-existing mailing list helped get early word out to a wide and diverse group of interested parties. Similar correspondence was sent out on December 6, 1993, with more specific information on the planning process and opportunities for participation. At both times, interested individuals were invited to submit their names to the Office to be contacted by OA staff as plans developed.

At the first advisory meeting, a Membership Selection subcommittee was formed and plans developed for an open nomination process. Based on these decisions, OA staff developed a formal nomination form which was sent to an expanded mailing list of over 250 names. The list included individuals who had responded to the previous correspondence, everyone who had been invited to the advisory meeting (including those unable to attend), local health department officers, Prevention and Education contractors, HIV Testing contractors, state and national HIV/AIDS advocacy organizations, and interested parties. This letter described the statewide planning initiative, the activities to date, the structure of the Advisory and Working Groups, and the criteria for membership in each. An enclosed nomination form allowed respondents to indicate whether or not they were interested in serving on the Working Group, and/or to recommend others. Nominations were to be FAXED to a designated OA staff member within three weeks.

Despite the fact that the three week nomination period included the Christmas and New Year's holidays, over 200 responses, nominating a total of 179 individuals, were sent to the Office of AIDS. Of the 179 individuals nominated for Working Group membership, 65% were self-nominated and 35% were nominated by someone else.

There were definite strengths in OA staff and advisors' efforts to create an open nomination process, as well as a few key challenges.

The open nomination process was enhanced by:

1. A pre-existing mailing list, easily mobilized for mailing to over 200 offices and organizations.

2. Early mailing from the Office of AIDS (August 2 and December 6) alerting interested parties to the upcoming planning process.

3. Quick response by OA staff once more specific information was available from CDC, and once the Advisory Group established a nomination framework.

4. The option to nominate oneself or someone else.

5. Active networking on the part of Advisory Group members and OA staff to ensure that a wide range of people considered nominating themselves or someone else.

6. Use of the FAX as a quick and easy way to make a nomination.

7. Staff's orderly receipt and handling of all nomination forms as they came in

Challenges to the open nomination process included:

1. The lack of detailed guidance from CDC in the early months of organizing the planning groups.

2. The fast timeline required to organize the Advisory Group, form a Membership Selection Subcommittee, and open nominations.

3. The timing of the nomination process over a busy holiday period.

The first two challenges were characteristic of the early days of the planning effort in which tremendous amount of OA staff time was spent analyzing the preliminary Community Planning information from CDC, seeking clarification, and attempting to mobilize the California effort. The timing of the nomination process initially was of concern to OA staff and several Advisory Group members. Indeed, tentative plans were made to extend the nomination process if necessary, even though that would have significantly set back the preliminary Working Group timeline. Fortunately, the number and diversity of nominations received over the three weeks reassured staff and advisors that an open, if somewhat rushed, nomination process had occurred.

Was the composition of the HIV Prevention Community Planning Group reflective of the characteristics of the current and projected epidemic in California?

The composition of the Community Planning Working Group strongly reflected the current and projected epidemic in California, as well as the diversity of the state's population. As is evident through membership records, analyses provided by OA staff, and accounts of both Working and Advisory Group members, the Community Planning Working Group members had both personal and expert knowledge of AIDS.

The Membership Selection Committee used a number of criteria in selecting potential Working Group members. The Committee began with the criteria specified in the *Guidance*. In an attempt to address California's multicultural populations, and to define multiculturalism as inclusively as possible, the Advisory Group developed additional criteria, or "cultural clusters". The clusters covered categories such as culture, sexuality, practitioners, policy, and government. The Membership Selection Committee carefully reviewed the 179 nominations against these combined criteria. A total of 45 individuals were selected and recommended to the Office of AIDS. All 45 were accepted.

Further analysis of the roster identified gaps in representation which were the result of the 45 person limit adopted at the advisory meeting. To broaden representation, the Office of AIDS recommended 10 additional names which would specifically enhance ethnic, rural, local health department, and affected group representation. The Selection Committee agreed to the additions and a total of 55 individuals were selected for the Community Planning Working Group.

The diversity of the Working Group is reflected across several dimensions. Nine members (16%) were persons living with HIV or AIDS. Results of an evaluation survey reveal the depth of experience with the AIDS epidemic reflected in the Working Group. Most members (84%) had lost friends, partners, children, or other loved ones to AIDS, nearly everyone (91%) had lost a colleague or friend. Three quarters of the group (75%) had at least some experience with direct caregiving for someone with AIDS. Over half of the Working Group had "a lot of experience" losing acquaintances, losing colleagues or friends, losing loved ones, and direct caregiving due to AIDS.

As described in California's February 15, 1994 *Supplemental Application to CDC*, the ethnic diversity of the Working Group generally paralleled the state's ethnic populations, with slightly higher representation of African Americans (+5%), and slightly lower representation of Native Americans (-6%), Asian/Pacific Islanders (-2%), and Latinos (-2%). European American representation was 10% less than the corresponding state population. Working Group membership also was generally comparable to the ethnicity of AIDS cases in California, with members representing from 2% -10% over the proportion of AIDS cases for African Americans (+2%), Asian/Pacific Islanders (+5%), Latinos (+10%), and Native Americans (+6%). European American representation was lower (-20%) than the current proportion of AIDS cases in response to epidemiologic projections of the ethnic distribution of future AIDS cases in California.

Thirty three members (60%) were male, twenty two (40%) were female. Nearly half of the group (46%) was gay, lesbian, bisexual, or transgender.

Members were employed across a wide variety of HIV prevention and education venues. The largest percentages were employed by AIDS service organizations (15%), local health departments (13%), and AIDS advocacy organizations (10%).

Working Group members came from slightly more than half of all 59 California counties (53%). The majority of unrepresented counties were northern or central rural areas with small populations. However, 29% of the Working Group membership came from rural or suburban communities. Several members represented statewide constituencies.

Through these varied criteria, the Office of AIDS was able to convene a planning group reflective of the characteristics of the current and proposed epidemic in California while also representative of the state's multicultural population. The final Working Group was

composed of representatives of persons affected by HIV/AIDS, state and local health departments, state and local education agencies, other government agencies, experts in epidemiology, behavioral and social sciences, evaluation research, health planning, and governmental and nongovernmental prevention service providers.

Did planning participants have clear roles and responsibilities?

The Community Planning Process proceeded most smoothly when roles and responsibilities were clear and agreed upon, and faced some of its most difficult challenges when they were not.

Establishing clear roles and responsibilities

An effort was made from the beginning of the planning process to clearly delineate members' roles and responsibilities. Formal presentations and written materials presented at the first Working Group meeting specified the mission of the planning process and the respective roles of the Office of AIDS, the Advisory Group, the Working Group, the facilitators, the logistics coordinator, and the Co-Chairs. A significant portion of the Working Group's first day agenda was devoted to reviewing and discussing these roles. Responsibilities and timeline were revisited on the second day during a presentation on strategic planning. Working Group members were encouraged to view planning as a practical process, and to "leave each meeting with a clear understanding of what they need to do, what the needs are, and how to get the information". Responses to the feedback survey indicated that this objective was substantially achieved by the end of the first meeting. Most participants (75-80%) said that they had a basic understanding of the CPP, understood the tasks and timelines, and understood their roles, responsibilities, and boundaries. Slightly fewer (67%) felt confident in their understanding of the decisions they were empowered to make.

Within a week of the first meeting, all Working Group members had signed the Letter of Commitment. The letter specified that members agreed to attend, prepare for, and participate in all Working Group meetings; gather community input regarding HIV prevention needs and priorities; distribute information to community groups; represent the Working Group at community meetings, and act on behalf of all HIV affected communities in Community Planning decision-making.

Roles, responsibilities, tasks, and timelines were also established for each committee and discussed when committees met for the first time at the second Working Group meeting. Written evaluation responses from that meeting indicate that most participants understood fairly well the roles and responsibilities of their own committee. Clarity on roles and responsibilities would come and go as committees became immersed in their respective tasks. However, particularly at the beginning, a very public effort was made by OA staff, facilitators, and the Advisory Group to ensure that Working Group members understood the scope and the boundaries of their responsibility.

Changing or undeveloped roles and responsibilities

The early work of establishing roles and responsibilities served the Community Planning Process well. However, there were several areas in which roles and responsibilities were either fluid, underdeveloped, or controversial. Examples from the roles of the facilitators, the Co-Chairs, the Resource Allocation Committee, and the Advisory Group are briefly discussed below. These examples provide insight into the importance of consensus around roles and responsibilities, and the need for open communication around changes in role expectations.

The facilitators' roles

Professional facilitators were selected for the crucial task of facilitating the Working Group meetings. Two well known professionals, one already a frequent contractor with the Office of AIDS, were hired on a consultant basis for this task. OA was willing to pay a fee significantly higher than that charged by any other consultants due to their concern for neutral and trusted facilitation and the high recommendations coming from the Advisory Group for the selected individuals.

The Office of AIDS always imagined an important but rather limited role for the facilitators. However, over the early months of planning, a more central and advisory role developed. The facilitators attended Advisory Group meetings and gave considerable input to the planning of the planning process. Many Advisors assumed that the facilitators would continue in this role. Some even thought that the facilitators should be facilitating Advisory Group meetings, although the Office of AIDS had always intended to facilitate those meetings themselves.

After a few months, OA reassessed the planning structure in lieu of the budget and progress to date, and decided to enforce the original, more limited, job description for the facilitators. Due to the facilitators' hourly fee, OA staff asked them not to continue to attend Advisory Group meetings. Seeing it as a budgetary issue within their purview as administrators of the planning funds, OA did not formally explain this development to other participants. However, the change was obvious and surprising to many, particularly Advisors, who felt that their meetings needed more neutral facilitation. Many Advisors were also concerned that the increasing complexity of Working Group decision-making required greater, rather than less, involvement of the facilitators. Later, many Working and Advisory Group members would claim that the facilitators' roles were limited so that the Office of AIDS could better control the planning process. OA staff insist that they were unaware of the group's concerns. These multiple perspectives reinforce the importance of a consensus around roles and a standard of open communication, particularly when roles of key players change.

The Co-Chairs' roles

The position of Working Group Co-Chair is a useful example of an important position for which roles and responsibilities were not fully developed during the first planning year. Although the *Guidance* and the Office of AIDS had some clear ideas about the nature of the Co-Chair role, the specific dynamics of the Co-Chairs in the California planning process, particularly in relation to facilitators and Advisory Group members, were not clearly conceptualized.

At its first meeting, the Working Group elected two members from a field of ten nominees to join the OA Chief as Co-Chairs. A basic role statement indicated that the Co-Chairs were empowered to convene the Working Group meetings and facilitate each public comment segment. Their individual and complementary styles were a vanguard of respectful engagement throughout Working Group meetings, "a beacon of commitment" in the words of one participant.

The Co-Chairs crafted their roles as they went along. Time after time, the group would draw strength from the spiritual grounding of one of the Co-Chairs, an American Indian man living with HIV. The Chief of the Office of AIDS shared a buoyant optimism about open and responsive government in his Co-Chair role. And the California Community Planning Working Group took great pride in being the first planning body of this stature to name a transgender to a leadership position. The Co-Chairs' participation in a national meeting of CPP Co-Chairs provided another infusion of excitement and perspective on California's role in the nationwide planning initiative. However, the formalized leadership of the facilitators, the Advisory Group, and the Office of AIDS left Co-Chairs and some Working Group members unsure of the true purpose of the Co-Chair role.

The Co-Chairs functioned as individuals rather than as a team. Each was responsible and effective in their own right, but the potential for them to combine their strengths was never realized. Geographic distance and fulltime jobs posed significant barriers to greater coordination between meetings. In evaluation surveys and interviews, many planning participants praised the strengths and sensitivities of the individuals elected to the Co-Chair position and regretted the fact that their abilities were not as fully utilized as they might have been. Some Working Group members wanted more advocacy with the Office of AIDS from the elected Co-Chairs. Some felt that the Co-Chairs might have been able to help OA with the crushing workload, particularly communication between Working Group members. Others felt that the Co-Chairs elected from the Working Group were in the best position to help the group monitor itself when discussions began to border on conflict of interest.

There is no doubt that the Co-Chairs played important and constructive roles in bringing undercurrents to the surface, helping craft the agenda to meet needs beyond the decisions at hand, and repeatedly reminding the group of the higher purpose of their work. The first year Co-Chairs have begun to craft a position of influence and reconciliation. Future

community planning efforts will benefit from continuing to define the Co-Chair role to more formally incorporate their leadership and commitment.

The Resource Allocation Committee's role

The area in which roles and responsibilities were most intensely debated was resource allocation. The mission of the 11-member Resource Allocation Committee was to identify the different procedures that OA could use in allocating federal and state prevention funds, describe how each process would work, and make specific recommendations to the Working Group about methods for allocating prevention dollars. However, during the planning process, committee members expanded this mission to include implementation and oversight.

The Resource Allocation Committee was the only one of the eight CPP committees taking on an issue not required by the CDC. Resource allocation was included in the California planning process because OA thought it important to involve the community in the difficult tasks of formulating how prevention money would be spent. However, the difficulties in making allocation decisions raised important questions about the committee's responsibilities, the authority of the Working Group, and increasingly evident conflicts of interest. Working very hard, but beyond the CDC guidance and eventually beyond the roles and responsibilities established by OA, the Resource Allocation Committee became painfully bogged down. Perceived mixed messages from the Office of AIDS and the lack of a clear conflict of interest policy further contributed to anguished and extended deliberations of all planning participants around resource allocation.

The roles of the Advisory Group

The experience of the Advisory Group provides a useful example of what can happen when roles and responsibilities are not revisited periodically. The Advisory Group had a clear mission statement and numerous agreed-upon objectives in place by February 1994. However, most of their objectives were linked to the early needs of the planning process (i.e., member selection, process evaluation planning). These tasks were largely completed by June. Although Advisors had roles on specific committees, some began to feel that their roles became less defined and increasingly marginalized as natural leadership emerged in committees and the needs of the planner became more central to the Working Group meetings. Minutes and accounts of Advisory Group meetings verify the central and proactive role that Advisors played in the early months, and the definite change that set in later on. Indeed, as their roles became less central, Advisors' attendance at both Advisory and Working Group meetings began to drop off.

As the Working Group moved into the uncharted waters of resource allocation and continuation of statewide planning, Advisors often felt caught between the Office of AIDS and the Working Group in conflicts related to roles and responsibilities, information, and

communication. This new tension was seldom addressed directly, forfeited often to the pressures of looming deadlines and the always heavy Advisory Committee meeting agenda. OA staff attempted to keep communication clear by dealing with individual Advisors on specific issues as time allowed. However, as tensions mounted, these efforts were seen by many as personalizing issues or problems, thereby increasing the tension. In retrospect, frequent and facilitated discussion of changing roles and needs for and of Advisors might have defused some of the hard feelings and miscommunication that grew over time. Indeed, dealing with issues more openly might have depersonalized problems and led to more insightful handling of some of the very important undercurrents of the planning process. It might also have helped Advisors find roles as meaningful and fulfilling in the latter parts of the Community Planning Process as those they had filled at the beginning.

Was a group process developed for operating the planning body?

Considerable attention was devoted to creating and maintaining a principled and formalized process for operating the planning body. Based on the concepts of respectful engagement and collaboration, a set of Working Group principles was presented and discussed at the first Working Group meeting. These principles acknowledged "a diversity and mutuality of interests" and reminded participants that "broad public involvement in decision making carries with it the responsibility for high quality decision making." The policy consultant called upon the group to "keep the principles of equity and fair play close to their hearts in this process". Subsequent evaluation survey and interview data from Working Group members highlight the value of establishing this early framework.

Working Group meetings

Significant process and organizational efforts were made to ensure that the community planning process was open, candid, and participatory. Travel arrangements were flexible enough that participants could arrive a day early or stay an extra day if necessary to ensure their full involvement. Large and small group discussions were incorporated into all Working Group meetings to facilitate candid and comfortable participation by all members. Written evaluation surveys, with room for additional comments, were distributed at each Working Group meeting. Survey responses were tallied and distributed to participants, along with meeting minutes and summaries of any formal small group discussions. Opportunities for open communication outside of CPP meetings were established by the distribution of a roster of all participants, their addresses and phone numbers.

Specific policies and procedures for resolving conflict within the planning group were developed over the first Working Group meetings. During the first meeting, both plenary and small group sessions included discussions of the way in which the group would engage in its deliberations over the coming months. The first meeting set the tone for the group process, as indicated by written evaluations in which 92% of Working Group members indicated that the meeting had at least substantially met its objective of creating respectful engagement.

Specific policies and procedures for decision-making within the planning group also evolved during the early Working Group meetings. Once the group had decisions to make, the facilitators took a strong role in managing the interactions and articulating policies and procedures for decision-making.

Working sessions of the planning body were highly organized. Each Working Group meeting was designed to meet specific objectives. An agenda for each day of each meeting was developed based on the decisions that needed to be made by the end of the meeting. The agenda was reviewed at the start of each Working Group session and modified if needed. Time frames were adhered to as closely as possible, with the facilitators moving discussion and making sure that objectives were met. A written evaluation survey at the end of each meeting provided feedback on the extent to which participants felt that the objectives had been met. Working Group meetings were audiotaped for transcription. The logistics coordinator prepared minutes, which were collated with handouts and support materials, and distributed to all members of the Working Group, Advisory Group, staff, consultants, and other planning participants.

A clear but casual form of parliamentary procedure was adopted for managing discussion and calling for votes. Operational points, such as changing an agenda item, meeting locations, and acceptance of recommendations, were decided by the group using majority + one voting when a 2/3 quorum was present. Most of these votes were taken by raising of hands and numbering off around the table. Occasionally, secret ballot voting was used. Facilitators worked hard to ensure that group members knew that a decision was being made and understood the options.

Careful attention was paid throughout the planning process to develop a task-oriented group sense, particularly among Working Group members. Seating was reconfigured several times until a large, open U shape was found to be the best, with Working Group and Advisory Group members intermingling. Office of AIDS staff, consultants, and the public sat behind. Name cards for the tables, in large print and without credentials, were helpful in learning names. Each Working Group session began with everyone in the room introducing themselves by name. Microphones at the table enabled all to hear and Working Group members to speak from their seats. Time schedules were adhered to as closely as possible, with meetings beginning on time and honoring scheduled breaks. Most meetings included a moment of silence in honor and remembrance of all those living with HIV and AIDS, and all who had passed since the previous meeting.

The careful attention to task enabled the Working Group to proceed in an orderly and explicit manner through the myriad issues, questions, and decisions necessary to establish the state's first HIV prevention plan. Working Group members always knew the stated purpose and objectives of meeting time, and could always see the way in which what they were doing fit in the bigger picture. However, as the pressure to make final decisions became more acute,

and the workload became particularly heavy, the formal group process focused almost exclusively on task. This shift in emphasis forced some very difficult group dynamics issues to be dealt with outside of meetings, without benefit of either professional facilitation or public record. The facilitators' commitment to moving the agenda through the designated tasks kept the underground conflicts from derailing the final decision-making. However, the affective dimension of the group process was significantly impacted by a number of internal issues that were not dealt with directly.

Working Group Committees

The Working Group Committees had tremendous responsibility in the Community Planning Process. This was the level at which parameters were established, missing data identified and gathered, and options developed for presentation to the Working Group. The documentation and recommendations from each committee, endorsed by the larger planning body, became the basis of the text of the HIV Prevention Plan.

Formal, uniform group process procedures were not imposed on committees. Instead, each committee formed its own group identity, including procedures for managing its workload and group process. Committees were structured to provide expertise, guidance, and technical assistance from within. In addition, outside support was available from staff and consultants. Advisory Group members were assigned facilitation and recorder roles in each committee. Detailed guidance of the specific decisions that needed to be made by each Committee was provided by the planner. OA attempted to provide technical assistance, but some committees felt that OA assistance was really control, and asked that staff not participate in their meetings at various points in their deliberations. By the end of the planning period, each committee had successfully completed its assigned tasks.

Within individual committees, group dynamics and productivity varied. Some Advisors felt that they did not have the necessary experience or expertise to effectively facilitate group process at the committee level. Certainly committees with at least one participant with strong facilitation skills tended to have an easier time understanding their charge and accomplishing their tasks. Yet even that was sometimes not enough. Even with experienced facilitators among its membership, the Resource Allocation Committee struggled over several months to understand, bound, and protect their mission, and to develop recommendations from which the Working Group could make decisions.

Given the responsibility lodged at this level, many planning participants feel that the committees would have benefitted from professional facilitation. Considerable meeting time was spent in committee meetings, and most committees held numerous conference calls or subcommittee meetings between Working Group meetings. In evaluation activities, many participants suggest that support was particularly needed with group process issues such as staying on task, managing time, dealing with domineering individuals, and the importance of attention to both task and group maintenance.

Conflict of interest

One area which remained problematic throughout the Community Planning Process was conflict of interest. With over 50% of the Working Group receiving state funds for prevention or education programs, and all participants having strong alliances with particular communities or perspectives on AIDS, it was clear that conflicts would arise as Community Planning members moved from advocating for particular groups to "global advocacy" for HIV prevention in California. In the words of an Advisory Group member, "[The epidemic has] trained people to be passionate advocates" but when voting on specific allocation formulae, advocacy and representation present significant conflict of interest.

Anticipating the importance of this issue, OA and the Advisory Group made sure that conflict of interest was presented and discussed at several Working Group meetings. In addition, OA staff sent the *Community Planning Handbook* to all planning participants, with a letter asking them to read and adhere to its guidelines on conflict of interest. However, many felt that conflict of interest took on new meaning and importance towards the end of the planning process when the Resource Allocation Committee could not reach consensus. At that point, discussion of specific formulae and allocation procedures came back to the Working Group, with significant funding implications for many who had to vote and for some Advisors. Planning participants saw individual group members wrestle with decisions that would affect their own programs, constituents, or contracts in very immediate ways. These conflicts of interest generated their own discomfort and resentments among participants, and may have influenced the content and implications of the HIV Prevention Plan.

In hindsight, many planning participants feel that they did not grasp the importance of the early conflict of interest discussions until the very end of the planning process. Knowing what they now know, most suggest that conflict of interest needs even greater attention in future planning efforts. Specific recommendations, made from individual members in evaluation interviews, include:

a) More public and full disclosure of sources of funding and individual relationships to state contracts;

b) More explicit ground rules identifying when members should excuse themselves from voting;

c) Specification of conflict of interest procedures in a signed letter of commitment from both Working and Advisory Group members;

d) Facilitated simulations of conflict of interest dilemmas and options before facing a vote in which conflict of interest may be present.

Was a common baseline established for planning participants?

Several formal attempts were made to establish a common baseline for planning participants. This was not a simple task, due to the nature of the group, the different perspectives and backgrounds represented, and the various cultural dynamics present. However, each of the activities contributed to establishing a common base from which participants could engage each other and engage in the tasks at hand. Two particular efforts, representing different approaches to different baseline markers, are examined below. These examples are selected for their impact on the subsequent planning process and the specific recommendations they elicited from participants.

Quienes Somos

Creating a viable working group requires cultivation of a group norm of mutual respect. One of the most valuable efforts towards this end was an exercise, *Quienes Somos*, introduced during an early Working Group meeting. The purpose of this exercise was to establish a common baseline of trust and sharing among participants. All participants were invited to answer a series of questions on large sheets of paper (i.e., Where did you grow up?, mother and father's names, languages spoken, sexual orientation, age, personal motto and logo, message to the world). Each participant's sheet was posted on the walls, while the group mingled, reading the comments, and then later asking questions of each other.

The exercise effectively brought forward elements of diversity and commonalty among group members in ways that were not necessarily obvious. Perhaps more importantly, the exercise established a common norm of trust, sharing, and heart-felt expression among those who participated. The exercise also provided sentiments to which the group was able to return at several key points in the planning process. For example, the messages to the world were revisited during the last Working Group meeting as one way of honoring the passion and wisdom of group members.

During evaluation interviews, many Working and Advisory Group members recalled the *Quienes Somos* exercise as being a key activity of the planning process and central to establishing a common base for participants. Many recommend continued incorporation of this kind of group development activity throughout the planning period.

Epidemiology as evidence

Another example of the importance of establishing a common baseline centers on the assumed basis for decision-making. Working Group members were selected and brought together because of the multiple perspectives they represented. Their instructions were to be open-minded, to learn, and to judge what they learned based on their own values. However, participants were also told to base their decision-making on evidence. Herein lies a difficulty.

For although diversity of perspective was assumed, it was also assumed by many Advisors and OA staff that once exposed to the epidemiologic data, a common baseline would be established. It was not to be that simple.

A significant amount of time at the second Working Group meeting was devoted to establishing the epidemiologic profile - the assumed common baseline for decision-making. Office of AIDS epidemiologists presented over six hours of surveillance and special study data on the AIDS epidemic in California. Their information fit the requirements of the *Guidance*, providing an overview of methods, an outline of findings, and identifying areas of future data collection. This information was essential, both to meeting the requirements of the *Guidance* and to familiarizing planning participants with the methods and results of HIV/AIDS data collection. Unfortunately, the data were presented in a way that was not particularly well-received by many Advisory and Working Group members.

The conflict arising from this session can be viewed as an example of cultural miscommunication, predictable in participatory community planning. Despite coaching from OA staff, the epidemiologists presented their information in the style common to scientific reporting. They presented a tremendous amount of data, supported by detailed overheads and text. Their remarks stayed within the parameters of their methodology. For the most part, they did not comment on the broader sociopolitical nature or implications of casefinding or surveillance methods.

Viewed from the perspective of a scientific meeting, this approach to presentation of data is both expected and necessary. However, this was not the perspective of many Working Group members. Indeed, many felt very strongly about being gathered together to sit for many hours, being "lectured at" about numbers that they knew to tell only part of the story of HIV in California. In subsequent evaluation surveys and interviews, many expressed their confusion at some of the terms being used, their own inexperience with this kind of analysis, and the accumulated frustration of not seeing what they know to be true in their communities reflected in the numbers used to officially define the epidemic. Others felt resentment at being brought together as experts, only to be expected to sit by while "the real experts" described the epidemic they already know. Many were suspicious of a meta-message demanding group support of the status quo. In subsequent meetings, qualitative studies and focus group reports would be presented to the Working Group. However, many participants were disturbed by what they perceived as the discrepancy between instructions to use a broad definition of evidence and the amount of time devoted to what they saw as one very limited type of evidence at the expense of time and attention to other ways of knowing.

One of the greatest concerns of many participants who watched these dynamics unfold was that Working Group members would reject the message of the epidemiology presentations as adamantly as they rejected the methods. To the credit of Working Group members, this was not the case. Although participants cited a broad range of information sources in their

daily work, almost everyone cited the epidemiology data as an important source of their decisions and final votes.

Although the epidemiology presentations happened early in the planning process, they were still on the minds of many planning participants several months later. During evaluation interviews, the following suggestions were offered as ways of mediating the conflict between ways of knowing about the AIDS epidemic:

a) Locate epidemiologic information in a broader context of evidence about HIV and AIDS from the beginning of the planning process;

b) Begin the epidemiology presentations with more interactive, new-user-friendly methods that define terms, articulate assumptions, and acknowledge limitations of this kind of evidence;

c) Present the epidemiology data using the skills and format of adult training, rather than scientific reporting;

d) Utilize as much Working Group expertise as possible in the planning and presentation of data;

e) Structure sessions that interweave different kinds of evidence, i.e., ethnographic studies, focus group reports, anecdotal accounts, and surveillance data.

Given the centrality of the epidemiologic profile in the CDC framework for community planning, and the subsequent transfer of a planning requirement to the local level in California, these suggestions make an important contribution to future community prevention planning.

Was the prioritization of needs based on an epidemiologic profile, resource inventory, gap analysis, and research on target populations?

The prioritization of needs for HIV education and prevention was based on the epidemiologic profile of HIV/AIDS in California; a review of present sources and trends in HIV prevention funding; the results of research on the needs and concerns of additional populations, and the Working Group's analysis of the gap between needs and prevention programs. This process was enhanced by the presence of several researchers and epidemiologists in the Working Group, the expertise of OA epidemiologists, the clearly specified expectation in the CDC *Guidance*, and the development of structured and systematic steps for the Working Group's decision-making.

Epidemiologic profile

Epidemiologic data on the present and future extent, distribution, and impact of HIV/AIDS in California were examined by the Working Group during the second CPP Meeting, May 5-6, 1994. The importance of the epidemiologic profile in an evidence-based planning process was emphasized by the decision by OA and the Advisory Group to make this the Working Group's first formal presentation and to allocate over five hours on the agenda for this topic. During the formal presentation, an Epidemiology Committee Working Group member presented an overview of key terms and the role of epidemiologic data in prevention planning. Epidemiologists from OA provided an extensive description of state epidemiologic data, including AIDS case data, results of serologic monitoring studies, HIV testing data, and relevant information from other data sources. There was an opportunity for questions and answers between Working Group members and the epidemiologists following the lecture-style presentations. The presenters distributed numerous handouts for Working Group members' later reference, including over 100 pages of HIV/AIDS data. A discussion of the data was included in the agenda for the second day of this meeting, and epidemiologic updates were provided to participants as available or requested throughout the planning process.

The epidemiologic profile was intended as a central and common reference point for Working Group members when later prioritizing needs. Results of the evaluation survey conducted immediately after the second meeting suggest that most Working Group members would be able to use the data as intended. Nearly all (90%) respondents felt that they at least partially understood the HIV/AIDS epidemiologic profile; 60% felt that they substantially or fully understood the data. Most (83%) either substantially or fully understood the epidemiologic terms used to describe the epidemic, and 75% at least substantially understood the strengths and limitations of the data in terms of HIV prevention planning.

Public comment

The concerns about basing decisions on a more complete picture of HIV in California led to the Working Group's decision to actively investigate the needs and concerns of as wide and varied a group of populations as possible. Two of the five questions previously developed as guidance for public comment addressed population needs ("What communities are not being served, or are underserved, by HIV education and prevention efforts in California?" and "What HIV education and prevention needs are not being addressed in your community and why?"). These questions were further explored during the question and answer period of each public comment session. Evaluation survey results indicate that Working Group members found these exchanges useful. For example, nearly all (93%) respondents said that by the end of the second meeting they at least substantially understood the education and prevention issues/problems presented by the public during the public comment period. A written comment expressed the opinion that public comment provided "excellent community input of unmet needs".

Multicultural Liaison Board

The entire Working Group also heard reports from OA's Multicultural Liaison Board (MLB) at the second and fourth meetings. A written summary of their prevention recommendations was distributed to all Working Group members at the San Diego meeting in July. The information was intended to add to Working Group members' understanding of HIV prevention needs in California for persons of color. Following the presentation at the second meeting, most (81%) evaluation respondents said that "they understood the role of the Multicultural Liaison Board" in the planning process.

Other needs assessment

The epidemiologic profile, public comment, and MLB report were supplemented by the activities of the Working Group's Other Needs Assessment Committee. This committee began with the results of the brainstorming small group sessions at the first Working Group meeting, in which small groups identified populations about which little is known but which should be considered in any analysis of HIV/AIDS in California. With substantial technical support from the planner, the Committee reviewed a number of significant reports, abstracts, and annotated literature summaries, including an annotated literature review of relevant journal articles on prevention needs prepared by the planning firm and cross-indexed by target population; selected abstracts from the University of California's AIDS Research Program (UARP); a summary memo from the planning firm on special needs of selected target populations; an OA report on surrogate marker status, and a mathematical model, developed by a Working Group member who is also a researcher, that estimates the effect of prevention spending on the number of future HIV infections for specific populations.

As a result of their analysis, the Other Needs Assessment Committee identified the need for five focus groups with populations traditionally under-represented or miscounted in the epidemiologic data: 1) Asian/Pacific Islanders, specifically men who have sex with men and male sex industry workers; 2) American Indian youth, ages 12-22, both in and out of school; 3) Migrant and seasonal farm workers; 4) Multi-ethnic women, including lesbians, bisexual women, and women who do not consider themselves to be at risk for HIV, and 5) the transgender community. These recommendations were presented to the Working Group at the third meeting, and accepted with minor modifications of location. The five focus groups were convened and conducted by the planning firm before the next meeting. Both oral and written reports were presented to the full Working Group at Meeting #4. Following the presentation, 75% of evaluation survey respondents indicated that they substantially or fully understood the findings of the focus groups.

Resource inventory

The identification and prioritization of needs was also based on the understanding of current prevention resources in California. The range and type of HIV prevention programs

and funding sources were first discussed by the Working Group at the second meeting, May 5-6, in Long Beach. An inventory of funding sources to the state, counties, cities, and community-based organizations was presented to the full Working Group by OA staff. The presentation described in detail the Education and Prevention (E&P) Program funded through state and federal resources in California. The four primary areas of focus of E&P priority interventions were described, and additional sources and trends in education and prevention funding were presented. A variety of programs were highlighted, including street and community outreach programs, community outreach worker training programs, risk reduction programs, and community intervention programs. Later in the meeting, the allocation and flow of HIV-related dollars from the CDC to different agencies throughout the state was described by OA staff.

The complexity of the funding mechanisms and overlapping bureaucratic systems is reflected in the responses to the evaluation survey following the first presentation of HIV prevention resources. At that point, roughly half of respondents felt that they understood the resources currently available. Specifically, 58% at least substantially understood HIV prevention funding sources and trends in California; 52% either substantially or fully understood the HIV prevention funding sources to the State, counties, cities, and CBOs, and 46% at least substantially understood the range and types of HIV prevention in California. In an effort to clarify the resource inventory, additional resource information was brought to the Working Group throughout the next meetings by OA staff, advisors, or Working Group members.

Prioritization of needs

Based on extensive deliberation of all of the above sources of information (the epidemiologic profile, public comment, other needs assessment data from research on target populations, and the resource inventory), the Other Needs Assessment Committee analyzed gaps in services and identified 13 recommended (but unprioritized) target groups. Their report was presented to the full Working Group at the fourth meeting, discussed and slightly modified, and then approved as modified by majority vote.

Prioritization of needs occurred between the fourth and fifth meetings as Working Group members "cast their votes" among identified populations and identified needs through worksheets prepared and analyzed by the planner. In correspondence accompanying the mailed worksheets and personal calls to each Working Group member from an Advisory Group member or the planner, voting members were reminded to weigh all of the available evidence when making their decisions. Worksheets were returned to the planner, individual scores were compiled, and means scores calculated for each population and priority needs by population. The results were presented to the Working Group at the fifth meeting, where they were discussed and endorsed.

There is no doubt that considerable epidemiologic evidence and information about needs and resources were made available to the participants throughout the planning process. The Working Group was clearly committed to extending that data base to include information about populations and needs that members felt are often undocumented or discounted in other policy-making forums. It is not possible to reconstruct the relative weights that individual members gave to the various types of information that they received. However, review of the CPP documents and evaluation interviews clearly indicate that Working Group members approached the prioritization of needs after lengthy exploration and discussion of the available information within the designated timeframes; deliberated with respect, empathy, and sometimes advocacy for those whose needs are often unrecognized, and cast their votes with clear recognition of the importance of their decisions.

Was the prioritization of interventions based on a list of unmet needs, effectiveness, cost-effectiveness, theory, and community norms and values?

The prioritization of interventions was based on the prevention strategies framework identified by the Prevention Strategies Committee and endorsed by the Working Group; the priority needs determined by the Working Group, and the criteria recommended by the Priority-setting Criteria Committee and endorsed by the Working Group. Effectiveness, cost-effectiveness, theory, and community norms and values were considered in the research and prioritization process. This effort was enhanced by clear expectations in the *Guidance*, the availability of data, the carefully structured and systematic steps for Working Group decision-making, and the inter-relationships of the work of several committees.

Identification of prevention strategies and theories

The initial exploration of prevention strategies was the responsibility of the Prevention Strategies Committee. The Committee began by carefully reviewing the *Guidance* to establish the scope and focus of their assessment. The Committee developed a matrix of HIV prevention and education strategies categorized across four levels of intervention: individual, one-on-one, group, and statewide programs. Between the second and third Working Group meetings, Committee members individually gathered and reviewed literature and other information on strategies and interventions, using the matrix to organize their findings. Information from the resource inventory, public testimony, and the relevant sections of the *CDC Handbook for HIV Prevention Planning*, was incorporated into the growing list of strategies within the matrix.

In accordance with the *Guidance,* the Committee wanted to ensure that their analysis of prevention strategies was based on a wide-reaching and systematic assessment of what works, and what doesn't, with particular target populations in California. At the third Working Group meeting, the Committee designed a survey instrument to be sent to all state-funded HIV Education and Prevention contractors. The results of the survey, administered and compiled by the planning firm in June 1994, provided additional information on the range of specific

strategies and interventions currently available. Survey results were compiled in a table displaying, for each strategy, the intervention level, priority target group, number served, location, reported effectiveness, type of evaluation, and any available information about cost or cost-effectiveness. Results were made available to Committee members and incorporated into the matrix.

Upon the request of the Committee, the planning firm also designed, implemented, and analyzed a survey of the HIV prevention programs of 12 state agencies. The subsequent report described the range, intervention level, target population, strategy, and evaluation approach (or findings) for the HIV prevention programs of the 11 responding agencies. The summary report was distributed to Committee members and the full Working Group at the fourth CPP Meeting in July.

Analysis of effectiveness

With significant technical assistance from the planner, additional research on effectiveness and cost-effectiveness (where available) was reviewed and analyzed by the Prevention Strategies Committee. The Committee reviewed key outcome and impact evaluation research, including an annotated bibliography of related journal articles on HIV prevention strategies; a comprehensive review of the empirical literature on outcome and impact of HIV prevention programs; a taxonomy of HIV prevention strategies; the Executive Summary of the Report on the Public Health Impact of Needle Exchange Programs; a review article of published evaluations o counseling and testing programs; an evaluation of the National AIDS Demonstration Research Program targeting out-of-treatment IVDUs; an article on prevention issues for women and people of color; a selected summary of CDC HIV prevention projects; and the mathematical model developed by a Working Group member that shows the effect of prevention spending on the number of future HIV infections for specific populations. Effectiveness of prevention strategies was explored with Working Group members and individuals providing public comment at the second, third and fourth meetings.

Community norms and values

The literature review, report of the Multicultural Liaison Board, and Working Group discussions provided important information on appropriate and effective strategies for particular populations. Public comment testimony was particularly valuable in this regard. One of the suggested guidelines asked participants to address "HIV education and prevention strategies/interventions [that] would work in your community". The subsequent testimony, and the interaction during the question and answer period with Working Group members, brought forward strategies, methods, and activities that are culturally and/or linguistically appropriate for a wide range of target populations. Committee members also drew on their own expertise to add interventions at each level of the matrix that would be appropriately responsive to diverse community norms and values.

Prioritization of interventions

The Prevention Strategies Committee found that the results of their own assessments fit well with the interventions and strategies suggested in the *Guidance*. To ensure that strategies were included for populations at greatest risk, the Committee reviewed the matrix one last time, checking each target population against very practical intervention criteria, such as availability, settings, and effectiveness. The results of this analysis, and all of the other assessments performed over the previous months, were synthesized by the Committee members as they developed a final list of unprioritized strategies and interventions. In conjunction with the planner, the Committee also developed a set of 11 factors to be considered when rating interventions (i.e., sound scientific theory, cultural appropriateness, links to secondary prevention). Both lists were presented to the Working Group as a conceptual framework for prioritizing HIV prevention strategies and interventions for California. The framework was presented, discussed, and adopted by majority vote of the Working Group at the San Diego Meeting, July 13-15.

Prioritization of interventions was determined at the fifth CPP Meeting in August 1994. Based on the Working Group's adoption of the criteria developed by the Priority-setting Criteria Committee, Working Group members filled out a detailed worksheet in which they voted for strategies for each priority need. In the worksheet, each voting member applied the priority-setting criteria to the list of needs, for each potential strategy. The weighted criteria included demonstrated or probable outcome effectiveness, demonstrated or probable cost effectiveness, congruence with the values, norms, and consumer preferences of the communities for whom the intervention is intended; the availability of other resources for HIV prevention, and the perceived HIV prevention need based on current or projected impact of AIDS on identified target populations. The result of the voting was a portfolio of prioritized HIV prevention strategies for identified but unmet needs in California.

In retrospect, it is impossible to determine the degree to which Working Group members relied on the evidence when prioritizing strategies and interventions. Member accounts and minutes of the meetings of the Prevention Strategies Committee indicate that they worked very hard to make sure that their analysis was thorough, systematic, and based on what was known about what strategies work with different populations. The directions to the Working Group regarding voting for strategies reminded members to use all of the information available to them, including the significant amount of scientific evidence provided by the planner, the public comment testimony, and their own personal and professional expertise. However, as with prioritization of need, all evaluation data underscore the serious and respectful manner in which Working Group members approached the task of prioritizing interventions.

How were the group deliberations transformed into a written prevention plan?

Transformation of the group deliberations into a written prevention plan was enhanced by the early decision to organize Working Group committees by the elements required of the document (i.e., Epidemiologic Profile, Target Populations, etc.). This decision helped participants see the linkages between their work and the work of the other committees throughout the planning process. It also helped participants see the relationship between the documents and recommendations coming from the committees and the first draft of the Prevention Plan.

The planner's involvement in all phases of the planning process was crucial to the transformation of the group deliberations into a written document. She worked closely with the Advisory Group, OA staff, and facilitators to establish a set of nested decisions that had to be made in order for her to begin writing the plan. Her growing certainty of what needed to be done provided leadership and grounding for other participants who, new to this kind of planning, sometimes felt uncertain of the ultimate outcome. This framework of linked decisions enabled even overwhelmed participants to mark the group's progress towards a complete plan.

The decision framework also made it very clear that certain decisions, no matter how hard, could not be delayed beyond specific dates if California was to complete its Draft Plan by the October CDC submission deadline. The framework and the deadline became increasingly powerful forces in determining the number, content, and focus of Working Group meetings. Indeed, many participants felt strongly that the related needs to reach closure on key decisions and to meet the submission deadline required attention to task at the expense of group development and maintenance. However, the Office of AIDS felt strongly that the deadlines and expectations both could and should be met on time. Despite the expense, OA staff were willing to schedule and support additional Working Group meetings to ensure that the Plan was the result of a participatory group process. The planner balanced firm guidance with flexibility as the Working Group struggled to complete difficult deliberations. Close and clear communication with the planner and OA staff enabled the facilitators to efficiently guide the Working Group through the necessary decisions.

As the CDC-required decisions were made, the planner took the Working Group decisions, literature and research reviews, committee documents, and notes from Working Group meetings, and transformed the work of each committee into a chapter in the Draft Plan. In many cases, high quality committee work facilitated this process. If the planner was unsure of the intent of the group or interpretation of a decision, she conferred directly with the appropriate committee or OA staff member. The planner, Research Assistant, other planning firm staff, and OA staff members worked intensively after the Working Group meeting in which final decisions were made to finalize the nearly 400 page document. Office of AIDS staff copied and distributed the Draft Plan by the agreed upon schedule, enabling each Working and Advisory Group member to receive a personal copy of the document as soon as

it was completed. Results of an evaluation survey illustrate planning participants' excitement when they saw the Plan for the first time. Frequent comments include...."I was thrilled!", "Unbelievable!", and "It made me weep to see what we had accomplished!".

Participants were invited to read the entire Plan but were specifically asked to carefully review the chapters related to the work of their own committees. At the next Working Group meeting, the planner chaired a session in which the Plan was reviewed chapter by chapter. The planner took all comment and correction, and incorporated it into the next version. Working Group members' clear understanding of the decisions they had made, their comfort with the planner, the close correspondence between committee wording and text in the Plan, and the planner's open attitude towards suggested revisions contributed to a smooth review process.

Summary: Strengths and challenges

In summary, the transformation of group deliberations into a written prevention plan was enhanced by:

1. The clear delineation of decisions to be made at each Working Group meeting.

2. The Office of AIDS willingness to support additional meetings as needed.

3. The participation of the planner in all Working Group meetings, and frequent committee consultation.

4. High quality committee work.

5. The facilitators' guidance of the group process to ensure that decisions were made by specified deadlines.

6. The planner's skill and professional leadership throughout the planning, writing, review, and revision of the document.

7. The commitment of the Office of AIDS staff to produce the Draft Plan in its entirety by the established deadlines.

8. Circulation of the entire Draft Plan to all Community Planning participants for review and comment.

9. The inclusion of an open review session before submission of the Draft Plan as part of the *CDC Cooperative Agreement Application*.

Challenges to the transformation of the group deliberations into a written prevention plan included:

1. The short amount of time between final decision-making and completion of the Draft Plan for the October 1994 *CDC Cooperative Agreement Application*.

2. The need for considerable work by the planner, OA staff, and some committees between meetings in order to gather and review information and prepare for group decision-making.

3. The competing needs for group maintenance and completion of tasks during increasingly pressured Working Group meetings.

4. The "newness" of the task for many planning participants.

In summary, archival review, observations, interview and survey data clearly indicate that each of the challenges to this part of the Community Planning Process was met. All participants did their part, even when those parts required significant personal sacrifice and hard work under tense circumstances. The result was California's first comprehensive plan for HIV prevention and education.

Outcome Evaluation Findings

Did the Planning Group coalesce into a productive working unit?

The Community Planning Working Group coalesced into a respectful and productive working unit. Despite numerous challenges, including their own diversity, the short time frame and newness of the task, the pressures on individuals outside of the group, and the strains of a long and uncharted planning process, the 55 Working Group individuals became a group with emerging norms, a common orientation to task, the capacity to learn from its mistakes, and pride in its accomplishments.

Group norms

Norms quickly emerged from the group that brought the term "respectful engagement" to life. Attendance at meetings was high, with participants staying at the table throughout presentation and discussion. Participants respected the facilitators and each other in their public comments. The common base of experience and purpose was reinforced with the moment of silence beginning most sessions. The commitment of the group to a long view of HIV prevention planning emerged early on, and was reflected in their efforts to be involved in implementation oversight. Although some members continued to wonder if their involvement was nothing more than "political cover" or "rubber stamping" sensitive allocation of

inadequate prevention dollars, the group agreed on the importance of their deliberations and continually sought ways to facilitate respectfully engaged group process.

Task orientation

One of the hallmarks of the Community Planning Working Group was its orientation to task. Led by the Office of AIDS staff and the planner, and guided by the facilitators, the Working Group attended to business. Meeting time was devoted to meeting. The group generally met from 8:00 or 9:00 a.m. until 5:00 p.m., with short breaks and a one hour, on-site lunch. Committees often met in the evenings before or during the meeting, and between meetings on conference calls or subcommittee groups. Presentations by committees to the larger Working Group were handled in a professional manner, with significant advance preparation. Most members maintained this attentive behavior throughout the scheduled five months of Working Group meetings and into the extended sessions necessary to finalize the Prevention Plan.

Learning from mistakes

Enhancing the group's productivity was its ability to learn from its mistakes. Numerous examples exist of self-correcting behavior by individuals or small groups: from relatively small but aggravating disagreements over the difference between points of clarification and discussion, to learning and respecting proper terminology. One of the most significant moments in the group experience came when the Resource Allocation Committee returned from a very difficult and contentious presentation to face the group with humility - and a new set of recommendations. Their humble and gently humorous way of asking the group's forgiveness for their previous confusion modeled the continual learning and renewal so necessary for group deliberations on complex issues. Similarly, planning participants' response to the presentation of evaluation results displayed an ability for learning and self-examination that served it well in the work it was convened to do.

Pride in group accomplishment

One of the characteristics of a productive working unit is pride in its process and product. Working Group members displayed both in their demeanor during meetings and in their responses to evaluation inquiries. When the draft plan was completed, fully 100% of the respondents to an evaluation survey said that they were proud of the work that they had done, and almost everyone (87%) said that they were proud of the work of the Working Group.

Learning to live respectful engagement

Planning participants met many of the group challenges; others they continued to struggle with. Living "respectful engagement" was not always easy, particularly given the diversity of perspectives and interests represented in such a large group. At various points,

frustrations emerged, flashpoints flared, untempered actions caused reactions, and lines of communication [were] too frequently scrambled.

Two specific examples of the challenge of living respectful engagement are examined below. These examples are selected for their recurring nature, their impact on the group process, and their origin in the scope and mandate of the Community Planning Process.

Imagining the future

The California planning group's movement into resource allocation and implementation of the Plan introduced dynamics which challenged and may eventually strengthen HIV prevention planning and programs.

Although strongly supported by the Chief of the Office of AIDS, the Working Group's actions beyond the CDC mandate raised questions among other OA staff members regarding professional boundaries, authority, and ultimate responsibility for state prevention efforts. These concerns persisted over a period of several months. Attempting to abide by the wishes of the Working Group, while uncertain of the appropriateness or viability of the new directions, led some OA staff members into seemingly incomplete or contradictory reactions. This was particularly noticeable in regard to ad hoc initiatives and subgroup meetings that were closed to OA staff.

Perceiving mixed messages from the Office of AIDS, many Working and Advisory Group members became even more vigilant about the importance of monitoring implementation. Long-standing patterns of mistrust and suspicion re-emerged, fueled by each new development in this uncharted part of the process. Working beyond the CDC mandate and without the *Guidance* as a common reference point, the differences and distrust between players escalated. Unresolved, these differences, peripheral to the initial planning mandate, became issues in their own right. However, when addressed and resolved respectfully, these differences led to new insight and understanding among stakeholders who must continue to work together in future prevention efforts.

Close observation, survey data, and extended conversation with most planning participants clearly revealed the deeply felt emotions that these rifts unleashed, and the universal desire to be understood and appreciated by the others. A greater investment in careful monitoring of group dynamics, including professional facilitation of subgroup meetings, might have enhanced this unique opportunity to learn respectful engagement under very difficult circumstances.

Living with HIV

Another area of unresolved engagement is based in the diversity of the group itself, specifically its inclusion of people living with HIV. Without naming it specifically, planning

participants struggled with how to work against almost impossible deadlines and protect the health of its members. The group's commitment to task posed barriers for some who wanted to participate but physically could not work from 8:00 - 5:00 and then again in the evening until nearly midnight. Similarly, same-day travel to the meeting site for an 8:00 a.m. start time was prohibitive for many, as were the 7 or 8 hours of sitting at a table with poor hotel lighting, uncomfortable chairs, and only brief breaks.

In the pressure to meet the deadlines, and the sometimes exuberant rush of collaborative work, the Working Group frequently established routines and expectations that were nearly impossible for people living with HIV. In the early stages of group formation, these barriers were dealt with privately as individuals struggled to be like the others. But as the stakes got higher and the decisions more important, people began speaking out. Future planning efforts will benefit from attention to the strain and demands of participation, particularly on those living with HIV and AIDS, and the subtle ways in which individuals may be excluded from the process by the emerging culture of the planning group.

Respect and celebration of the group

Despite the challenges to group coalescence, community planning participants frequently demonstrated respect for each other and their emerging group identity. The Office of AIDS allocated funds to support each Working Group member's full participation in the planning process. They nurtured group identity with CPP binders and tote bags at the first meeting, a party when the Draft Plan was approved, and certificates and paperweights to all participants at the last Working Group meeting. The logistics coordinator worked hard to learn about and anticipate the individual needs of planning participants, particularly those with HIV. For example, bottled water, something hot for lunch, fruit at breaks, refrigerators in the rooms, and nearby pharmacies were all factored in to the selection of meeting sites and schedules. Similarly, group members supported each other in numerous formal and informal ways. The Co-Chairs' vigilance in honoring participants too ill to be the table, and the member who passed away during the planning period, solemnly reinforced the growing bonds between many participants. And at key times in the planning process, individual members would publicly encourage the group in its work, acknowledging how hard it was and how far they had come, and reinforcing the higher purpose to which they were all committed - stopping the AIDS epidemic.

Was the Planning Group able to develop a Prevention Plan?

The first draft of the Prevention Plan was completed and mailed to all planning participants in mid-September 1994. The draft did not include recommendations on resource allocation or implementation, as the work of the Resource Allocation Committee and the Ad Hoc Committee was not yet completed.

The nearly 400 page Draft Plan was reviewed at the September Working Group meeting and reproduced with agreed upon changes for the October 3, 1994 CDC submission. Public hearings on the plan, held in November in seven sites around the state, generated additional suggestions. The public testimony was discussed at the next and final Working Group meeting. When appropriate, minor text changes were made based on questions raised in the hearings. At that meeting, the Working Group was able to vote on the final recommendations of the Resource Allocation Committee, which included the preliminary work of the Ad Hoc Committee, and to hear selected evaluation results. The final version of the Plan was completed during the final two weeks of December, incorporating resource allocation, implementation, and a draft of the Community Planning Process evaluation. The evaluation was finalized _____ and added to the Plan on _____. Copies of the complete HIV Prevention Plan were mailed to CDC and to all planning participants _____.

Was the HIV prevention funding application based on the Prevention Plan?

The October 4, 1994 prevention funding application was based, to the degree possible, on the *California HIV Prevention Plan*. The plan that was submitted with the application was the draft, subject to modification following public hearings and the final meeting of the Community Planning Working Group. The Plan has since been finalized. Its recommendations will be incorporated into state prevention programs beginning with the July 1996 funding cycle.

The gap between the application and implementation is due to discrepancies in the funding cycles of state and federal prevention programs. The CDC operates on a calendar year, the state on a fiscal year schedule. The Office of AIDS has already committed prevention dollars to two-year contracts (July 1993-June 1995). Initially, it was thought that recommendations from the Plan would be operationalized in state contracts as of July 1, 1995. However, the extended deliberations of the Resource Allocation Committee led to the recommendation that local jurisdictions be given a one year start on implementing their own community planning process. As a result, OA is considering extending the current two year Education and Prevention contracts for another year, while allocating the money necessary for local areas to gear up for their own planning processes as of July 1995. This means that the recommendations in the *California HIV Prevention Plan* would become operational as of the new contracts beginning July 1, 1996.

Is the Plan a useful document?

The HIV Prevention Plan will be of immediate use within the Office of AIDS. It will also be useful in a number of other settings.

The Plan represents the culmination of four years of effort to bring stronger community participation to the Prevention and Education Section of the Office of AIDS. The methodological descriptions provide a template for future community planning efforts.

The *Prevention Plan* establishes a framework for future OA prevention and education priorities, initiatives, and programs. Its requisite chapters outline the epidemiologic profile, analyses of target populations and prevention strategies, resource inventory, and recommendations. As such, it can be used to educate others within state government about the core HIV prevention issues identified by the Working Group. The recent designation of the Office of AIDS as lead agency for AIDS extends the reach of the document and the scope of its potential influence.

The Plan clearly lays out the purposes, steps, findings and recommendations of the Community Planning Process. It will be a useful guide for local communities about to commence participatory planning for their own jurisdictions, as well as for other states continuing their statewide planning efforts. The Plan can also be used by state agencies engaged in community planning on other topics.

The HIV Prevention Plan will be of interest to a wide range of scholars, policy makers, and researchers, in addition to HIV educators, advocates, and constituent groups. As a public document, the Plan will be available through the Office of AIDS. At over 400 pages, OA may find it useful to distill the complete Plan into an executive summary, or some other shortened format for wider dissemination.

Is the public aware of the Plan?

Public participation was an important component of the Community Planning Process. Although there is currently no complete measure of public awareness of the Plan itself, there are indicators of public awareness of the planning process, the Plan, and their implications for HIV education and prevention in California.

Public involvement was built into the selection of Working Group members. The signed letters of commitment specified members' pledge to "gather community input regarding HIV prevention needs and priorities; distribute information to community groups; and to represent the Community Planning Working Group at community meetings". Numerous anecdotal accounts describe the ways in which Working Group members acted as a bridge between the needs and priorities of their communities and the Community Planning Process. All meetings of the Community Planning Working Group were open to the public. In addition, individuals who were nominated but not selected for either Advisory or Working Group membership received a letter from the Office of AIDS inviting their involvement on an ad hoc basis.

The Community Planning Process itself was structured as a vehicle for open and participatory planning by the wider body of interested parties throughout California. All Working Group meetings were open to the public. Meetings were held in different parts of California in order to provide maximum public input. The selection of cities was guided by criteria including easy access and ability to draw from large and diverse groups of people. Public comment was structured into the agenda for 90 minutes at each of four Working Group meetings (Long Beach, Redding, Fresno, and San Diego), with an additional 30 minutes of dialogue between planning participants and the individuals offering public comment. Groups and individuals in each local area were also invited to provide written testimony. A total of 200 individuals provided public comment over several hours of formal CPP meeting time.

Public hearings were held in November in seven cities in California (an eighth was scheduled but cancelled due to weather conditions). Hearings were held from noon until 7 or 8:00 p.m., and attended by two Office of AIDS staff members. Both Working Group and Advisory Group members were encouraged to attend; at least one was present at all public hearings. The public turnout at the hearings was surprisingly low, given the interest that Advisory and Working Group members had heard through their own networks. Reasons for the low turnout include concurrent scheduling with the San Francisco hearings, a major funding proposal deadline in Southern California, the beginning of a three day weekend, and bad weather.

There are several informal indications that the public is becoming aware of the *California HIV Prevention Plan.* Over 2,000 copies of the Draft Plan were disseminated by OA to state Education and Prevention contractors, service providers, community based organizations, and other interested parties. OA staff have received dozens of calls from local health jurisdictions, CBOs, and other providers of education and prevention services inquiring about the plan and its implications for their programs. The most urgent questions seem to be 1) How do I get money to continue my programs, and 2) Do we have to do local planning? How will we do it? When do we start?

OA plans to mail the final version of the *California HIV Prevention Plan* to all who received the Draft, all Community Planning participants, and all other interested parties in _____ 1995. Subsequently, the Plan will continue to be available to the public upon request of the Office of AIDS.

Are there plans for implementing the HIV Prevention Plan in California?

The *California HIV Prevention Plan* has been accepted by the Office of AIDS as a part of their guidelines for future decision-making regarding resource allocation, priorities, and special initiatives. OA intends to use the Plan as an internal document, incorporating as many of the recommendations as possible into future HIV education and prevention efforts.

Some of the specific recommendations (i.e., needle exchange, services for everyone regardless of immigration status) are at odds with the policies of the current state administration. This will inevitably limit OA action on these particular recommendations. However, Office of AIDS staff intend to support the Plan as the work of the Community Planning Working Group and to promote and implement as many of the recommendations as possible. Over the final months of the planning period, OA staff became increasingly involved in the deliberations of the Resource Allocation Committee. This helped narrow the distance between the Plan's recommendations and what the Office of AIDS, the Department of Health Services, and ultimately the governor, can and will support.

Some concrete commitments have been made that verify OA's intention to honor as many of the Plan's recommendations as possible. These include:

1. Inclusion of a request for $350,000 to continue the statewide Community Planning Process in the October 4, 1994 *CDC Cooperative Agreement Application.*

2. OA support of the Working Group's recommendation that 20% of the $5 million augmentation be dedicated to support local community planning efforts (currently pending in the Department of Health Services).

3. OA verbal commitment to continue the Community Planning Process in accordance with the Working Group's final recommendations on continuation.

It must be noted that the Office of AIDS is bound only to consider the recommendations of the Community Planning Process. However, OA staff have repeatedly stated that it is their intention to implement as much of the plan as they possibly can, within the constraints of their budget and the policies of the current administration.

Impact Evaluation Findings

What were the costs of the community planning process?

Participatory community planning in a state as large and diverse as California was costly. Significant resources, including dollars, time, and in-kind contributions, were dedicated by many participants to ensure that the planning process had adequate support.

Financial costs

The Office of AIDS allocated at least $650,000 to the Community Planning Process. The initial $350,000 came from CDC planning grant funds. However, once the size of the planning group and the number of necessary meetings were finalized, OA staff knew that the initial allocation would be insufficient for participatory planning in a jurisdiction as large as California. At that point, an additional $150,000 was added from state general funds. Over

half of the money was spent on travel, per diem, conference expenses, and stipends for participants living with HIV/AIDS. Towards the end of the first year, as the group continued to work on issues of resource allocation and the future of the planning process, the state allocated another $150,000 of federal prevention funds. This augmentation was necessary to cover the costs of the public hearings in seven cities, the reproduction and mailing of 2,000 copies of the Plan, and a final two-day meeting of the Working Group.

The total allocation of $650,000 represents 20% of the Office of AIDS Education and Prevention budget. This figure does not reflect the dedication of the equivalent of 2.5 full-time staff positions and clerical support (one full-time equivalent) for the planning year.

One of the strengths of California's Community Planning Process was the availability of funds for the range of things the Working Group wanted to do. Very few Working Group initiatives were constrained by lack of funds, giving the planning body extraordinary freedom to convene, and plan, and deliberate virtually without regard for the costs of the process. Conference calls, delivery services, copying, were almost always available to planning participants as needed, even when costly.

As a result of this freedom, the few instances in which costs were presented as the reason for decisions by the Office of AIDS became highly controversial within the Working and Advisory Groups. For example, OA's decision to no longer support very costly conference calls that did not include an OA representative was perceived by many other planning participants as a decision based more on control than cost issues, particularly since this decision was made in the midst of difficult group process regarding resource allocation and implementation of the prevention plan. Similarly, OA's decision to limit the facilitators' roles to managing the Working Group meeting agenda was explained to the Advisory Group as a cost concern but perceived by many as OA's attempt to more directly control the planning process.

Without a pre-existing framework for discussing costs, or consensus around the planning budget, cost-driven decisions took many participants by surprise. Some felt that concern over the budget was arbitrarily applied to limit activities that the Office of AIDS did not want to support. OA staff insist that their costs concerns were legitimate and that any other decisions would have been fiscally irresponsible.

These examples are useful in several respects. First, they highlight how seldom the statewide planning group was encumbered by financial constraints. The fact that cost-based decisions were a surprise to many illustrates the degree of freedom experienced by the Working Group during this first planning year. However, the examples also suggest the potential importance of a frank discussion of the full planning budget, at least within an advisory or steering group, since it will never be possible to fund all of the ideas that come from a diverse and productive planning body. Broader consensus would assist the lead agency, in this case the Office of AIDS, in fiscal policy decisions, including consultant fees,

committee support, and other key budget lines. Periodic revisiting of the planning budget would provide a forum for discussing, and understanding, the context and implications of those decisions that are driven by cost concerns. These lessons learned from a well-supported planning process anticipate problems that will surely arise when community planning is conducted on a tighter budget.

Other costs

The Community Planning Process incurred non-monetary costs that are important to note. For example, the re-assignment of two OA staff members from E&P program monitoring and technical assistance was perceived as a loss to a number of state contractors. The dedication of state dollars to community planning meant that some special initiatives planned by the Office of AIDS had to be postponed or cancelled.

The strains were also felt by the organizations that Working and Advisory Group members serve, often understaffed to begin with. Planning participants reported having to spend extra, uncompensated time when they returned from CPP meetings to catch up with work that had built up while they were away. Several participants reported difficulty managing childcare and other caregiving responsibilities while they attended overnight meetings. OA staff similarly dedicated countless uncompensated overtime hours to the constant workload of the Community Planning Process. This overload, and stress on home and work, was particularly pronounced for planning participants in highly visible and/or leadership roles.

In an attempt to contain costs, the Office of AIDS and the logistics coordinator carefully managed the planning budget to make full participation possible and economical. All Working and Advisory Group meetings were held in hotels that accepted lower government rates. Participants were encouraged to travel cheaply, and in groups when appropriate. However, OA staff made it clear that the costs of travel were never to prohibit a member's participation, particularly those with limited resources or living with HIV. Whenever possible, travel and lodging costs were handled directly by the logistics coordinator. Travel and per diem stipends were made available in advance. These considerations were greatly appreciated by planning participants.

Did the planning process result in a more participatory process for the Office of AIDS in its decision-making and resource allocation?

The Community Planning Process provided an opportunity for the Office of AIDS to operationalize its public commitment to increasing community participation in its decision-making and resource allocation. OA staff were committed to maximizing this opportunity and community members were enthusiastic in their response. In the words of one Working Group member, "If this process doesn't slow the spread of HIV, nothing will!" Clearly, a definitive

impact of this experience was a more participatory process for the Office of AIDS regarding the direction and scope of education and prevention efforts.

Planning participants were aware of the longterm importance of their participation in statewide planning. In evaluation surveys, many participants noted the historic diversity of the Working Group as in itself creating a more participatory process, at least for prevention planning. Many proudly pointed out that they represented groups that have never before been invited to the policy table. However, many also expressed concern that planning decisions might not materialize in actual resource allocation. In the words of an Advisory Group member, "we have yet to see whether this was an interesting exercise in theoretical reconstruction or really a change in the process of HIV prevention in California".

Did the planning process change the way in which the Office of AIDS and community stakeholders relate to each other?

One of the clear impacts of the Community Planning Process was a structural change in the way that the Office of AIDS and some community stakeholders relate to each other. Although the end of a first year is too soon to determine long term impact, there are indications that important strides have been made in this direction.

The Office of AIDS has had the opportunity to work more closely with a wider variety of education and prevention experts than ever before. Many pre-existing professional relationships have deepened and many new relationships have been formed over the course of the Planning Process. The experience has helped all players understand the epidemic in new ways. It has also helped participants understand the other players. For example, after the presentation of evaluation results, many Working Group members remarked that they "had never thought about this process from their [OA's] perspective". Similarly, some of the OA staff members said that they had come to better understand what it means to live with HIV and AIDS as a result of their experience with Working Group members. The long term impact of these changes of heart will be seen in the coming months.

Impact can be measured in some other ways. Many of the current projects of OA epidemiologists, such as new initiatives on youth in school and not in school; pregnant Native American women; and migrant workers, reflect the issues raised during the planning discussions and fit well with the recommendations in the *California HIV Prevention Plan*. Staff epidemiologists are also now more aware of the need for more specific data collection within the broad Asian/Pacific Islander category. Many planning participants were enthusiastic about these directions when they were shared at the final Working Group meeting, viewing them as examples of the ways in which the Office of AIDS and community stakeholders can better work together.

What was the impact of participation on individuals involved in the planning process?

Participation in the Community Planning Process had a significant impact on the skills, understanding, sensitivities, and professional networks of participants, particularly Working Group members.

Some of these impacts are reflected in the responses of 48 Working Group members to a written evaluation survey administered near the end of the planning process. Working Group participants clearly felt significant benefits from their involvement. All respondents (100%) had gained new information, and most (97%) had a new perspective that they agreed "will help me in my work". Almost everyone (96%) said that they had an increased understanding of the needs of target populations, with many specifically mentioning transgenders, immigrant and undocumented individuals, persons with hemophilia, Asian/Pacific Islanders, Native Americans, and youth.

Most Working Group respondents (90%) said that they now have a greater appreciation for the diversity of California, and a greater understanding of the contribution of diverse perspectives in HIV prevention. Nearly everyone (90%) had an increased understanding of the role of community input and 77% had an increased understanding of the role of epidemiology in HIV prevention, including its limitations.

Most participants (75-84%) agreed that participation in the Community Planning Process had increased their skills in planning, organization, cultural sensitivity, cultural competence, scientific and technical areas, and leadership. Nearly everyone (97%) felt that they now have more colleagues to contact for technical help and a deeper respect for those involved in the fight against AIDS. Most Working Group respondents said that they now have a deeper commitment to HIV prevention - those who disagreed said that this was only because they had such a strong commitment *before* participating in the Community Planning Process.

Many of these sentiments were echoed by Advisory Group members and consultants. Understanding the bigger picture, the honor of making a contribution, and personal and professional growth were often mentioned as benefits of participation. Most indicated that they had been challenged, energized, and enriched by the Community Planning Process. Many indicated that they want to continue with this process and almost everyone said that they would like to be involved in other community planning efforts. In the words of one participant, "I now have new relationships for the next decade of work".

SUMMARY

This report has addressed the process, outcome, and impact of the California HIV Prevention Community Planning Process. It has described the context in which the planning effort was undertaken and the key components of the planning structure. It has also examined the products of the planning process, its costs, and its potential effects on the Office of AIDS and individual participants.

Particular strengths of the process have been described, including the strong and consistent staff support for the Community Planning Process from the Office of AIDS; an effective two-tier organizational structure, supported by experienced consultants, advisors, and staff; the diversity and expertise of the planning group; the delineation of roles and responsibilities; the development of a group process for operating the planning body, and efforts to create a common baseline among participants. The process of prioritizing needs and interventions has been described, as has the process by which the group deliberations were transformed into a written prevention plan.

The two most important outcomes of the Community Planning Process were 1) the development of the *California HIV Prevention Plan*, the first comprehensive plan for HIV education and prevention in California, and 2) the coalescence of planning participants into a productive group for this and future prevention efforts. The October 4, 1994 CDC prevention funding application was based on the *California HIV Prevention Plan*, which is a document that will be useful to many involved in HIV prevention, advocacy, public policy, and participatory planning. Over 2,000 copies of the Plan have already been disseminated and there are numerous plans for implementing its recommendations.

The financial and other costs of the Community Planning Process have been reviewed, as have the impact of the process on decision-making within the Office of AIDS and the relationships between OA and community stakeholders. Finally, the impact of participation on individuals has been explored, identifying a wide range of skills, understandings, and commitments that have been enhanced as a result of being a part of the Community Planning Process.

Limitations

There are several limitations to this evaluation.

1. **The independent evaluator was only involved in the second half of the planning process.** Not only did this constrain the scope of the evaluation, but it also affected the choice and timing of data collection methods, and the early utility of findings to the planning group.

Fortunately, complete archival records were available dating back to the year before the planning process began so that a documented account of the context and early activities

could be constructed without direct observation. The record was verified and brought to life with data collected from participants through questionnaires and interviews. Another important effect of the late inclusion of the evaluator was the short time in which to develop trust and establish the relationships so necessary to a thorough evaluation.

To counter this limitation, the evaluator tried to be as available as possible, providing a home phone number, self-addressed and stamped envelopes, and a welcoming presence to all participants from the very first introduction. Even so, complete information (four written questionnaires and an interview) was not obtained from all planning participants. Formative results were presented to participants at the last two Working Group meetings. These presentations of emerging themes and patterns did not generate a single contradiction of the findings by Working Group or Advisory Group members who had not completed all data collection opportunities.

Another limitation of the timing of the evaluation was the lost opportunity for CPP participants to learn from formative results on a more regular basis. Once hired, the evaluator made an effort to present something at each Working Group meeting. Formal presentation of evaluation findings was always met with enthusiastic appreciation and requests for more. Establishing an independent evaluator from the start of the process would have enabled the group to better utilize the findings while still planning.

2. **The evaluation is relatively limited in scope.** This evaluation was designed to be a chapter in the *California HIV Prevention Plan*, thereby placing significant constraints on its scope and ultimate size. The 20 final evaluation questions were selected from a list of over 45 intriguing and relevant questions about the process, outcomes, and impacts of this planning process suggested by the *Guidance*, OA staff, the evaluator, and other planning participants. Emphasis was placed on those questions which would provide the Office of AIDS with the most useful review of the California Community Planning experience. Things that were done well are emphasized. Only those areas of tension or miscommunication that are fixable within the existing OA parameters are examined in this document. A fuller account of the planning process requires a format without the constraints imposed upon this report.

3. **The first complete draft of the evaluation had to be completed less than a week after the final Community Planning Working Group meeting.** Ideally, an evaluator, and all planning participants, would have time to reflect and comment on the full findings before a final report was written. However, as with the other components of the planning process, the evaluation timeline was faster and more compact than would be ideal.

The evaluator was able to share selected summary findings with planning participants over 90 minutes during the final Working Group meeting. However, the full report could not be written until the conclusion of that meeting. As a result, the Office of AIDS staff were the only participants to read and comment on the written report before its inclusion in the *California HIV Prevention Plan.* OA review was an essential step in the process, particularly

since staff had full responsibility for implementing a successful statewide planning process. However, it must be noted that no other planning participants had the opportunity to critique the written evaluation report or request revisions based on their perspectives of the Community Planning Process.

The timeframe effected the selection of areas to be included in this report in other ways as well. For example, there was not time to also evaluate the interface between the statewide planning process and the parallel processes in San Francisco and Los Angeles. Similarly, an analysis of the validity and utility of some of the decision-making tools was not included. Some of the longer term outcomes of the Community Planning Process will be known within months of this writing - others will not be known for years. This evaluation is thus offered as an analysis of California's statewide Community Planning Process at the end of its first year, with the understanding that the coda to be added later may be as important as the body of the report.

Recommendations for Future Community Planning Efforts

The California Community Planning Process was an experiment rich in lessons learned, problems solved, and visions shared. It accomplished its goals and identified underlying tensions that will most likely be present in other community planning efforts. In the spirit of continual learning, the following recommendations are offered from the California Planning Process. Background on each of these recommendations can be found throughout earlier sections of this report.

Administrative recommendations

Administrative commitment to participatory community planning was central to the success of California's planning process. Based on the statewide successes and lessons learned, the following administrative recommendations are made for future community planning efforts.

Give careful thought to the appropriate staffing and structure of the planning process. In the California Community Planning Process, the best possible staffing and structure were carefully deliberated. Considerations that can be generalized to other planning efforts include 1) the planning mandate, 2) the time frame, 3) available resources, 4) current staffing levels, 5) the scope and diversity of the planning jurisdiction, and 6) the state of relations with community stakeholders.

Commit to the basic principles of community planning and participatory decision-making. Community planning was found to be qualitatively different from other community-based education and prevention activities coordinated by the Office of AIDS. Commitment to the basic principles of participation and inclusion encouraged staff and other participants to remain

patient and open to the unique dynamics of this type of program administration. Commitment from the top of the lead agency is essential.

Involve staff or consultants with experience in community planning or community organization. Understanding how to work collaboratively with diverse communities turned out to be as important as technical expertise. Comfort and experience with community organization and diverse populations should be included as criteria when assigning staff to other community planning efforts, and when selecting consultants for facilitation, planning, coordination, and evaluation.

Allocate appropriate time for this most time-intensive process. California's Community Planning participants found that this process takes time, resources, staff, and resilience beyond what most imagined. Allocating adequate staff support is crucial. In addition, facilitating ways in which other participants can be supported in meeting the demands of their own jobs and fully participating in the planning process should be actively explored.

Seek as broad a resource base as possible. Inclusive planning can not be done on a shoestring budget. Based on California's community planning experience, it can be expected that many participants will not be able to contribute financial resources. Travel, meetings, meals, materials, and communication methods (i.e., Federal Express, FAX, teleconferences, phone access) need not be lavish but will be costly.

Involve consultants as integral parts of the planning process. The more closely consultants are involved in planning, the more effectively and efficiently they can execute their responsibilities. The California Community Planning experience demonstrates this different approach to traditional consulting arrangements. These expectations should be taken into account when negotiating fees and scopes of work so that cost does not preclude important participation.

Establish and revisit timelines. A clear sense of "what must happen by when" was crucial to the success of California's Community Planning Process. Working backwards from decision deadlines and carefully noting all support necessary for the group to be able to make decisions on time and with confidence enables both staff and participants to mark progress and organize their work.

Closely follow any guidance provided. The CDC *Guidance*, the *Supplemental Guidance*, and the *Community Planning Handbook* were constantly referred to as California's scope of work was established and individual committees tackled their assignments. The more detailed the guidance, the more focused and productive a planning group can be. Well crafted documentation of expected process and product also provide crucial reinforcement for those new or resistant to participatory planning.

Structural recommendations

The structure of California's Community Planning Process was clearly delineated, based on previous experience, and designed to provide several channels for public input and representation. Based on the success of that structure, and the lessons learned in supporting it, the following recommendations are made for future community planning efforts.

Establish and implement an open nomination process. The open nomination process was the beginning of public input into California's statewide planning efforts. Several mechanisms, easily generalizable to other planning situations, enhanced this part of the process. Specific mechanisms include frequent correspondence to a wide mailing list, an open invitation for nominations, the ability to nominate self or others, and the use of multiple communication channels (i.e., mail and FAX).

Carefully address diversity and representation in the selection of planning group members. Standard demographic categories of diversity were not sufficient when dealing with HIV in California. The statewide planning group's expanded diversity characteristics included professional affiliation, geographical area, sexuality, among others. Future planning groups may want to consider developing additional "cultural clusters" based on the particulars of the issue and planning jurisdiction.

Analyze and provide, whenever possible, the support needed for affected community members to actively participate in all planning activities. Affected community members may have special needs for transportation, meals, child care, access to medical care or pharmacies, etc. In the California Community Planning Process, the staff and logistics coordinator sought to understand and meet those needs. Continual learning about the needs of planning group members, particularly those most important to a representative planning group, is crucial to their full participation.

Establish clear, written roles and responsibilities for all participants. California's Community Planning Process was organized with clearly delineated roles and responsibilities. Work proceeded most smoothly when it occurred within those parameters. Mission statements, scopes of work, decision trees, project charts, and letters of commitment are crucial. These should be established at the beginning of the planning process and revisited (and revised as needed) throughout.

Include written feedback surveys at all planning functions. This was done after each day of the Working Group meetings, and might have been included at the end of other key meetings (i.e., Advisory Group, committees). Even brief questionnaires provide participants an opportunity to comment on the degree to which objectives were met and any other issues they care to raise.

Group process recommendations

Effective and skillful facilitation of the group process aspects of community planning is essential. Ultimately, responsibility for this task is shared among all planning participants. Based on California's community planning experience, the following group process recommendations are offered for other planning efforts.

Develop specific procedures to ensure that the group process is participatory, candid, and open. A diverse planning body will bring widely varying levels of experience and comfort with large and formal group deliberations. Ground rules for discussion, mixing large and small group discussions, opportunities for anonymous feedback, and other varied and clearly delineated procedures provide a range of ways in which participants may openly participate in the large group.

Devote careful attention to the planning of each agenda. A careful balance of task and maintenance activities is essential, as is maintaining flexibility for late-breaking issues while still meeting deadlines. In the California planning process, organizing the meetings by necessary tasks and decisions enabled participants to clearly see the accomplishments of their efforts and the links to the end product.

Ensure expert and neutral facilitation of community planning meetings. Neutral facilitation of the Working Group meetings emerged as crucial for navigating and resolving the most complex planning or group process issues. Future planning efforts may want to consider neutral facilitation for other meetings as well (i.e., committees, Advisory Group).

Nurture the group spirit. According to California participants, community planning can be challenging, exhausting, and frustrating. It can also be rewarding, educational, and empowering. Individual members (including leaders and staff) will need attention and renewal at various points in the process. The planning process itself may have unique vulnerabilities at the beginning, the middle, and the end. Awareness of these dynamics, and attention to the affective dimension of a rational planning process, serves the process and its participants well.

Encourage the group to develop its own rituals. The California Community Planning Process found that these can not be planned - or even imagined - in advance, but will emerge as the group works together. Group rituals, whether around food, meetings, recreation, humor, encourage trust and sense of community among members who may begin as strangers. Rituals also help the group remain aware of its higher purpose.

Establish a work pace that facilitates full participation. California's statewide planning process picked up speed and intensity as key deadlines approached. However, participants came to realize that maintaining a pace that is healthy and reasonable for all concerned was both difficult and essential. Respecting timeframes, building in breaks, and establishing reasonable working hours allows full participation by those with differing abilities

or resources. Planning leaders can model a calm and purposeful approach to the scope of the task and the pressures of looming deadlines.

Establish clear rules for discussion and voting. The early investment in determining a group decision-making process paid off for California's Community Planning Process. Some participants may find this premature or slow-going at the beginning, but the utility of pre-determined protocols will be clear when controversial or important decisions need to be made later on.

Establish and revisit protocols for dealing with conflict of interest within the group. The California Community Planning Process found this to be one of the most complex group issues, but its importance became clear as the group approached decisions regarding resource allocation and implementation of the *California HIV Prevention Plan*. Other planning efforts might benefit from even greater emphasis on conflict of interest protocols early in the planning process, and more rigorous re-examination of those protocols at key junctures. Simulating conflict of interest dilemmas and public disclosure of sources of program support among planning participants are recommendations from the statewide planning group to future community planning bodies.

Provide technical assistance to the core planning units. OA staff, Advisors, and consultants spent considerable time and resources in providing technical assistance to individual committees and to the Working Group as a whole. Timely, responsive, and use-friendly assistance was greatly appreciated and incorporated by many planning participants. The Office of AIDS learned that offers of technical assistance can also be perceived as attempts to control or influence a community planning process. Careful attention to the goals, techniques, nuances, and politics of technical assistance is warranted.

Strive to maintain a balance in group attention to task and maintenance. The early days of a community planning process typically balance both, but as deadlines approach, task often subordinates maintenance. The California Community Planning Process found that group maintenance issues did not go away just because they were not put on the agenda, or were included but only for a short time. Future planning projects will benefit from a commitment to continue to address task and maintenance throughout the planning period.

Continually link local activities to bigger efforts, and all planning efforts to a higher cause. Many in the statewide planning process carefully nurtured the group's pride in its own learning, productivity, and accomplishments. The sense of being part of a new way of making state policy, identity as a leader among other planning jurisdictions, and the over-riding optimism that this process might help put an end to the AIDS epidemic and enhance the health of the people in California were all motivating reasons that were articulated at key junctures with positive results. Planning process leaders can provide perspective for other participants by continually linking local action to relevant social contexts. Linking the

planning efforts to the broader principles to which participants are committed also reinforces the importance of the sometimes mundane work of community planning.

Planning recommendations

California's Community Planning Process was based on sound planning techniques that provided a baseline of information, a structure for decision-making, and considerable expertise in the areas required for statewide policy discussion. Many of the planning approaches are applicable to other community planning efforts.

Anticipate differences in perspective, experience, and learning styles that participants will bring to the planning process. A diverse and representative planning body will bring a diverse set of skills and expectations to the planning process. At the same time, many of the assumptions of those familiar with bureaucracies, the policy process, and research may not be shared by planning colleagues from other backgrounds. Patience by all participants is crucial, as is respectful and systematic presentation of key material. Adult learning theory and training methods were found to be more effective than didactic presentation. Including participants in planning and evaluation of sessions also encourages participants to suggest effective styles and approaches to presentations, deliberations, and decision-making.

Utilize as much planning group expertise as possible. California's planning group was rich with expertise, and the experts were generous in their sharing. Building upon the group's expertise saves time, adds depth, and nurtures group pride as the planning body gathers and synthesizes information.

Practice methods for decision-making. Not everyone is used to complicated worksheets, ranking protocols, or staged policy decision-making, standard tools for policy and planning. In the California Community Planning Process, many participants struggled with the methods of decision-making, particularly when they involved worksheets or voting between meetings. Future planning efforts might include more specific orientation to the planning techniques to make sure that everyone understands the methods, time required, and implications of the specific tools that will be used. Simulations, practice sessions, small group trainings, and a buddy system were spontaneously and informally implemented at various times during Working Group decision-making. These approaches might be formally structured in to future planning efforts.

Strive to make the final planning product as useful, readable, and accessible as possible. The task of developing a statewide HIV prevention plan was a big one, and so is the final document. Efforts were made to make the Plan itself as readable and accessible as possible, within the planning charge. A summary document will enhance the usefulness and dissemination of this landmark document. Future planning efforts may wish to consider the range of final products needed to meet the needs and interests of various stakeholders.

Evaluation recommendations

The California Community Planning Process was characterized by an open and participatory commitment to evaluation. The following evaluation recommendations can be made for future planning efforts.

Arrange for an independent evaluator to evaluate selected dimensions of the planning process, outcomes, and impact. Evaluation is a significant undertaking. Assigning the task to designated individuals without other planning responsibilities helps ensure appropriate attention to the task. Furthermore, an independent evaluator brings a neutral presence to the documentation and analysis of the planning effort. This becomes particularly important when assessing and reporting the inevitable multiple perspectives on the planning process. Specific evaluation objectives can be negotiated between the evaluator, staff, and other planning participants based on reporting requirements, staff needs, and other areas of interest.

Begin the formal evaluation from the very start of the process. Careful documentation of actions, expectations, and decisions is essential and should begin immediately. Not only do these data provide an archival record of the process, but they also establish baseline markers against which periodic assessment of growth, progress, and change can be measured.

Utilize a variety of data collection methods. The California Community Planning Process evaluation utilized short answer questions, check-off lists, phone and face-to-face interviews, brainstorming, direct observation, archival review, and deep conversation to gather as wide a range of perspectives as possible. Each of these methods added opportunities for participation and contributed perspective to the emerging evaluation analysis. Future planning effort should continue to expand the ways in which evaluation data are elicited and collected.

Present emerging findings to participants. Preliminary results serve as an ongoing check of validity by providing opportunities for alternative perspectives to be offered. Sharing results also serves the planning process itself by identifying areas of concern that might not be apparent or perceived as important by other players. Evaluation data can be empowering to a planning group. In the statewide planning process, sharing selected evaluation results was often used to build group solidarity and sense of accomplishment. Future planning efforts might incorporate evaluation feedback as a regular agenda item for planning meetings. Similarly, a retreat or other dedicated time with the evaluator might help planning staff and leadership understand the more sensitive evaluation findings.

Each of these recommendations is offered from the experience of the California Community Planning Process. It is hoped that they will be useful in similar participatory planning efforts and that, together, these efforts will stop the spread of AIDS and build communities that nurture the health of all of their members.

APPENDIX

The following attachments are included in this appendix:

HIV Prevention Community Planning Advisory Group Members

Brinkley, Barry
M.S., M.P.H.
Alameda County Health Director,
Planning & Fiscal Agency

Coates, Tom, Ph.D., Director
Center for AIDS Prevention Studies

Corby, Nancy, Ph.D.
Community Research & Services Program
CA State University Long Beach

Cowan, Geni
Executive Director
CA Association of AIDS Agencies

Crisostomo, Vince
Asian AIDS Project

Conner, Tomiko, MPP, MPH
BAHAN Community Organizer
San Francisco AIDS Foundation

Dunn-Mortimer, John, Ph.D.
AIDS Project Los Angeles

Ellerby, Pat
AIDS Program
Santa Cruz Co. Health Services Agency

Francis, Donald, M.D., D.Sc.
Genentech Corporation

Franks, Pat
UCSF
Institute for Health Policy Studies

Garcia, Barbara
Executive Director
Salud Para La Gente

Herring, Marshia
AIDS Office
City/County of San Francisco

Lenker, Su-Lin
Santa Clara County Health Dept.

Lewis, David, Ph.D.
Universitywide AIDS Research Program

Lobdell, George
Executive Director
Hemophilia Council of CA

Martin, Rand
Chief of Staff
C/O The Honorable John Vasconcellos
Member of the Assembly

Meshar, Helyne
CADPAAC

Osborne, Kerrington
Director of Public Policy
National Task Force for AIDS Prevention

Rice, Hugh
Clinic Manager
L.A. Gay and Lesbian Comm. Ser. Ctr.

Rios, Robert
Legislative Advocate
Life AIDS Lobby

Romney, Brenda L.
Legislative-Advocate
Planned Parenthood Affiliates of California

Sandoval, Chris
Project Director
Polaris Research & Development

Shriver, Mike
Executive Director
Mobilization Against AIDS

Swartz, Marjorie
Principal Consultant
Assembly Ways and Means

Topper, Ken
Consultant
C/O The Honorable David Roberti
Member of the Senate

Facilitators Selection Committee

Barbara Garcia
Tom Lee Eades
Kerrington Osborne
Su-Lin Lenker
Nancy Corby

Membership Selection Committee

John Dunn-Mortimer
Barbara Garcia
Robert Rios
Chris Sandoval
Kerrington Osborne

Membership Appeals

Robert Rios
Chris Sandoval
Wayne Sauseda

Agenda Development Committee

Chris Sandoval
Robert Rios
Barry Brinkley
John Dunn-Mortimer
Brenda Romney
Pat Franks
Hugh Rice

Health Planner/Writer Selection Committee

Barry Brinkley
Pat Ellerby
Pat Franks
Su-Lin Lenker
Hugh Rice
Robert Rios

Evaluation Committee

Barry Brinkley
Geri Cowan
Pat Franks
Marshia Herring
Kerrington Osborne

HIV COMMUNITY PLANNING WORKING GROUP
MEMBERSHIP CATEGORIES

The HIV Prevention Community Planning Work Group members will be selected from the following categories:

- **Population characteristics of persons affected by HIV/AIDS to include:**
  - a. Age
  - b. Sex
  - c. Race/ethnicity
  - d. Socioeconomic status
  - e. Geographic distribution
  - f. Sexual orientation

- Representatives from HIV exposure categories to include:

  a. Men having sex with men-young gay/bisexual men and gay/bisexual men of color regardless of age
  b. Substance users-injection drug users (IDU) using opiates/stimulants, alcohol and other drug users (e.g. crack/cocaine), IDU-inner city
  c. Sex partners of individuals practicing high risk behaviors or HIV negative sex partners of HIV infected individuals
  d. Hemophilia; health care worker exposure
  e. Occupational exposure in the health care setting
  f. Advocate for children infected with HIV

- **State/local health departments.**

- **State/local education agencies.**

- **Other government agencies; i.e., Substance Abuse, Mental Health, Family Planning, Corrections.**

- **Experts in epidemiology, behavioral and social sciences, evaluation research, and health planning.**

- **Governmental and nongovermental prevention service providers to include:** sexually transmitted disease (STD), tuberculosis (TB), substance abuse, mental health, HIV care (Title II care group representatives), and social services.

Representatives from clusters to include:

- **Cultural Cluster:**

Religious	Cross cultural
Immigrant	Monolingual
Non-English speaking	Hearing impaired
Latino	American Indian
African-American	Asian-Pacific Islander
European-American	Communities of mixed heritage
Youth	Women's/men's communities

- **Addiction Cluster:** Legal and illegal drugs, alcohol behaviors.
- **Sexuality Cluster:** Lesbian, gay, bisexual, transsexual, transgender, heterosexual.
- **Geographical Cluster:** Urban/inner city, suburban, correctional system, rural/remote, regional, transient.
- **Practitioner Cluster:** MPH Clubs, peer educators, outreach educators, CBO, County, State, training and technical assistance, evaluators, primary care advisory group.
- **Government Cluster:** Office of Statewide Health Planning and Development, Department of Alcohol and Drug Programs, Department of Developmental Services, Department of Corrections, Department of Health Services, Department of Mental Health, Department of Social Services, Indian Health, Rural Health.
- **Exposure Cluster:** Hemophilia, gay men of color, HIV positive, health care workers.
- **Research Cluster:** Cultural researcher, community-based researchers, behavioral researchers, bio-medical researchers, independent researchers, CAPS, UC, Evaluators.
- **Policy Cluster:** CCLAD, CAAA, Life Lobby, S.F.A.F., AIDS Budget Coalition, LLEGO, CPHA, CCHO, CASOA, CCDHE, Legislature, Regional Advocacy Foundations or projects.
- **Epi-surveillance Cluster:** Epidemiologists, surveillance professionals.

OTHER MEMBERSHIP CRITERIA

- **Representative from Los Angeles and San Francisco Community Planning Councils (persons who have authority to act on behalf of these entities).**
- **Must possess "hands on" experience in providing prevention services to affected populations.**
- **Engage and consult/communicate with the community they are representing.**
- **Possess the ability to advocate on behalf of the community they represent.**

★ Final membership composition may not include a representative from each category fue to Working Group size limitations.

HIV Community Planning Working Group

James Atolagbe, D.H.Sc., M.P.H.
Kern County Health Department

Lynne Barnett, Chief
Clinical Services Section
Office of Family Planning

Tony Barrett
c/o Paul Melbospad

Patty Blomberg
California Department of Corrections
Health Care Services Division
Public Health Section

Alex Campos
East Valley Community Clinic

Rafael Chang
Gay Asian Pacific Alliance
Community HIV Project

Yolanda Chavers

Jeff Clingenpeel, MPPA
California Department of
Alcohol and Drug Programs
Office of Treatment & Recovery

Ross Conner, Ph.D.
University AIDS Research Program
School of Social Ecology
University of CA, Irvine

A. Gene Copello, D.Div., M.S.
California Conference of Local AIDS Directors

Alberto Cortes
San Ysidro Health Center

Brian Dobrow
AIDS Office
City/County of San Francisco

Rebecca Denison
Women Organized to Respond to Life
Threatening Diseases (WORLD)

Corey Dubin
Director of News & Production
Coyote Radio

Reverend Yvette Flunder
The ARK of Refuge, Inc.

Reuben D. Garza
Del Norte Clinics, Inc.

Gail Gibson
Lake County Health Services Department

Brad Gilbert, M.D., M.P.P.
Health Officer
Riverside County Health Department

Dean Goishi, Director
Special Service for Groups
Asian Pacific AIDS Intervention Team

Matiana Grogan
Member MLB
Santa Barbara County
Department of Health Services

Arthur J. Hernandez
Pioneers Memorial Hospital

Mario Hernandez
Salud Para La Gente

James G. Kahn, M.D., M.P.H.
San Francisco General Hospital

Andrea Learned
Face to Face

Tom Lidot
Indian Health Council

Estela Martinez
OPTIMA

Julio Mastro

Gail Maurer, Consultant
California Department. of Education
Healthy Kids, Healthy California Office

Frank McGarvey
Program Coordinator
Mendocino County Alcohol & Drug

Darren H. Megee
El Dorado County

William J. Mitchell, M.P.H., Director
San Joaquin County Public Health Services

Connie Norman
AIDS Service Center

Pat Norman, Executive Director
Institute for Community Health Outreach

Charlie O'Malley
California Rural AIDS Project

Robert Pardo
Gay and Lesbian Resource Center

Erma Patterson
California Association of Alcohol and
Drug Program Executives, Inc.

Gena Pennington, M.D.
Humbolt County Department of Public Health

Harold Rasmussen
Chief, Surveillance, Research & Evaluation
California Department of Health Services
Division of Communicable Disease Control

Juan Reardon, M.D., M.P.H.
Contra Costa County
Health Services Department

Oscar Reconco
Hollywood Sunset Free Clinic

Alice Ryan
Parent Teacher Association

Wayne Sauseda, Chief
Office of AIDS

Marylou Scavarda. M.S.N.
Association of Regional Center Agencies

John Schunhoff, Ph.D.
Program Director
Los Angeles County AIDS Program

Ruth I. Slaughter
Prototypes

Greg Smith
Minority AIDS Project

Andy Spieldenner
Lavender Youth Recreation Information Center

Hank Tavera, M. Ed.
LLEGO California, Latina/o Lesbian,
Gay & Bisexual Organization
San Francisco City Clinic

Alexander Taylor, M.P.H.
San Bernardino County Health Department

Sharen Trammell
Black Coalition on AIDS

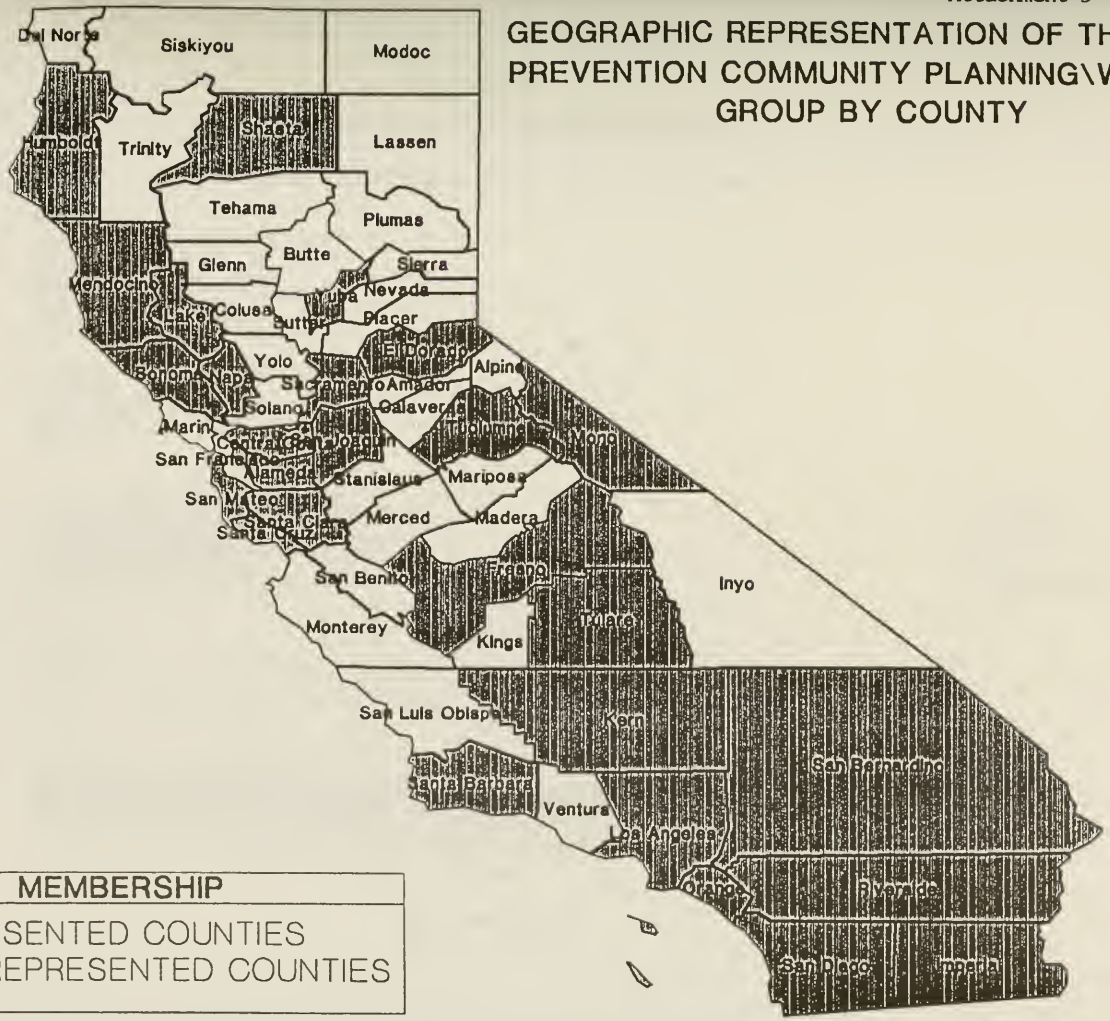
Rose Vasquez, N.P.
AIDS Health Care Foundation

Heidi Vert
Shasta County Health Department

HIV PREVENTION COMMUNITY PLANNING WORKING GROUP

	NAME		COUNTY/REGION	EXPERTISE
1	Atolagbe	James	KERN COUNTY	LOCAL HEALTH DEPARTMENT
2	Barnett	Lynne	STATEWIDE	PRIMARY CARE AND FAMILY HEALTH
3	Barret	Tony	MONO COUNTY	CA RURAL HEALTH ASSOCIATION
4	Blomberg	Patty	STATEWIDE	DEPARTMENT OF CORRECTIONS
5	Campos	Alex	SANTA CLARA COUNTY	COMMUNITY REPRESENTATIVE
6	Chang	Rafael	SAN FRANCISCO	COMMUNITY REPRESENTATIVE
7	Chavers	Yolanda	TULARE COUNTY	LOCAL HEALTH DEPT. MULTICULTURAL LIAISON BOARD
8	Clingenpeel	Jeff	STATE PROGRAM	DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
9	Conner	Ross	STATEWIDE	UNIVERSITYWIDE TASK FORCE ON AIDS
10	Copello	Gene	STATE/SAN MATEO COUNTY	CA CONFERENCE OF LOCAL AIDS DIRECTORS
11	Cortes	Alberto	SAN DIEGO COUNTY	COMMUNITY REPRESENTATIVE
12	Dobrow	Brian	SAN FRANCISCO	LOCAL HEALTH DEPT.: CDC COOPERATIVE AGREEMENT
13	Denison	Rebecca	ALAMEDA COUNTY	COMMUNITY REPRESENTATIVE
14	Dubin	Corey	SANTA BARBARA COUNTY	COMMUNITY REPRESENTATIVE
15	Flunder	Yvette	ALAMEDA COUNTY	COMMUNITY REPRESENTATIVE
16	Garza	Reuben	YUBA COUNTY/RURAL	COMMUNITY REPRESENTATIVE
17	Gibson	Gail	LAKE COUNTY	LOCAL HEALTH DEPARTMENT
18	Gilbert	Brad	STATEWIDE/RIVERSIDE CO.	CA CONFERENCE OF LOCAL HEALTH OFFICERS
19	Goishi	Dean	LOS ANGELES COUNTY	MULTICULTURAL LIAISON BOARD
20	Grogan	Matiana	SANTA BARBARA COUNTY	MULTICULTURAL LIAISON BOARD
21	Hernandez	Arturo	IMPERIAL COUNTY	COMMUNITY REPRESENTATIVE
22	Hernandez	Mario	SANTA CRUZ COUNTY	COMMUNITY REPRESENTATIVE
23	Kahn	James G.	STATEWIDE	UNIVERSITY OF CALIFORNIA, SAN FRANCISCO/RESEARCH
24	Learned	Andrea	SONOMA COUNTY	COMMUNITY REPRESENTATIVE
25	Lidot	Tom	SAN DIEGO COUNTY	COMMUNITY REPRESENTATIVE
26	Martinez	Estella	ORANGE COUNTY	LOCAL HEALTH DEPARTMENT
27	Mastro	Julio	FRESNO COUNTY	COMMUNITY REPRESENTATIVE
28	Maurer	Gail	STATEWIDE	DEPARTMENT OF EDUCATION
29	McGarvey	Frank	MENDOCINO COUNTY	LOCAL HEALTH DEPARTMENT
30	Megee	Darren	EL DORADO COUNTY	COMMUNITY REPRESENTATIVE
31	Mitchell	Bill	SAN JOAQUIN COUNTY	LOCAL HEALTH DEPARTMENT
32	Norman	Connie	LOS ANGELES COUNTY	COMMUNITY REPRESENTATIVE
33	Norman	Pat	SAN FRANCISCO COUNTY	MULTICULTURAL LIAISON BOARD
34	O'Malley	Charlie	NAPA COUNTY	COMMUNITY REPRESENTATIVE
35	Pardo	Robert	SANTA BARBARA COUNTY	COMMUNITY REPRESENTATIVE
36	Patterson	Erma	LOS ANGELES COUNTY	ASSOC. ALCOHOL AND DRUG PROGRAM EXECUTIVES
37	Pennington	Gena	HUMBOLDT COUNTY	LOCAL HEALTH DEPARTMENT
38	Rasmussen	Harold	STATEWIDE	DIVISION OF COMMUNICABLE DISEASE CONTROL
39	Reardon	Juan	CONTRA COSTA COUNTY	LOCAL HEALTH DEPARTMENT EPIDEMIOLOGIST
40	Reconco	Oscar	LOS ANGELES COUNTY	COMMUNITY REPRESENTATIVE
41	Ryan	Alice	STATEWIDE	PARENT TEACHER ASSOCIATION
42	Sauseda	Wayne	STATE/OFFICE OF AIDS	OFFICE OF AIDS
43	Scavarda	Mary Lou	STATEWIDE	ASSOCIATION OF REGIONAL CENTERS
44	Schunhoff	John	LOS ANGELES COUNTY	LOCAL HEALTH DEPT.: CDC COOPERATIVE AGREEMENT
45	Slaughter	Ruth	LOS ANGELES COUNTY	COMMUNITY REPRESENTATIVE
46	Smith	Greg	LOS ANGELES COUNTY	COMMUNITY REPRESENTATIVE
47	Spieldenner	Andy	SAN FRANCISCO COUNTY	COMMUNITY REPRESENTATIVE
48	Tavera	Hank	STATEWIDE	LATINA/O LESBIAN & BISEXUAL GAY ORG. (LLEGO, CA)
49	Taylor	Alex	SAN BERNARDINO COUNTY	LOCAL HEALTH DEPARTMENT EPIDEMIOLOGIST
50	Trammell	Sharen	ALAMEDA/SAN FRANCISCO COUNTY	COMMUNITY REPRESENTATIVE
51	Vasquez	Rose	LOS ANGELES COUNTY	COMMUNITY REPRESENTATIVE
52	Vert	Heidi	SHASTA COUNTY	LOCAL HEALTH DEPARTMENT

GEOGRAPHIC REPRESENTATION OF THE HIV PREVENTION COMMUNITY PLANNING\WORKING GROUP BY COUNTY

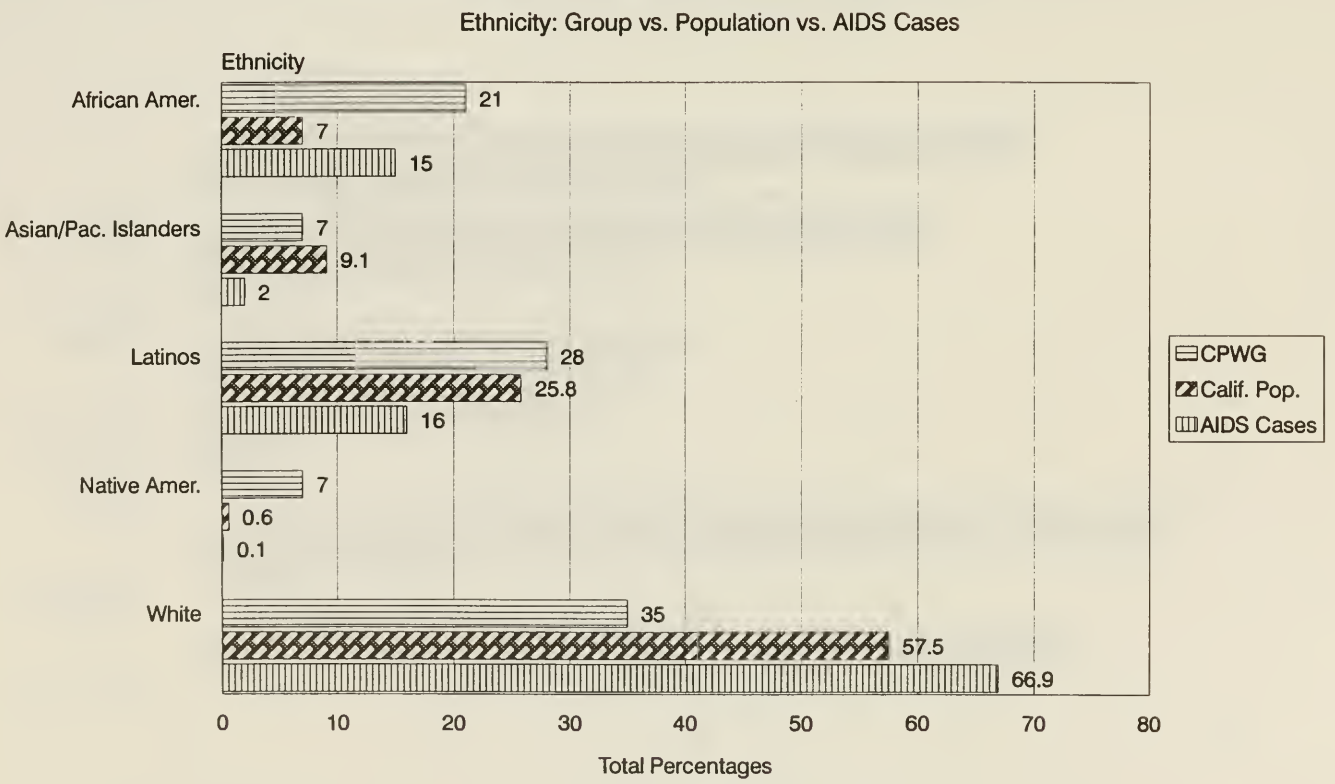


MEMBERSHIP

- REPRESENTED COUNTIES
- NON-REPRESENTED COUNTIES

Attachment 6

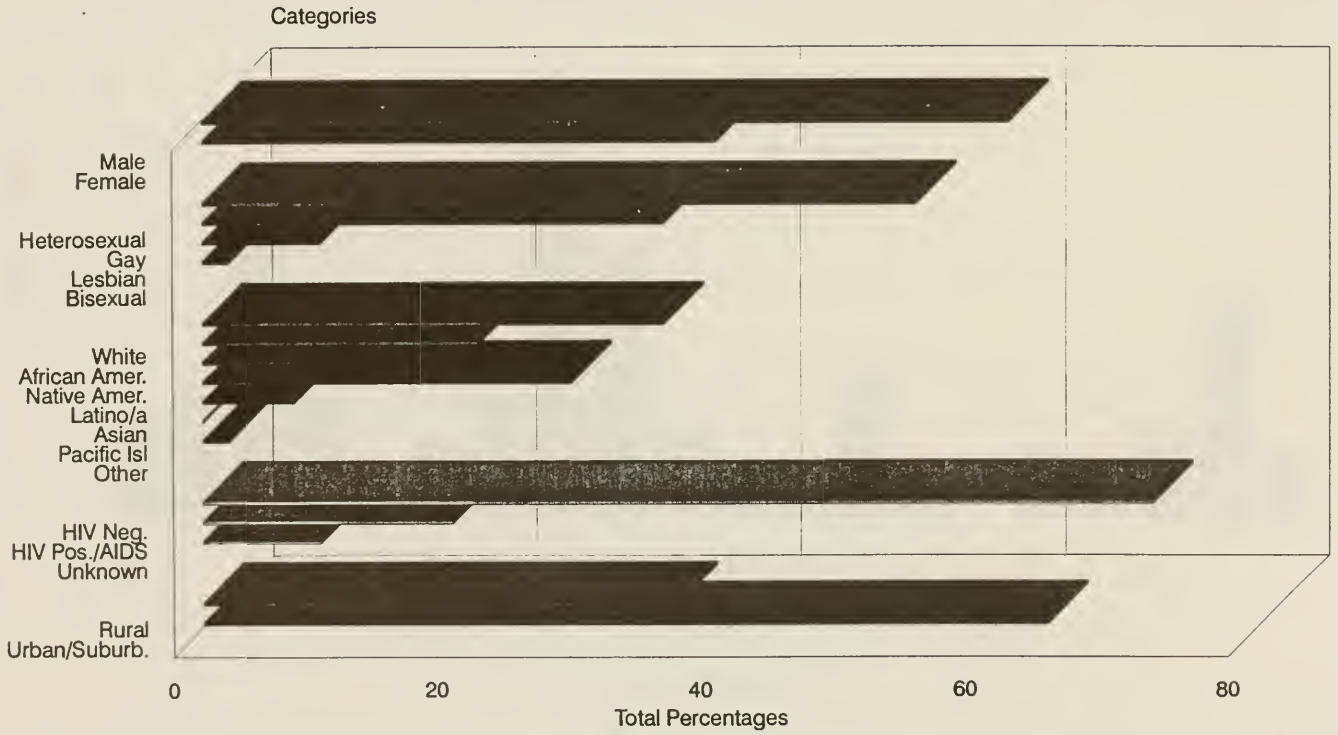
California Community Planning Working Group



Attachment 7

California Community Planning Working Group

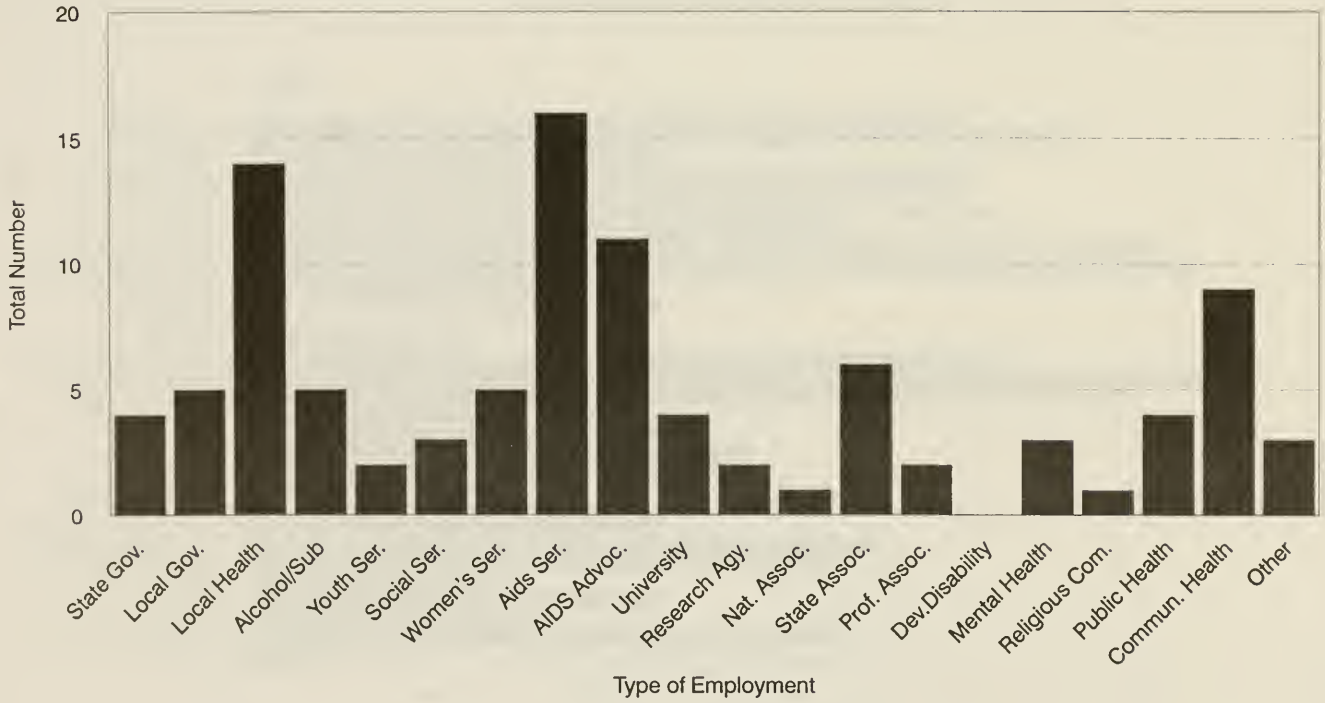
General Membership Information



Attachment 8

California Community Planning Working Group

Membership Employment Status

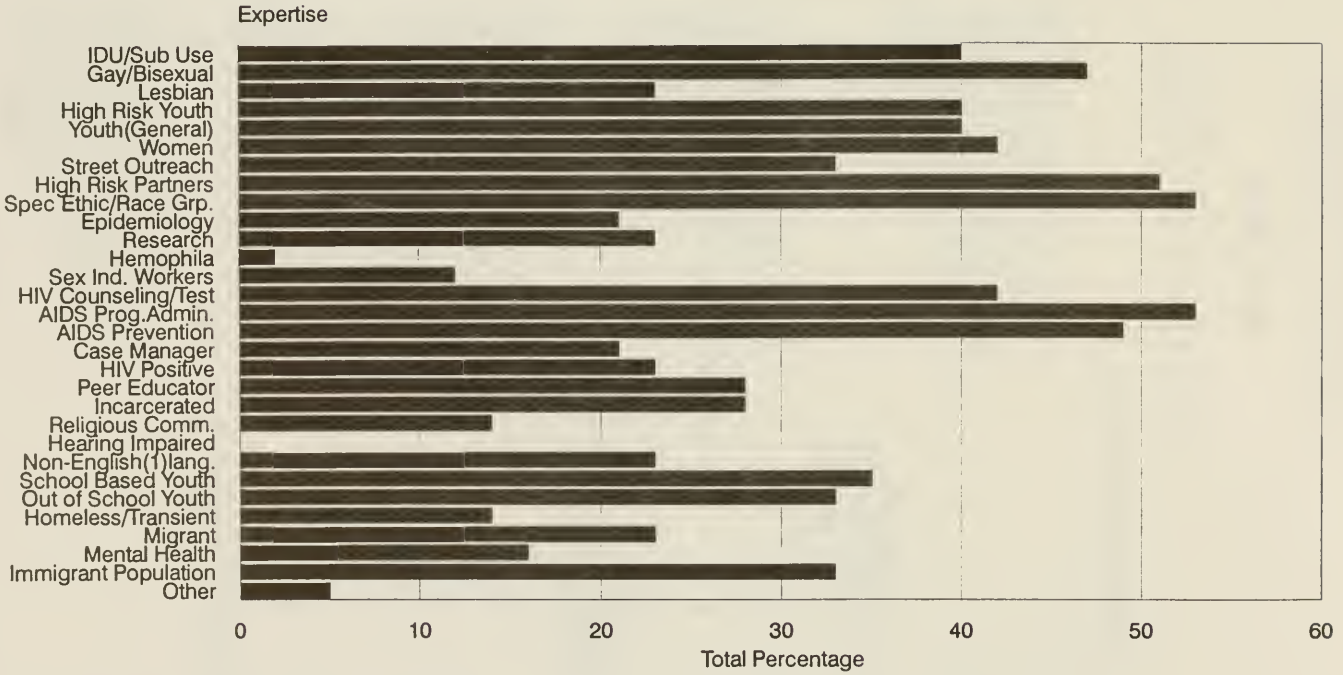


Total Number = 100

Attachment 9

California Community Planning Working Group

Type of Personal or Professional Expertise



% will exceed 100% in total amount due to partcipants
partcipants in more than one category.

HIV COMMUNITY PREVENTION PLAN

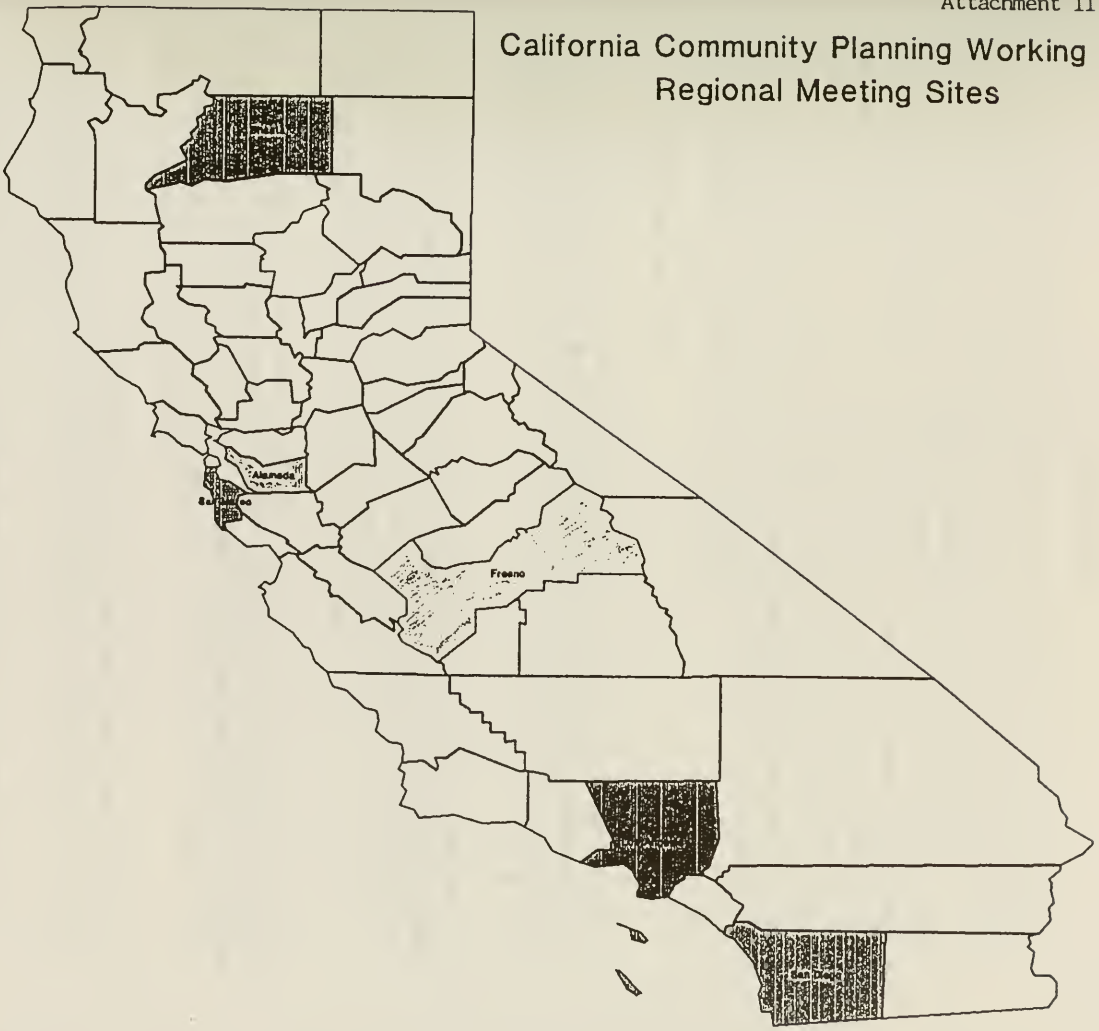
TIMELINE

GOALS FOR EACH MEETING

			Related Ongoing Activities
Oakland	•	Introduction and Team Building	
4/7 - 4/8	•	Orientation to Planning Process	
	•	Ground Rules and Philosophies	
	•	Assess the Needs of the Community Prevention Working Group	
	•	Election of Co-chair	
			Conduct needs assessment and resource inventory
Long Beach	•	Overview of HIV Prevention Plan	
5/5 - 5/6	•	Overview of Prevention in California	
	•	Review EPI Inventory Profile of the State	
	•	Form Subcommittees	
	•	Public Comment	
			Needs assessment, Focus groups, Technical Assistance needs, etc.
Fresno	•	Public Comment	
6/7 - 6/8	•	Report on Resource Inventory	
	•	Report on Needs Assessment	
	•	Priority Setting	
	•	Set Goals and Objectives	
			Focus Groups
San Diego	•	Develop First Draft Input	
7/14 - 7/15	•	Public Comment	
	•	Priority Setting (Continued).	
	•	Goals and Objectives	
			April 1-31 Public Hearings
Redding	•	Discuss Draft Plan.	
8/31 - 9/1	•	Comments from the Community Prevention Working Group	
	•	Discuss Input from Meetings	
	•	Public Comment	

Attachment 11

California Community Planning Working Group
Regional Meeting Sites



Focus Groups

The CPWG requested five focus groups around the state to find out about HIV risk behaviors and barriers to prevention education in groups for which little information exists. Harder+Kibbe Research facilitated focus groups for each of five populations specified by the CPWG. Local service providers recruited the participants and made the logistical arrangements that allowed the focus groups to take place. The State Office of AIDS provided incentives to increase participation. These incentives included a $25 consumer goods voucher, reimbursement for travel or local transportation to and from the focus group, a light meal, and in one case, child care. In order of occurrence, the groups were: Native American Youth in Eureka on July 5, Latino Migrant Farmworkers (all men) in Calexico on July 7, Transgender Persons in San Diego on July 8, Asian/Pacific Islander Men Who Have Sex With Men in Santa Ana on July 9, and HIV Positive Women in Oakland on July 11. This section of the report summarizes the findings from these focus groups.

Native American Youth

There were nine participants in their late teens, six female and three male. All participants were members of the Teen Advisory Group (TAG) and were involved in an on-going group that devises educational events for their peers. As a group they were articulate and interactive in the discussion.

They said that many of their peers engage in risky behavior, especially unprotected sex. They believe their peers may have inaccurate ideas about how HIV is transmitted, but all of them are aware of the risk of transmission through unprotected sex and sharing injection equipment. The major barrier to consistently protecting themselves was the belief that "it can't happen to me," and carelessness when drunk or stoned.

We asked what would be effective in overcoming the "it can't happen to me" belief. None of the participants knew anyone with AIDS, although they had seen a speaker with AIDS make a presentation. There may be some AIDS cases on the reservation, but they don't know who. Seeing someone like themselves—an Indian youth with AIDS, even on a video, would make the risk seem more real to these youth.

When asked how to reach their peers the focus group participants were clearly proud of their own program—some of them had been participating for as long as four years—and they spoke from that experience.

They told us, first you have to get the attention of the people you want to reach. In reaching other Indian youth, it is very important that the educators are Native American because there is a shared background and a common understanding of the world. This makes

it much easier for them to understand each other. In presentations you have to have somebody who is not afraid to talk openly about sex, and it helps when teens talk to teens.

Participants told us that TAG uses theatrical productions and tournaments. They said that these events have to be fun. They also use games, raffles, awards—but all with some educational message. One of them said it was a sneaky way to teach other kids while they are having fun. They sometimes incorporate elements of Native American ritual in their events. They also produce newsletters and produce tee shirts with local art-work and educational messages that catch people's attention. In order to expand their outreach, they use a trial and error method to see what brings other youth to the activities.

The participants said that the support of parents and community elders was essential in their being able to continue. They said that both parents and the community elders provided them with resources including space for events, volunteer support for advertising, and moral support for TAG's efforts and aims.

They said that getting others to come to one event is not enough—there needs to be continuing reminders of the risk. The participants' own experience was that it was important to be in an ongoing group where people can talk about their personal experience. They said that for people to open up, there needs to be trust and confidentiality; and in that kind of group, people will eventually open up to talk about what really concerns them. According to the participants this is what gives the support that really reduces risk behavior. And in this matter of trust, they said, it is very important that the people share a common background. They also said that it takes time to bring new people fully into such a group.

The participants knew they could not reach all their peers, even with their programs with different kinds of outreach. They said one group that did not attend their events were the youth using drugs; they simply would not come. They said that some other youth sometimes had an attitude that they were too cool for this kind of activity. Participants seemed unsure whether there might be closeted gay youth who were not being reached. They thought similar programs might work in other Indian communities, if there were the same level of community support. However, they had not been in communication with youth in other Indian centers.

Migrant Latino Farm Workers

There were five participants. One was in his 20s; the others ranged in age from the late 30s to late 50s and were members of various migrant worker organizations. The focus group was conducted in Spanish. The older men were eager to talk; however some of them said they had not previously talked much about AIDS. The participants were quite willing to discuss the risk of sexual transmission through heterosexual intercourse, but did not mention the risk of transmission through men having sex with men. When this question was raised, the participants remained silent.

The participants described two fairly distinct migrant worker populations. Although there was some overlap, the risk behaviors, barriers to prevention education, and possible strategies for the two groups were differentiated.

As described by the participants, one group, found largely in labor camps, comprises single men, most of whom are young, and most of whom are recently arrived in the U.S. This was described as a highly mobile population. These men were said to be from a largely rural background with very little education—a significant number of them indigenous people who speak little if any Spanish. Many of them are said to work here for 6 or 7 months a year and then return to Mexico.

Participants described the other population as consisting mostly of permanent residents in the U.S., many of whom have been here for a long time. They described this as a more stable population living in family units. When speaking of the risk in this population, their primary concern appeared to be with the behavior of adolescent youth, some of whom were born in the U.S., and some of whom are not themselves farmworkers, although their parents are. They said that there are no longer any labor camps in the Imperial Valley, and virtually all of the migrant workers there fall into this more settled category—though they may follow crops here in the U.S. All of the participants considered themselves to be members of this second group. Indeed, one of the characteristics of the more mobile population is a lack of any formal organizations of the sort that the participants represent.

Participants recognized that reaching the workers in camps is a difficult challenge. They pointed out that one of the difficulties of reaching this population is that many of the labor camps are privately owned, and it might be difficult to get access for any kind of program. They said that many of the young men in the camps know nothing about AIDS, but that it would be hard to get their attention, and even harder to get them to modify their behavior. They were described as impulsive, willing to write off the future in the moment. We were told that as soon as they get paid, they want to have some beers and find a woman. They said that prostitutes are sometimes brought into the camps or locate nearby. The participants also mentioned that some of the prostitutes probably travelled back and forth across the border on a regular basis.

One participant suggested that the only way to have an impact might be to try to identify the leaders in the camps—he said that there were always a few men that the others looked up to and followed. He suggested that if those leaders could be identified and given some training—and perhaps paid for it—that might have an effect: the educators would be those that others look up to and emulate. Others said that alarming messages might be tried, over local Spanish radio stations or through videos if those could be shown in the camps.

The participants were also concerned about AIDS education in the Imperial Valley for families like their own. They said that it makes people nervous to talk about AIDS; some

people joke about it. According to one participant, the local Catholic Church does not mention it at all. They said they knew there must be people in the Valley with AIDS, but nobody knows who—it is very hidden. They said that local obituaries never mention AIDS as the cause of death.

There was strong agreement that it was important to reach youth in school. Several participants emphasized that the education should not be just a one-time event, but rather a continuing program.

Participants also suggested a community effort to persuade the Catholic Diocese to become more active—to alert people to the danger and to offer educational workshops. They also suggested that local government should become more involved in informing residents about AIDS.

Several of the participants had seen people with HIV appear on Mexican TV programs. Some suggested that to have people with AIDS who have the courage to talk about their condition—especially if they were local people or migrant workers from elsewhere in California—could have a powerful effect.

Transgender Persons

The three participants in this focus group were all people who have taken visible leadership roles in the community. The focus group and the incentives were well publicized, but recruitment proved difficult. The participants thought this was demonstrative of the reluctance of many transgender persons to come forward in a public forum and of the widespread distrust (based on repeated experiences of misunderstanding and/or personal rejection) of activities that are perceived in some way to be officially sponsored. The participants were quite articulate and clearly committed to giving public voice to the concerns of transgender persons.

The participants described some of their personal experiences of social rejection and abuse for being transgender. They said that extreme discrimination and lack of understanding has led them to be very cautious, slow to open up, and very sensitive to slights and insults. We were told that most of the transgender persons who work at a professional level are very carefully closeted, afraid that someone will give them away. It is often difficult to bring the transgender community together, participants said, because of this lack of trust.

They said that the transgender population is very sophisticated sexually. Participants said transgender persons generally have little need of AIDS 101, yet they are a very high risk group—although there is apparently very little reliable data on the transgender population. Participants said that the high risk behavior is a consequence of low self-esteem and the need

for validation from others; reducing high risk behavior is not a matter of information, they said, but of increasing self-esteem.

Participants indicated that HIV risk behavior in this population included sexual and injection modes of transmission. They said that the transgender identity itself is sexually defined, and that sexual activity often serves as the vehicle for self-identification and self-validation. Drug use, they said, may be a way to self-medicate and anesthetize the pain of social and personal rejection.

The participants emphasized the importance of outreach being done by an out and open transgender person who can both understand and respond to the nuances of communication and who can model mature self-esteem. The participants reported that transgender persons are often treated insensitively by providers who do not understand their needs. We were told that this can lead some transgender people (especially those who for one reason or another cannot easily "pass") to "revert" (to the previous gender role) in order to get services—hence some providers think they have no transgender clients when in fact some of the clients may have "reverted." However, this is said to lead to even greater personal pain and stress for the client.

We were told that one important intervention could be a Transgender 101 course—placing transgender identity in a positive cross-cultural and historical context. One participant said this can be a first step toward greater self understanding and appreciation. Participants said that the very general lack of social understanding of transgender persons needs to change. They said that the whole of society forces one into the mutually exclusive options of male or female, whereas gender is really a continuum. They talked of a number of ways in which the strong cultural expectation of discrete, alternative gender roles has painful and problematic consequences for the transgender person every day. The participants agreed that there are few if any positive images of transgender persons in the media. They said it is hard to feel good about oneself when all public images are negative, and that this must change if HIV risk behaviors in the transgender population are to be significantly reduced.

One of the participants said that it is important to attempt to identify and to support and educate transgender youth. She said that many of the transgender adults of this generation passed through a phase of identifying as gay, but that now some teens are coming out directly as transgender.

Asian/ Pacific Islander Men Who Have Sex With Men

The 17 participants were all gay-identified, mostly young, men. Some were service providers. They were from diverse ethnic backgrounds including Cambodian, Chinese, Filipino, Japanese, Korean, Okinawan, Samoan, and Vietnamese. They were extremely articulate. Many of them were active in various gay and/or Asian/Pacific Islander (A/PI)

organizations. With such a large group of articulate participants, the facilitator had to cut short discussion of some topics in order to at least touch upon other topics in the allotted time. The risk factor implicit to the whole discussion was men having unprotected sex with men. More than in any of the other groups, the participants talked about the diversity of this population and of the different levels of identification. They emphasized that prevention needs and strategies need to be considered separately for each sub-population.

There were two strands of discussion about identity. One in which the Asian/Pacific Islander identities were differentiated. The one Pacific Islander in the group felt he was Pacific Islander, not Asian; but primarily he was Samoan. Nearly all of the participants volunteered that they identified primarily with nationality/language—Chinese, Cambodian, Vietnamese, and so on. Even those who are 3rd generation Americans identified themselves as hyphenated Americans. A couple of participants with different ethnic backgrounds but who had grown up in Hawaii said that was yet another level of identity for them. One said, "Just try putting a group of Japanese and of Koreans in the same room and telling them they have the same background."

From this perspective of differentiated identity, the A/PI grouping seemed relatively new to some, and generally appeared to participants as a pragmatic strategy for coming together collectively so that they had enough numbers to be represented and to have some political clout.

The discussion illustrated in some detail how, within the ethnic subgroups, there was another dimension of how long one has been here, and of how that relates to acculturation. There was agreement that the recent arrival is likely to have different perceptions and needs. And the generational differences were also seen to be important: successful outreach to older men and to youth were said to require different strategies, and in some cases might require outreach workers with different personal characteristics.

The other strand of the discussion of identity delineated how much these diverse A/PI ethnic groups share in cultural attitudes, expectations, and behavior that distinguish them from other ethnic groups in the U.S. Participants found this difficult to articulate in an abstract way, but it was clearly a part of their experience. Some of the elements were about shame, and how that was not just an individual's but reflected on the whole family. There was a consensus that in all the Asian groups it was more difficult to talk with others about personal matters, more difficult to ask for help, more difficult to assert one's independence, and more difficult to come out as gay. There was also a sense that the A/PI label was allowing people to recognize and actualize a more inclusive identity from working together and coming to recognize the similar cultural patterns and the ways these impact on AIDS prevention.

Several of the participants commented that no matter how westernized they felt they were in many ways, many of these cultural patterns persist—even when they do not speak the

ancestral language—and have a powerful impact on their lives. They explained that there is a lot of non-verbal communication within these groups and that what is not explicitly said doesn't have to be recognized. Some said it would be hard for a white person to pick up on this kind of culturally appropriate non-verbal communication; and some said they preferred talking to another Asian about personal matters because of these shared cultural expectations.

They said that throughout these communities AIDS is perceived as the result of shameful behavior, so it is difficult for people to talk about it openly. Straight Asian providers, they said, often find it uncomfortable to talk about AIDS, and hence they are limited in their ability to provide effective prevention services.

Participants agreed that, within the A/PI community, it is best to have a person of the same ethnic/national group doing outreach. The one exception, they said, is that a few of the ethnic communities are so closed that a closeted gay person might find it easier to speak to someone from outside that community—at least initially—because there would be less fear that others in the community would find out they are gay. However, participants said that for most of these communities a person from the same ethnic background is needed to reach people. And it was also said that people need to see someone from that same community who has AIDS—otherwise they say that it doesn't apply to them. They said it has been hard to find A/PI PWAs who are willing to be speakers. They indicated that in the A/PI community, disclosure of HIV is very difficult even for people who are out as gay; in part, they said, this is a matter of not wanting to ask others for anything or to be seen as in need.

They said that for some of the more recent immigrants and for some men who have sex with men—many of whom are married and do not identify as gay—it is important to give them basic AIDS information. However, they said that most of the A/PI gay community is already very sophisticated about transmission risks—what is needed is more support and pride in identity. Participants said that some of the risk factors are around pleasing some ideal white partner or other behavior that comes from low self-esteem. Part of this has to do with changing images, and here the A/PI grouping can work—for example, by picturing Asian men as sexy and attractive.

Participants also said that, related to the difficulty in self-disclosure, a traditional western mental health approach does not work well in this community. One participant said: "Asians hate support groups." They said the need is to bring people in with social activities, some Asian-only and some mixed gay events—you get different Asians going to each kind. One of the providers suggested that for the transgenders there may need to be some kind of prevention case management program to provide adequate support. And because it is difficult to begin to organize this population outside the largest urban areas, they said that existing groups should not be arbitrarily limited by some county or city line in their outreach.

HIV Positive Women

The 12 participants were very diverse in regard to ethnicity/race, educational background, income level, and mode of transmission. Five were white, one was an Asian immigrant, and six were African-American.

Almost half of these women got HIV from a partner in a situation where they did not think there was a risk factor.

Participants discussed the knowledge they had of HIV/AIDS before they discovered they were HIV+. Some thought it was just a gay disease that could really be contracted only by anal intercourse. Others thought it would only be transmitted through risky behavior: "good girls" would not get it.

Participants discussed what puts women at risk. In one way or another, trying to please a man, not wanting to jeopardize a relationship, and a lack of self respect were recurring themes. However, for some of the women, there was a sense that their trust of their partners was what put them at risk, even when they had no reason to believe that it would.

Some of the participants said that their partners did not like condoms, and that there was a stigma attached to insisting on using condoms. They said that changing perceptions about self-worth was vital to the prevention of HIV.

There was a strong disagreement among participants about whether all women were equally at risk or whether poor women and women of color were at greater risk. The division over this issue cut across income and ethnic lines. Some of the participants felt that poorer women were more vulnerable to be being pushed into risky behavior by need; they argued that statistics indicate a rising proportion of HIV cases are in poor and minority communities. Other participants agreed with this, but felt it was very important to make the point that all women are equally at risk of HIV—having unprotected sex just once is enough—and that it was important to get that message to everybody.

Participants felt that it was important that HIV testing be easily available for everybody. Several of them said that if they had taken a risk behavior screening test, they would have been told they did not need the blood test. In fact, this occurred with one of the participants. They mentioned that there were some women at little risk who take the test regularly as if it were some kind of absolution, and they agreed that it was important that testing resources be used for those at great risk. However, they suggested that everyone who comes for counseling be given the blood test at least once; repeat testing could be controlled by screening for risks.

Some participants felt that there needs to be more emphasis on needle exchange programs in areas like Richmond.

They felt it was important to have a general campaign to try to alert women to the real risks; perhaps have posters with very diverse women, all with HIV contracted in so-called monogamous relationships, saying "maybe your husband is bringing something home for you."

A number of the participants said that Magic Johnson's message had been important to them; perhaps other celebrity figures could be involved.

Participants agreed that it is important to have outreach to women by women in the community who are already affected and who understand the difficulties of protecting oneself. A number of participants linked safer sex practices to increased self-respect among women. Some said that this requires changes in the learning of sex and gender roles and in the way children are raised.

NEEDS OF TARGET GROUPS

Substance Users and Their Sex Partners	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.6	Medium	Office of AIDS - 68% Other Agencies - 24% Both - 8%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.7	Medium	Office of AIDS - 3% Other Agencies - 68% Both - 22%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.3	High	Office of AIDS - 73% Other Agencies - 21% Both - 5%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.7	Medium	Office of AIDS - 60% Other Agencies - 35% Both - 5%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.4	High	Office of AIDS - 66% Other Agencies - 26% Both - 9%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.6	Medium	Office of AIDS - 69% Other Agencies - 19% Both - 11%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.7	Medium	Office of AIDS - 65% Other Agencies - 29% Both - 6%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.8	Medium	Office of AIDS - 73% Other Agencies - 22% Both - 5%

Substance Users and Their Sex Partners	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.8	Medium	Office of AIDS - 72% Other Agencies - 19% Both - 8%
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.9	Medium	Office of AIDS - 75% Other Agencies - 17% Both - 8%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.8	Medium	Office of AIDS - 73% Other Agencies - 16% Both - 11%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	2.2	High	Office of AIDS - 69% Other Agencies - 19% Both - 11%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.8	Medium	Office of AIDS - 73% Other Agencies - 19% Both - 8%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.7	Medium	Office of AIDS - 72% Other Agencies - 17% Both - 11%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.8	Medium	Office of AIDS - 72% Other Agencies - 19% Both - 8%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.7	High	Office of AIDS - 77% Other Agencies - 17% Both - 6%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.7	High	Office of AIDS - 76.5% Other Agencies - 20.6% Both - 2.9%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.9	Medium	Office of AIDS - 77.8% Other Agencies - 16.7% Both - 5.6%

Gay and Bisexual Men	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.3	Low	Office of AIDS - 92% Other State Agency - 5% Both - 3%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.3	Low	Office of AIDS - 89% Other State Agency - 8% Both - 3%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	1.8	Low	Office of AIDS - 94% Other State Agency - 6% Both - 0%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.5	Low	Office of AIDS - 84% Other State Agency - 16% Both - 0%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.0	Low	Office of AIDS - 74% Other State Agency - 20% Both - 6%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.2	Low	Office of AIDS - 78% Other State Agency - 17% Both - 6%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.3	Low	Office of AIDS - 77% Other State Agency - 24% Both - 5%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.2	Low	Office of AIDS - 87% Other State Agency - 11% Both - 3%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.1	Low	Office of AIDS - 91% Other State Agency -9% Both - 0%

Gay and Bisexual Men	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	3.0	High	Office of AIDS - 83% Other State Agency - 11% Both - 6%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.5	Low	Office of AIDS - 89% Other State Agency - 11% Both -0%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	1.7	Low	Office of AIDS - 86% Other State Agency - 11% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?			
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.4	Low	Office of AIDS - 86% Other State Agency - 6% Both - 8%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.4	Low	Office of AIDS - 89% Other State Agency - 6% Both - 6%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.4	Low	Office of AIDS - 89% Other State Agency - 9% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.4	Low	Office of AIDS - 88% Other State Agency - 12% Both - 0%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.7	Medium	Office of AIDS - 94% Other State Agency - 6% Both - 0%

Sex Industry Workers	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.5	Low	Office of AIDS - 75% Other State Agency - 22% Both - 3%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.5	Medium	Office of AIDS - 80% Other State Agency - 17% Both - 3%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.2	Low	Office of AIDS - 78% Other State Agency - 22% Both - 0%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.6	Low	Office of AIDS - 78% Other State Agency - 22% Both - 0%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.2	Low	Office of AIDS - 74% Other State Agency - 24% Both - 3%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.5	Low	Office of AIDS - 78% Other State Agency - 17% Both - 6%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.5	Low	Office of AIDS - 74% Other State Agency - 27% Both - 0%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.5	Medium	Office of AIDS - 84% Other State Agency - 14% Both - 3%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.5	Medium	Office of AIDS - 83% Other State Agency -17% Both - 0%

Sex Industry Workers	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.9	Medium	Office of AIDS - 81% Other State Agency - 14% Both - 6%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.7	Medium	Office of AIDS - 87% Other State Agency - 14% Both - 0%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	2.1	Low	Office of AIDS - 78% Other State Agency - 19% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.5	Low	Office of AIDS - 81% Other State Agency - 16% Both - 3%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.6	Medium	Office of AIDS - 78% Other State Agency - 14% Both - 8%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.7	Low	Office of AIDS - 81% Other State Agency - 17% Both - 3%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.7	Low	Office of AIDS - 80% Other State Agency - 17% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.6	Low	Office of AIDS - 79% Other State Agency - 21% Both - 0%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.7	Low	Office of AIDS - 89% Other State Agency - 11% Both - 0%

Youth and Adolescents (12-24 years)	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.8	Medium	Office of AIDS - 54% Other State Agency - 30% Both - 16%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.6	Low	Office of AIDS - 54% Other State Agency -32% Both - 14%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.4	Low	Office of AIDS - 62% Other State Agency - 27% Both - 11%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.9	Low	Office of AIDS - 60% Other State Agency - 30% Both - 11%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.3	Low	Office of AIDS - 60% Other State Agency - 29% Both - 11%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.7	Medium	Office of AIDS - 58% Other State Agency - 30% Both - 11%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.7	Medium	Office of AIDS - 47% Other State Agency - 38% Both - 15%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.9	High	Office of AIDS - 54% Other State Agency - 27% Both - 19%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.6	Medium	Office of AIDS - 54% Other State Agency - 27% Both - 19%

Youth and Adolescents (12-24 years)	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?			
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.7	Medium	Office of AIDS - 65% Other State Agency - 22% Both - 14%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	1.9	Low	Office of AIDS - 66% Other State Agency - 20% Both - 14%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.4	Low	Office of AIDS - 65% Other State Agency - 22% Both - 14%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.5	Low	Office of AIDS - 61% Other State Agency - 22% Both - 17%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.5	Low	Office of AIDS - 69% Other State Agency - 19% Both - 11%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.5	Low	Office of AIDS - 66% Other State Agency - 20% Both - 14%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.4	Low	Office of AIDS - 62% Other State Agency - 27% Both - 12%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.9	Medium	Office of AIDS - 64% Other State Agency - 25% Both - 11%

People of Color Communities	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.6	Medium	Office of AIDS - 92% Other State Agency - 5% Both - 3%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.6	Medium	Office of AIDS - 89% Other State Agency - 8% Both - 3%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.6	Low	Office of AIDS - 92% Other State Agency - 8% Both - 0%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.8	Medium	Office of AIDS - 87% Other State Agency - 11% Both - 3%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.2	Low	Office of AIDS - 79% Other State Agency - 18% Both - 3%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.7	Medium	Office of AIDS - 81% Other State Agency - 14% Both - 6%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.7	Medium	Office of AIDS - 77% Other State Agency - 24% Both - 0%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.7	Medium	Office of AIDS - 95% Other State Agency - 5% Both - 0%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.6	Medium	Office of AIDS - 89% Other State Agency - 11% Both - 0%

People of Color Communities	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.8	Medium	Office of AIDS - 86% Other State Agency - 8% Both - 6%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.7	Medium	Office of AIDS - 95% Other State Agency - 5% Both - 0%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	2.2	Low	Office of AIDS - 89% Other State Agency - 8% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.7	Medium	Office of AIDS - 81% Other State Agency - 14% Both - 5%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.6	Medium	Office of AIDS - 81% Other State Agency - 11% Both - 8%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.7	Medium	Office of AIDS - 83% Other State Agency - 11% Both - 6%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.6	Low	Office of AIDS - 87% Other State Agency - 9% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.7	Medium	Office of AIDS - 88% Other State Agency - 12% Both - 0%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.7	Medium	Office of AIDS - 92% Other State Agency - 8% Both - 0%

Transgender and Transvestite Individuals	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.3	Low	Office of AIDS - 78% Other State Agency - 19% Both - 3%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.3	Low	Office of AIDS -81% Other State Agency - 17% Both - 3%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.0	Low	Office of AIDS - 81% Other State Agency - 9% Both -0%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.5	Low	Office of AIDS - 84% Other State Agency - 16% Both - 0%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.2	Low	Office of AIDS - 77% Other State Agency - 21% Both - 3%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.5	Low	Office of AIDS - 83% Other State Agency - 11% Both - 6%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.3	Low	Office of AIDS - 77% Other State Agency - 24% Both - 0%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.3	Low	Office of AIDS - 87% Other State Agency - 14% Both - 0%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.2	Low	Office of AIDS - 86% Other State Agency - 14% Both - 0%

Transgender and Transvestite Individuals	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.5	Low	Office of AIDS - 83% Other State Agency - 11% Both - 6%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.5	Low	Office of AIDS - 89% Other State Agency - 11% Both -0%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	1.8	Low	Office of AIDS - 81% Other State Agency - 17% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	1.2	Low	Office of AIDS - 82% Other State Agency - 18% Both - 0%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.5	Low	Office of AIDS - 83% Other State Agency - 8% Both - 8%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.6	Medium	Office of AIDS - 83% Other State Agency - 14% Both - 3%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.6	Low	Office of AIDS - 83% Other State Agency - 14% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.5	Low	Office of AIDS - 47% Other State Agency - 50% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.6	Low	Office of AIDS - 91% Other State Agency - 9% Both - 0%

People in the Criminal Justice System	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.5	Medium	Office of AIDS - 38% Other State Agency - 54% Both - 8%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.4	Low	Office of AIDS - 39% Other State Agency - 53% Both - 8%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.3	Low	Office of AIDS - 41% Other State Agency - 54% Both - 5%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.4	Low	Office of AIDS - 36% Other State Agency - 58% Both - 6%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.3	Low	Office of AIDS - 41% Other State Agency - 50% Both - 9%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.6	Medium	Office of AIDS - 44% Other State Agency - 47% Both - 8%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.4	Low	Office of AIDS - 41% Other State Agency - 53% Both - 6%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.5	Medium	Office of AIDS - 32% Other State Agency - 60% Both - 8%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.7	Medium	Office of AIDS - 42% Other State Agency - 50% Both - 8%

People in the Criminal Justice System	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.8	Medium	Office of AIDS - 43% Other State Agency - 49% Both - 9%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.6	Medium	Office of AIDS - 43% Other State Agency - 49% Both - 8%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	1.8	Low	Office of AIDS - 42% Other State Agency -50% Both - 8%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.3	Low	Office of AIDS - 43% Other State Agency - 51% Both - 5%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.4	Low	Office of AIDS - 50% Other State Agency - 39% Both - 11%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.5	Low	Office of AIDS - 39% Other State Agency - 53% Both - 8%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.5	Low	Office of AIDS - 43% Other State Agency - 49% Both - 9%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.5	Low	Office of AIDS - 47% Other State Agency - 50% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.7	Medium	Office of AIDS - 42% Other State Agency - 53% Both - 6%

Homeless and Transient Persons	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.5	Medium	Office of AIDS - 76% Other State Agency - 22% Both - 3%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.6	Medium	Office of AIDS - 78% Other State Agency - 19% Both - 3%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.3	Low	Office of AIDS - 76% Other State Agency - 24% Both - 0%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.4	Low	Office of AIDS - 68% Other State Agency - 30% Both - 3%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.3	Low	Office of AIDS - 68% Other State Agency - 27% Both - 6%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.6	Medium	Office of AIDS - 75% Other State Agency - 17% Both - 8%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.4	Low	Office of AIDS - 77% Other State Agency - 21% Both - 3%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.6	Medium	Office of AIDS - 81% Other State Agency - 16% Both - 3%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.6	Medium	Office of AIDS - 78% Other State Agency - 17% Both - 6%

Homeless and Transient Persons	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.8	Medium	Office of AIDS - 78% Other State Agency - 14% Both - 8%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.6	Low	Office of AIDS - 87% Other State Agency - 11% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	2.1	Low	Office of AIDS - 78% Other State Agency - 14% Both - 8%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.5	Low	Office of AIDS - 81% Other State Agency - 14% Both - 5%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.5	Low	Office of AIDS - 72% Other State Agency - 17% Both - 11%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.7	Medium	Office of AIDS - 75% Other State Agency - 17% Both - 8%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.7	Low	Office of AIDS - 77% Other State Agency - 17% Both - 6%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.7	Low	Office of AIDS -77% Other State Agency - 21% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.7	Medium	Office of AIDS - 92% Other State Agency - 8% Both - 0%

Immigrants and Undocumented Persons	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.4	Low	Office of AIDS - 78% Other State Agency - 17% Both - 6%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.5	Medium	Office of AIDS - 78% Other State Agency - 14% Both - 8%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.5	Low	Office of AIDS - 76% Other State Agency - 16% Both - 8%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.6	Medium	Office of AIDS - 70% Other State Agency - 24% Both - 5%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.4	Low	Office of AIDS - 73% Other State Agency - 21% Both - 6%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.7	Medium	Office of AIDS - 76% Other State Agency -16% Both - 8%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.5	Medium	Office of AIDS - 74% Other State Agency - 24% Both -3%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.6	Medium	Office of AIDS - 73% Other State Agency - 22% Both - 5%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.1	Low	Office of AIDS - 75% Other State Agency - 22% Both - 3%

Immigrants and Undocumented Persons	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.5	Low	Office of AIDS - 75% Other State Agency - 17% Both - 8%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.4	Low	Office of AIDS - 81% Other State Agency - 16% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	2.1	Low	Office of AIDS - 75% Other State Agency - 19% Both - 6%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.5	Low	Office of AIDS - 76% Other State Agency - 19% Both - 5%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.4	Low	Office of AIDS - 81% Other State Agency - 11% Both - 8%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.5	Low	Office of AIDS - 72% Other State Agency - 17% Both - 11%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.5	Low	Office of AIDS - 80% Other State Agency - 14% Both - 6%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.5	Low	Office of AIDS - 79% Other State Agency - 18% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.6	Low	Office of AIDS - 81% Other State Agency - 17% Both - 3%

Women and Their Sex Partners	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.6	Medium	Office of AIDS - 92% Other State Agency - 5% Both - 3%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.5	Low	Office of AIDS - 86% Other State Agency - 11% Both - 3%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.3	Low	Office of AIDS - 89% Other State Agency - 8% Both - 3%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.6	Low	Office of AIDS - 81% Other State Agency - 16% Both - 3%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.2	Low	Office of AIDS - 74% Other State Agency - 21% Both - 6%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.6	Low	Office of AIDS - 75% Other State Agency - 14% Both - 11%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.4	Low	Office of AIDS - 74% Other State Agency - 24% Both - 3%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.7	Medium	Office of AIDS - 92% Other State Agency - 5% Both - 3%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.3	Low	Office of AIDS - 83% Other State Agency - 11% Both - 6%

Women and Their Sex Partners	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.7	Low	Office of AIDS - 83% Other State Agency - 8% Both - 8%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.6	Low	Office of AIDS - 89% Other State Agency - 8% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	2.1	Low	Office of AIDS - 81% Other State Agency - 14% Both - 6%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.8	Medium	Office of AIDS - 84% Other State Agency - 11% Both - 5%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.5	Low	Office of AIDS - 81% Other State Agency - 11% Both - 8%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.6	Low	Office of AIDS - 83% Other State Agency - 11% Both - 6%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.5	Low	Office of AIDS - 86% Other State Agency - 9% Both - 6%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.5	Low	Office of AIDS - 85% Other State Agency - 12% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.7	Low	Office of AIDS - 89% Other State Agency - 8% Both - 3%

Seasonal Farm Workers/Agri-related Workers	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.4	Low	Office of AIDS - 78% Other State Agency - 17% Both - 6%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.5	Medium	Office of AIDS - 80% Other State Agency - 14% Both - 6%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.4	Low	Office of AIDS - 78% Other State Agency - 17% Both - 6%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.6	Low	Office of AIDS - 70% Other State Agency - 24% Both - 5%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.3	Low	Office of AIDS - 72% Other State Agency - 25% Both - 3%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.6	Medium	Office of AIDS - 76% Other State Agency - 19% Both - 5%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.5	Low	Office of AIDS - 71% Other State Agency - 29% Both - 0%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.7	Medium	Office of AIDS - 81% Other State Agency - 16% Both - 3%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.0	Low	Office of AIDS - 81% Other State Agency - 17% Both - 3%

Seasonal Farm Workers/Agri-related Workers	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.4	Low	Office of AIDS - 81% Other State Agency - 14% Both - 6%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.4	Low	Office of AIDS - 81% Other State Agency - 14% Both - 5%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	2.1	Low	Office of AIDS - 77% Other State Agency - 20% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.4	Low	Office of AIDS - 78% Other State Agency - 19% Both - 3%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.4	Low	Office of AIDS - 81% Other State Agency - 11% Both - 8%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.5	Low	Office of AIDS - 81% Other State Agency - 14% Both - 6%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.5	Low	Office of AIDS - 83% Other State Agency - 14% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.5	Low	Office of AIDS - 82% Other State Agency - 18% Both - 0%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.6	Low	Office of AIDS - 83% Other State Agency - 17% Both - 0%

People who Engage in Gender Opposite Sex	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.1	Low	Office of AIDS - 86% Other State Agency - 11% Both - 3%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	2.0	Low	Office of AIDS - 86% Other State Agency - 11% Both - 3%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.0	Medium	Office of AIDS - 78% Other State Agency - 19% Both - 3%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.0	Low	Office of AIDS - 76% Other State Agency - 24% Both - 0%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	1.8	Low	Office of AIDS - 72% Other State Agency - 25% Both - 3%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.2	Low	Office of AIDS - 76% Other State Agency - 19% Both - 5%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.0	Low	Office of AIDS - 77% Other State Agency - 24% Both - 0%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.1	Low	Office of AIDS - 84% Other State Agency - 16% Both - 0%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	1.8	Low	Office of AIDS - 83% Other State Agency - 17% Both - 0%

People who Engage in Gender Opposite Sex	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.3	Low	Office of AIDS - 81% Other State Agency - 14% Both - 6%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.2	Low	Office of AIDS - 87% Other State Agency - 14% Both - 0%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	1.8	Low	Office of AIDS - 75% Other State Agency - 22% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.1	Low	Office of AIDS - 81% Other State Agency - 19% Both - 0%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.2	Low	Office of AIDS - 81% Other State Agency - 11% Both - 8%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.3	Low	Office of AIDS - 75% Other State Agency - 22% Both - 3%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.2	Low	Office of AIDS - 76% Other State Agency - 20% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.3	Low	Office of AIDS - 82% Other State Agency - 18% Both - 0%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.4	Low	Office of AIDS - 83% Other State Agency - 17% Both - 0%

Those in Group Living Situations	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	1.8	Low	Office of AIDS - 65% Other State Agency - 30% Both - 5%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	1.8	Low	Office of AIDS - 67% Other State Agency - 28% Both - 6%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	1.6	Low	Office of AIDS - 68% Other State Agency - 30% Both - 3%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	1.7	Low	Office of AIDS - 57% Other State Agency - 41% Both - 3%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	1.9	Low	Office of AIDS - 61% Other State Agency - 30% Both - 9%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.1	Low	Office of AIDS - 65% Other State Agency - 24% Both - 11%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	1.8	Low	Office of AIDS - 62% Other State Agency - 32% Both - 6%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmisslon of HIV?	1.9	Low	Office of AIDS - 65% Other State Agency - 30% Both - 5%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injectlon drug use?	1.5	Low	Office of AIDS - 64% Other State Agency - 33% Both - 3%

Those in Group Living Situations	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.2	Low	Office of AIDS - 67% Other State Agency - 25% Both - 8%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	1.9	Low	Office of AIDS - 73% Other State Agency - 24% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	1.6	Low	Office of AIDS - 67% Other State Agency - 25% Both - 8%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	1.8	Low	Office of AIDS - 68% Other State Agency - 24% Both - 8%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.1	Low	Office of AIDS - 71% Other State Agency - 20% Both - 9%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.1	Low	Office of AIDS - 69% Other State Agency - 22% Both - 8%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.1	Low	Office of AIDS - 69% Other State Agency - 23% Both - 9%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.0	Low	Office of AIDS - 68% Other State Agency - 27% Both - 6%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.2	Low	Office of AIDS - 64% Other State Agency - 31% Both - 6%

Differently-Abled Communities	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	2.0	Low	Office of AIDS - 51% Other State Agency - 35% Both - 14%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	1.9	Low	Office of AIDS - 58% Other State Agency - 33% Both - 8%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	2.0	Low	Office of AIDS - 57% Other State Agency - 38% Both - 5%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	2.2	Low	Office of AIDS - 49% Other State Agency - 43% Both - 8%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.0	Low	Office of AIDS - 55% Other State Agency - 33% Both - 12%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.4	Low	Office of AIDS - 57% Other State Agency - 32% Both - 11%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	2.1	Low	Office of AIDS - 47% Other State Agency - 41% Both - 12%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	2.2	Low	Office of AIDS - 54% Other State Agency - 35% Both - 11%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	1.5	Low	Office of AIDS - 56% Other State Agency - 42% Both - 3%

Differently-Abled Communities	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.2	Low	Office of AIDS - 58% Other State Agency - 33% Both - 8%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	2.1	Low	Office of AIDS - 62% Other State Agency - 27% Both - 11%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	1.7	Low	Office of AIDS - 56% Other State Agency - 33% Both - 11%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	2.0	Low	Office of AIDS - 62% Other State Agency - 30% Both - 8%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	2.1	Low	Office of AIDS - 67% Other State Agency - 19% Both - 14%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.1	Low	Office of AIDS - 61% Other State Agency - 31% Both - 8%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.2	Low	Office of AIDS - 66% Other State Agency - 26% Both - 9%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.1	Low	Office of AIDS - 71% Other State Agency - 21% Both - 9%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.4	Low	Office of AIDS - 64% Other State Agency - 28% Both - 8%

Persons who Pierce and/or Tattoo	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	1.8	Low	Office of AIDS - 76% Other State Agency - 22% Both - 3%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	1.7	Low	Office of AIDS - 81% Other State Agency - 17% Both - 3%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	1.6	Low	Office of AIDS - 78% Other State Agency - 22% Both - 0%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	1.7	Low	Office of AIDS - 72% Other State Agency - 28% Both - 0%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	1.9	Low	Office of AIDS - 67% Other State Agency - 30% Both - 3%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.1	Low	Office of AIDS - 70% Other State Agency - 24% Both - 5%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	1.7	Low	Office of AIDS - 68% Other State Agency - 29% Both - 3%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	1.7	Low	Office of AIDS - 77% Other State Agency - 24% Both - 0%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	2.1	Low	Office of AIDS - 74% Other State Agency - 23% Both - 3%

Persons who Pierce and/or Tattoo	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.2	Low	Office of AIDS - 72% Other State Agency - 22% Both - 6%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	1.9	Low	Office of AIDS - 73% Other State Agency - 24% Both - 3%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	1.5	Low	Office of AIDS - 69% Other State Agency - 28% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	1.6	Low	Office of AIDS - 72% Other State Agency - 25% Both - 3%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	1.9	Low	Office of AIDS - 77% Other State Agency - 17% Both - 6%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	2.1	Low	Office of AIDS - 72% Other State Agency - 22% Both - 6%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	2.1	Low	Office of AIDS - 71% Other State Agency - 23% Both - 6%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	2.0	Low	Office of AIDS - 77% Other State Agency - 24% Both - 0%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.2	Low	Office of AIDS - 75% Other State Agency - 22% Both - 3%

Children (0 to 11 years)	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Goal I Knowledge/Skills			
Obj. 1-3 &6 Do these target groups need further education/prevention to know how HIV is transmitted, be able to assess their personal risk, and have skills to and tools to protect themselves and others? This includes risk from sexual activities, injection drug use, etc.	1.6	Low	Office of AIDS - 42% Other State Agency - 50% Both - 8%
Obj. 4 Do these target groups need further education/prevention in order to have access to HIV counseling and testing at appropriate intervals?	1.4	Low	Office of AIDS - 49% Other State Agency - 42% Both - 9%
Obj. 5 Do these target groups need further general information about HIV/AIDS?	1.8	Low	Office of AIDS - 49% Other State Agency - 43% Both - 8%
GOAL II Norms			
Obj. 1-2 Do these target groups need further education/prevention to establish peer and groups/social norms by which families, friends, peers, and social/cultural groups support each other to protect themselves from HIV infection?	1.7	Low	Office of AIDS - 46% Other State Agency - 51% Both - 3%
Obj. 3 Do the institutions that serve these target groups need further education/prevention to establish institutional norms by which providers maintain universal precautions and a safe supply of blood and tissues for target groups?	2.0	Low	Office of AIDS - 52% Other State Agency - 42% Both - 6%
Obj. 4 Do the providers, schools, employers, and community leaders that serve these target groups need further education/prevention to establish institutional norms by which they are trained and updated to provide HIV prevention information for these target groups?	2.4	Low	Office of AIDS - 54% Other State Agency - 41% Both - 5%
Obj. 5 Is further education/prevention needed to establish norms in communities that support HIV prevention efforts and programs, (including harm-reduction programs) for these target groups?	1.9	Low	Office of AIDS - 47% Other State Agency - 50% Both - 3%
GOAL III Behavior Change			
Obj. 1 Do target groups need further education/prevention to protect themselves from the sexual transmission of HIV?	1.7	Low	Office of AIDS - 51% Other State Agency - 46% Both - 3%
Obj. 2 Do target groups need further education/prevention to protect themselves from HIV transmission that can occur through injection drug use?	1.2	Low	Office of AIDS - 51% Other State Agency - 48% Both - 0%

Children (0 to 11 years)	Mean Score	Level of Agreement	Primary Responsibility for Prevention
Obj. 3 Do youth in these target groups need further age-appropriate comprehensive prevention services which enable them to protect themselves from the risks of HIV transmission?	2.2	Low	Office of AIDS - 50% Other State Agency - 44% Both - 6%
GOAL IV Behavior Change, HIV+			
Obj. 1-2 Do these target groups need further education/prevention to enable HIV positive persons to protect their sexual and or needle-sharing partners from transmission of HIV?	1.3	Low	Office of AIDS - 58% Other State Agency - 42% Both - 0%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to protect others by not donating blood, tissues, sperm or breast milk?	1.1	Low	Office of AIDS - 55% Other State Agency - 40% Both - 6%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive pregnant women and nursing mothers to reduce perinatal transmission of HIV?	1.3	Low	Office of AIDS - 63% Other State Agency - 37% Both - 0%
Obj. 5 Do these target groups need further education/prevention to enable HIV positive persons to seek counseling about disclosing their status to their sexual and/or needle-sharing partners and seek assistance in partner notification?	1.3	Low	Office of AIDS - 63% Other State Agency - 31% Both - 6%
GOAL V Early Intervention			
Obj. 1 Do these target groups need further education/prevention to enable HIV positive persons to have information about the range of early intervention services and treatment available?	1.7	Low	Office of AIDS - 63% Other State Agency - 34% Both - 3%
Obj. 2 Do these target groups need further education/prevention to enable HIV positive persons to receive counseling, referral, and linkage to early intervention programs?	1.7	Low	Office of AIDS - 59% Other State Agency - 34% Both - 6%
Obj. 3 Do these target groups need further education/prevention to enable HIV positive persons to have access to early intervention programs?	1.8	Low	Office of AIDS - 55% Other State Agency - 42% Both - 3%
Obj. 4 Do these target groups need further education/prevention to enable HIV positive persons to have the skills to initiate and continue safe behavior?	2.1	Low	Office of AIDS - 59% Other State Agency - 41% Both - 0%

GOAL VI To enhance the state of California's capacity	Mean Score	Level of Agreement
Obj. 1 All local HIV prevention programs should receive the technical assistance to maintain quality prevention services.	2.8	Medium
Obj. 2 Training should be available as necessary to prevention providers.	2.8	Medium
Obj. 3 Evaluations of all prevention programs should be conducted. Consumers and providers should be included in the research and evaluation design.	2.7	Medium
Obj. 4 The functions of the Office of AIDS should be maintained and improved, including capacity to award, process, monitor, and reimburse contractors, and continued and improved epidemiologic surveillance efforts.	2.7	Medium
Obj. 5 Behavior studies and prevalence studies should be conducted. Information from these studies should be shared broadly among prevention programs.	2.8	Medium

Summary of CPWG Strategies Survey

	Program Name	Type of Program	Level	Priority Target Group
1	AIDS Education Project (Shasta Co. PHD)	multi-sessions w/small groups	group	high risk youth
2	AIDS Education Project (Shasta Co. PHD)	support group	group	gay/lesbian Youth
3	ARCA AIDS Education Project	6+ extended HIV education	group	all
4	Asian Pacific Islander Men w/Men (Special Service for Groups/APAIT)	outreach and behavior modification	all	Asian men w/ men
5	Calif. Dept. of Corrections	case mgt.	individual	Inmates
6	Calif. Dept. of Corrections	mini-residency	group	inmates
7	Calif. Dept. of Corrections	peer education	group	inmates
8	Calif. Dept. of Corrections	testing	individual	inmates
9	Dos Caminos (Orange Co. Ctr. for Health)	culturally sensitive outreach	Individual	Latinos
10	Early Intervention Project (Health Care Agency)	community Forums	group	HIV+ adults
11	Educational Models for Community Change (NTFAP)	multi-prong outreach and education	community	people of color
12	Enlace Latino: SIDA (Delhi Center)	peer education, outreach, and counceling	all	Latinos
13	Health Program Specialist (Santa Cruz Co. HSA)	multiple group sessions	group	all
14	HIV Bilingual Project (Pioneers Memorial Hospital)	peer education and 3 day AIDS 101	group	all
15	HIV Set Aside (Alcohol and Drug, Sacto, CA)	counseling and testing and EI	individual	African Amer. and Latinos
16	HIV: Woman's Voices (AIDS Services Foundation)	multi-level ed. involving HIV+ women	all	women
17	Lake Co. AIDS Education & Prevention Project	multi-level outreach	all	All
18	Mendocino County AIDS Education/Prevention Proj.	outreach, community ed.,	all	all
19	Mobile AIDS Awareness Project (Santa Cruz Co. HSA)	outreach by cab driver	individual	all
20	Multi-session Intervention for IDUs and Crack users (CSULB)	9 session individual and group ed.	individ./group	drug users
21	North Coast AIDS Project (Humboldt Co. DPH)	community education at community events	community	all
22	Office of Family Planning-Clinical Services (Calif. DHS)	individual counseling	individual	all
23	Project First Hand (Santa Cruz AIDS Project)	train HIV+ speakers	group	all
24	Prototypes/Warn	outreach		IDUs, sex workers, partners
25	Relationship Based Human Sexuality (CCAP)	5 part school-based education	group	adolescents
26	Road Dogs (CSULB)	volunteer peer outreach workers	community	IDUs, partners & sex workers
27	Southern CA. Hotline (APLA)	hotline	individual	all
28	Surviving for the 90s (Planned Parenthood/Orange & San Bernardino)	small group, multi-intervention prgrm	group	out of school youth
29	The Prevention Symbol (Art for Life's Sake)	media campaign	community	all
30	Tulare County AIDS Program (Tulare Co. HSD)	education and referral	group	high risk groups

			Summary of CPWG Strategies Survey			
	No. Served	Location	Reported Effectiveness	Evaluated	Evaluation Type	Cost Information
1	50-75	rural	4	Yes	in house survey	$34/participant
2	20-30	rural	4	Yes	feedback from participants	$147/person
3	1,100	all	4	Yes	in-house pre, post-test	None
4	1,400	urban	3	Yes	survey and questionnaire	None
5	120,000	prisons	2	Yes		None
6	120,000	prisons	2	Yes		None
7	120,000	prisons	2	Yes		None
8	120,000	prisons	2	Yes		None
9	3,000	urban	3	No		None
10	300	urban	3	Yes	SOA collects transmission data	None
11	3,011	urban		Yes	project monitoring, case study	None
12	2,000	urban	3	Yes	pre and post-tests; field notes	Peer education has increased no. served by 10 times
13	4,275	rural	3	Yes	post test and one on one interviews	
14		rural	3	Yes	pre, post-test, survey	None
15		urban	3	No		None
16	8,000	suburban	4	Yes	pre, post-test	Very low costs
17	2,000	rural	3	Yes	in-house ethnographic studies	None
18	2,000	rural	3	Yes	increase in number of clients using services	None
19	1,500	suburban	4	No		$550 per year
20	1,000	urban	4	Yes	periodic interviews with participants	None
21	2,000	rural/suburban	4	Yes	pre, post-test, follow ups, focus groups, feedback	2000 served : 2.0 FTE
22	450,000	all		No		None
23	16,000		4	Yes	post test type survey of audience	None
24	16,000		3	Yes	NIDA funded , 6 mo follow up	None
25	3,000	urban	2.5	No		None
26	2,000	urban	4	Yes	multiple interviews with participants	None
27	90,000		4	Yes	survey of repeat callers	None
28	1,400	suburban	3.5	Yes	in-house evaluation, post-test surveys	$36/person
29		all	4	No		Very low costs
30	4,000	rural	3	No		None

Results of CPWG Prioritization of Strategies by Defined Populations

Strategies	Substance Users & Their Sex Partners	Gay and Bisexual Men	Sex Industry Workers	Youth & Adolescents	People of Color Communities	Transgenders & Transvestite Individuals	People in the Criminal Justice System	Homeless & Transient Persons
Counseling & Testing	2.28	2.59	2.28	2.12	2.64	2.15	2.06	2.34
Hotlines	1.6	2.34	1.6	2.3	1.95	1.73	0.97	0.95
Outreach	2.67	2.59	2.59	2.61	2.64	2.33	1.67	2.34
Peer Education	2.53	2.62	2.5	2.68	2.57	2.45	2.45	2.13
On-site Risk Reduction Education & Counseling	2.44	2.39	2.3	2.24	2.28	2.05	2.22	1.98
Prevention Case Mgmt	2.34	2.44	2.26	2.23	2.1	2.09	2	1.85
Needle Exchange Programs	2.69	1.79	2	1.8	1.87	1.83	1.64	1.8
Bleach & Barrier Demonstration & Distribution/Accessibility	2.62	2	2.26	2.04	2.11	2.10	1.91	2.03
Condom Demonstration & Distribution	2.5	2.67	2.64	2.58	2.51	2.45	2.42	2.19
Speakers' Bureaus	1.65	2.18	1.44	2.32	2.32	1.79	2.12	1.58
Group Presentations	1.68	2.04	1.33	2.21	2.19	1.55	1.95	1.35
Multi-session Groups	2	2.26	1.8	2.34	2.23	1.83	2.13	1.51
Peer Education	2.23	2.36	2.32	2.56	2.36	2.32	2.24	1.73
Social Marketing	1.62	1.92	1.59	2.07	2.15	1.56	1.28	1.09
Media Relations	1.54	1.93	1.59	2.1	2.04	1.27	1.39	1.28
Public Events	1.5	2.13	1.21	2.1	2.13	1.13	0.87	1.35

Strategies	Substance Users & Their Sex Partners	Gay and Bisexual Men	Sex Industry Workers	Youth & Adolescents	People of Color Communities	Transgenders & Transvestite Individuals	People in the Criminal Justice System	Homeless & Transient Persons
Natural Opinion Leaders	1.3	1.9	1.74	1.98	2.05	1.65	1.54	1.45
Community Mobilization	1.68	2.46	1.97	2.25	2.51	2.14	1.57	1.89
Social Marketing	1.79	2.12	1.7	2.11	2.11	1.52	1.28	1.26
Media Relations	1.21	1.74	1.37	1.7	1.81	1.32	1.16	1.21
Public Events	1.26	1.85	0.98	2.05	2.09	1.34	0.66	1.21

Strategies	Immigrants and Undoc-umented Persons	Women & Their Sex Partners	Seasonal/ FarmWork-ers/Agri-related Workers	People who Engage in Gender Opposite Sex	Those in Group Living Situations	Differentl y-abled Com-munities	People who Pierce or Tatoo	Children
Counseling & Testing	1.9	2.05	1.92	1.74	2.05	1.61	1.14	.60
Hotlines	1.53	2.09	1.49	1.89	2.09	1.66	1.07	.55
Outreach	2.15	2.38	2.39	1.50	2.38	1.82	1.19	1.11
Peer Education	2.16	2.40	2.23	1.74	2.40	1.90	1.22	1.10
On-site Risk Reduction Education & Counseling	1.94	2.10	1.93	1.70	2.10	1.73	1.40	1.00
Prevention Case Mgmt	1.83	2.27	1.99	1.40	2.27	1.48	1.07	.89
Needle Exchange Programs	1.49	1.43	1.36	1.23	1.43	.97	1.34	.45
Bleach & Barrier Demonstra-tion & Distribution/Ac cessibility	1.74	1.79	1.65	1.73	1.79	1.53	1.67	.51
Condom Demonstra-tion & Distribution	2.28	2.42	2.33	2.23	2.42	1.92	1.90	.50
Speakers' Bureaus	1.85	2.24	1.75	1.90	2.24	1.80	1.11	1.29
Group Presenta-tions	1.64	2.06	1.63	1.54	2.06	1.73	1.05	1.28
Multi-session Groups	1.71	2.08	1.83	1.56	2.08	1.78	.94	1.05
Peer Education	1.81	2.10	2.10	1.65	2.10	1.79	1.41	.94
Social Marketing	1.44	1.86	1.80	1.60	1.86	1.23	1.03	.92
Media Relations	1.56	1.85	1.56	1.64	1.85	1.24	1.02	1.02
Public Events	1.56	1.92	1.93	1.44	1.92	1.08	.89	.96
Natural Opinion Leaders	1.49	1.92	1.76	1.47	1.92	1.30	.89	.91
Community Mobilization	2.01	2.17	2.20	1.67	2.17	1.56	1.16	.98

Strategies	Immigrants and Undoc-umented Persons	Women & Their Sex Partners	Seasonal/ FarmWork-ers/Agri-related Workers	People who Engage in Gender Opposite Sex	Those in Group Living Situations	Differentl y-abled Com-munities	People who Pierce or Tatoo	Children
Social Marketing	1.57	2.05	1.71	1.52	2.05	1.23	1.03	.89
Media Relations	1.4	1.68	1.45	1.42	1.68	1.14	.87	.73
Public Events	1.56	1.93	1.84	1.24	1.93	.95	.67	.79

Bibliography

SELECTED BIBLIOGRAPHY

JOURNAL ARTICLES AND SPECIAL REPORTS

Abramson, P.R., Sekler, J.C., Berk, R., & Cloud, M.Y. "An Evaluation of an Undergraduate Course on AIDS". *Evaluation Review*, 13(5):516-532, 1989.

Adib, S.M., Joseph, J.G., Ostrow, D.G., Tal, M. & Schwartz, S.A. "Relapse in Sexual Behavior Among Homosexual Men: A 2-year Follow-up from the Chicago MACS/CCS". *AIDS*, 5(6):757-760, 1991.

AIDS Project Los Angeles, Statistics and Conclusions from Southern California HIV/AIDS Hotline, third quarter of FY 1993.

Airhihenbuwa, C.O., DiClemente, R.J., Wingood, G.M., & Lowe, A. "HIV/AIDS Education and Prevention Among African-Americans: A Focus on Culture". *AIDS Education and Prevention*, 4(3) 267-276, 1992.

American Public Health Association, "HIV Education and Condoms in Correctional Facilities: Policy Statement", American Journal of Public Health, 81(2):252.

Anthony, J.C., Vlahov, D., Nelson, K.E., Cohn, S., Astemborski, J., & Solomon, L., "New Evidence on Intravenous Cocaine Use and the Risk of Infection with Human Immunodeficiency Virus Type 1", *American Journal of Epidemiology*, 134:1175-1189, 1991.

Avins, A.L., Woods, W.J., Lindan, C.P., Hudes, E.S., Clark, W., & Hulley, S.B. "HIV Infection and Risk Behaviors Among Heterosexuals in Alcohol Treatment Programs". *Journal of the American Medical Association*, 271(7):515-518, 1994.

Bastani, R., & Marcus, A.C. General Population Survey of AIDS Related Attitudes and Risk Behaviors in California. Submitted to the California Department of Health Services, Office of AIDS, July 1991.

Becker, M.H., & Joseph, J.G. "AIDS and Behavioral Change to Reduce Risk: A Review". *American Journal of Public Health*, 78(4):394-410, 1988.

Berrios, D.C., Hearst. N., Perkins, L.L., Burke, G.L., Sidney, S., McCreath, H.E., & Hulley S.B. "HIV Antibody Testing in Young, Urban Adults". *Archives of Internal Medicine*, 152:397-402, 1992

Berrios, D.C., Hearst N., Coates, T.J., Stall, R., Hudes, E.S., Turner, H., Eversley, R., & Catania, J. "HIV Antibody Testing Among Those at Risk for Infection: The National AIDS Behavioral Surveys". *Journal of the American Medical Association*, 270(13):1576-1580, 1993.

Birkel, R., Golaszewski, T., Korman, J., Singh, B.K., Catan, V., & Souply, K., "Findings from the Horizontes Acquired Immune Deficiency Syndrome Education Project: The Impact of Indigenous Outreach Workers as Change Agents for Injection Drug Users", *Health Education Quarterly*, 20(4): 523-538, 1993.

Bond, L.S., Maznin, R. & Jiminez, M.V. "Street Youth and AIDS". *AIDS Education and Prevention*, Supplement: 14-23, Fall 1992.

Bowser, B.P.,Thompson- Fullilove, M., & Fullilove, R.E. "African-American Youth and AIDS High-Risk Behavior: The Social Context and Barriers to Prevention". *Youth & Society*, 22(1):54-66, 1990.

Brown, L.K., Barone, V.J., Fritz, G.K., Cebollero, P., Nassau, J.H. "AIDS Education: The Rhode Island Experience". *Health Education Quarterly*, 18(2):195-206, 1991.

Brown, L.K., DiClemente, R.J., & Beausoleil, N.I., "Comparison of Human Immunodeficiency Virus Related Knowledge Attitudes, Intentions, and Behaviors Among Sexually Active Abstinent Young Adolescents", *Journal of Adolescent Health*, 13:140-145, 1992.

Brown, L.K., DiClemente, R.J., & Park, T., "Predictors of Condom Use in Sexually Active Adolescents", *Journal of Adolescent Health*, 13:651-657, 1992.

Brown, L.K., Fritx. G.K., & Barone, V.J. "The Impact of AIDS Education on Junior and Senior High School Students". *Journal of Adolescent Health Care*, 10(5):386-392, 1989.

California Department of Health Services, Office of AIDS. AIDS-Related Knowledge, Attitudes, Beliefs, and Behaviors Among African-Americans and Latinos, March 1992.

California Department of Health Services, "California HIV/AIDS Update", Volume 7, No. 2, April, 1994.

California Department of Health Services, Office of AIDS, HIV-Related Risks Among Out-of-School Youths, December 1993.

California Department of Health Services, Office of AIDS, Frameworks for Change: Report of the Multicultural Liaison Board, July 1994.

California Homeless and Housing Coalition, Homeless in California, Special Report, Nov. 1993.

California Senate Office of Research, Analysis of the Nelson-Ezell Undocumented Immigration Initiative, June 29, 1994.

California Senate Office of Research, Californians Together: Defining the State's Role in Immigration, July 1993.

Campostrini, S., & McQueen, D.V. "Sexual Behavior and Exposure to HIV Infection: Estimates from a General-Population Risk Index". *American Journal of Public Health*, 83(8):1139-1143, 1993.

Carnegie Corporation of New York, A Matter of Time: Risk and Opportunity in the Non-school Hours, Report of the Task Force on Youth Development and Community Programs, Carnegie Council on Adolescent Development, New York, NY, 1992.

Caron, S.L., Davis, C.M., Wynn, R.L., & Roberts, L.W. "'America Responds to AIDS,' But did College Students? Differences between March, 1987, and September, 1988". *AIDS Education and Prevention*, 4(1):18-28, 1992.

Catania, J.A., Coates, J.T., Stall, R., Bye, L., Kegeles, S.M., Capell, F., Henne, J., McKusick, L., Morin, S., Turner. H., & Pollack, L. "Changes in Condom Use Among Homosexual Men in San Francisco". *Health Psychology*, 10(3):190-199, 1991.

Catania, J.A., Coates, T.J., Stall, R., Turner, H., Peterson, J., Hearst, N., Dolcini, M.M., Hudes, E, Gagnon, J., Wiley, J., & Groves, R. Prevalence of AIDS-Related Risk Factors and Condom Use in the United State". *Science*, 258:1101-1106, 1992.

Chaisson, R., Moss, A., Onishi, R., Osmond, D., & Carlson, J., "Human Immunodeficiency Virus Infection in Heterosexual Intravenous Drug Users in San Francisco", *American Journal of Public Health*, 77:169-172, 1987.

Chang, R. (Ed.), U.S. National Asians and Pacific Islander HIV/AIDS Agenda, Asian Pacific AIDS Coalition, October 1993.

Choi, Kyung-Hee. "What Do U.S. Heterosexual Adults Believe about Condoms? abstract presented at the IXth International Conference on AIDS, Berlin, June 7-11, 1993.

Chu, S.Y., Buehler, J.W., Fleming, P.L., & Berkelman, R.L., "Epidemiology of Reported Cases of AIDS in Lesbians, United States 1980-1989", *American Journal of Public Health*, 80:1380, 1990.

Coates, T.J. "Prevention of HIV-1 Infection: Accomplishments and Priorities". *The Journal of NIH Research*, 5:73-76, 1993.

Coats, T.J., Stall, R., Catania, J.A., Dolcini, M.M., & Hoff, C.C. "Priorities for AIDS Risk Reduction: Research and Programmatic Direction". (in) AIDS Risk Reduction Research

Coates, T.J., & Stryker, J. "HIV Prevention: Looking Back, Looking Ahead". Keynote address presented at the 1994 Charels C. Shepard Award Ceremony, CDC, Atlanta. May 5, 1994.

Cohen, E. Mackenzie, R.G., & Yates, G.L. "HEADSS, a Psychosocial Risk Assessment Instrument: Implications for Designing Effective Intervention Programs for Runaway Youth". *Journal of Adolescent Health*, 12(7):539-544, 1991.

Cohen, M.I. "A Youth Portrait Gallery: Its Problems, Its Prospects and Some New Paradigms". Keynote address at the Annual Meeting of the Association of Maternal and Child Health Program, March, 1993.

Communication Technologies, A Report On: Planning for the AIDS Epidemic in California: A Population-Based Assessment of Knowledge, Attitudes, and Behaviors, Prepared for the State of California Department of Health Services Office of AIDS, San Francisco, CA, June 30, 1988.

Conner, R.F., "Preventing AIDS Among Migrant Latino Workers: An Intervention and Model". Wellness Lecture Series, School of Social Ecology, University of California, Irvine. 1992.

Conway, G.A., Ambrose, T.J., Epstein, M.R., Chase, E., Johannes, P., Hooper, E.Y. "Prevalence of HIV and AIDS in American Indians and Alaska Natives", *The Provider, A Journal of the Indian Health Service*, 17(5):65-70, 1992.

Conway, G.A., "Racial Misclassification of AI/AN Patients with Class IV HIV Infection", *The Provider, A Journal of the Indian Health Service*, 17(5):72, 1992.

Corby, N.H., Wolitski, R.J., Thornton-Johnson, S., & Tanner, W.M., "AIDS Knowledge, Perception of Risk, and Behavior Among Female Sex Partners of Injection Drug Users", *AIDS Education and Prevention*, 3(4):353-366, 1991.

Crocker, A.C., Cohen, H.J., & Kastner, T.A., "Epidemiology of HIV in Developmentally Disabled" HIV Infection and Developmental Disabilities, Paul Brooks Publishing Co., Baltimore, MO, 1992.

Day, N.A., Houston-Hamilton, A., Taylor, D., Jang, M., & Crowe, G., A Report on the First Tracking Survey of AIDS Knowledge, Attitudes, and Behaviors in San Francisco's Black Communities, for the AIDS Surveillance Office, San Francisco Department of Public Health, by Polaris Research and Development, San Francisco, CA, 1989.

de Wit, J.B.F. & van Griensven, G.J.P. "Time form Safer to Unsafe Sexual Behaviour Among Homosexual Men". *AIDS*, 8(1):123-126, 1994.

Diaz, R.M. *Latino Gay Men and the Psycho-Cultural Barriers to AIDS Prevention*. Stanford University, School of Education and the Centers for AIDS Prevention Studies, UCSF.
DiClemente, R.J. "Confronting the Challenge of AIDS Among Adolescents: Directions for Future Research". *Journal of Adolescent Research*, 8(2):156-166, 1993.

DiClemente, R.J., "The Emergence of Adolescence as a Risk Group for Human Immunodeficiency Virus", *Journal of Adolescent Research*, 5(1):7-17, 1990.

DiClemente, R.J. "Epidemiology of AIDS, HIV Prevalence, and HIV Incidence Among Adolescents". *Journal of School Health*, 62(7): 325-330, 1992.

DiClemente, R.J. "Predictors of HIV-Preventive Sexual Behavior in a High-Risk Adolescent Population: The Influence of Perceived Peer Norms and Sexual Communication on Incarcerated Adolescents; Consistent Use of Condoms". *Journal of Adolescent Health*, 12(5):385-390, 1991.

DiClemente, R.J. "Psychosocial Determinants of Condom Use Among Adolescents". (in) Adolescents and AIDS: A Generation in Jeopardy. R.J. DiClemente (ed). Sage Publications, Inc., Newbury Park, CA, 1992.

DiClemente, R.J., Boyer, C.B., & Morales, E.S., "Minorities and AIDS: Knowledge, Attitudes, and Misconceptions Among Black and Latino Adolescents", *American Journal of Public Health*, 78(1):55-57, 1988.

DiClemente, R.J., Durbin, M., Siegal, D., Kranovsky, K., Lazarus, N., & Comacho, T., "Determinants of Condom Use Among Junior High School Students in a Minority, Inner-City School District", *Pediatrics*, 89(2):197-202, 1992.

DiClemente, R.J., & Hamilton-Houston, A. "Health Promotion Strategies for Prevention of Human Immunodeficiency Virus Infection Among Minority Adolescents". *Health Education* 20(5): 39-43, 1989.

DiClemente, R.J., Lanier, M.N., Horan, P.F., & Lodico, M., "Comparison of AIDS Knowledge, Attitudes, and Behaviors Among Incarcerated Adolescents and a Public School Sample in San Francisco", *American Journal of Public Health*, 81(5):628-630, 1991.

Dorfman, L., Derish, P., & Cohen, J., "Hey Girlfriend: An Evaluation of AIDS Prevention Among Women in the Sex Industry", *Health Education Quarterly*, 19(1):25-40, 1990.

Durbin, M., DiClemente, R.J., Siegel, D., Kranovksy, F., Lazarus, N., & Camacho, T., "Factors Associated with Multiple Sex Partners Among Junior High School Students", *Journal of Adolescent Health*, 14:202-207, 1993.

Dusenbery, L., Botvin, G.J., Baker, E., & Laurence, J., "AIDS Risk Knowledge, Attitudes, and Behavioral Intentions Among Multi-Ethnic Adolescents", *AIDS Education and Prevention*, 3(4):367-375, 1991.

Eisner Freitas, H.H., Lucero, J., & Perez, E. Latino Men Who Have Sex With Men Health Project - Salud es Poder. Tucson AIDS Project, August 1993.

Ekstrand, M.L., & Coates, T.J., "Maintenance of Safer Sexual Behaviors and Predictors of Risky Sex: The San Francisco Men's Health Study", *American Journal of Public Health*, 80(8):973-977, 1990.

Fairbank, Bregman, and Maulin, Inc., A Survey of AIDS Knowledge, Attitudes, and Behaviors in San Francisco's American-Indian, Filipino, and Latino Gay and Bisexual Male Communities, Prepared for the San Francisco Department of Public Health, AIDS Office, May 1991 (Unpublished Report).

Flaskerud, J.H., & Nyamathi, A.M. "An AIDS Education Program for Vietnamese Women". *New York State Journal of Medicine*, 88:632-637, Dec. 1988.

Ford, K., & Norris, A.E. "Knowledge of AIDS Transmission, Risk Behavior, and Perceptions of Risk Among Urban, Low-Income, African-American and Hispanic Youth". *American Journal of Preventive Medicine*, 9(5):297-306, 1993.

Forrest, K.A., Austin, D.M., Valdes, M.I., Fuentes, E.G., Wilson, S.R. "Exploring Norms and Beliefs Related to AIDS Prevention Among California Hispanic Men". *Family Planning Percpectives*, 25(3):111-117, 1993.

Foster, P.M., Phillips, F., Belgrave, F.Z., Randolph, S.M., & Braithwaite, N. "An Africentric Model for AIDS Education, Prevention, and Psychological Services Within the African-American Community". *Journal of Black Psychology*, 19(2): 123-141, 1993.

Franzini, L.R., Sidman, L.M., Dexter, K.E., & Elder, J.P. "Promoting AIDS Risk Reduction Via Behavioral Training". *AIDS Education and Prevention*, 2(4):313-321, 1990.

Froner, G., & Rowniak, S. "The Health Outreach Team: Taking AIDS Education and Health Care to the Streets". *AIDS Education and Prevention*, 1(2):105-118, 1989.

Fullilove, R.E., Thompson-Fullilove, M., Bowser, B., & Gross, S., "Crack Users: The New AIDS Risk Group?", *Cancer Detection and Prevention*, 14(3):363-368, 1990.

Gans, A. *An Exploration of the Relationship of Oral Sex and HIV Transmission Among Gay and Bisexual Men.* Department of Health Science, San Jose State University, May, 1992.

Gans, A., HIV/AIDS and Safer Sex Survey of Gay and Bisexual Men, conducted for the HIV/AIDS Program of the Santa Clara County Health Department, San Jose, CA, June 25, 1993.

Gerard, Gill and Associates, Inc., Qualitative Assessments of Populations with Special Needs: A Report on 13 Focus Groups Conducted for the Alameda-Contra Costa HIV Planning Council, Los Angeles, CA, November 19, 1993.

Gerrard, M., & Reis, T.J. "Retention of Contraceptive and AIDS Information in the Classroom". *The Journal of Sex Research*, 26(3):315-323, 1989.

Gilliam, A., & Seltzer, R. "The Efficacy of Educational Movies on AIDS Knowledge and Attitudes Among College Students". *College Health*, 37:261-265, 1989.

Givertz, D., Katz, M., & Shalwitz, J. Draft: Youth and HIV disease in San Francisco. San Francisco Department of Public Health, AIDS Office and Special Programs for Youth, San Francisco, CA; April, 1993.

Gorrez, L., Araneta, M.R.G., AIDS Knowledge, Attitudes, Beliefs, and Behaviors in a Household Survey of Filipinos in San Francisco, a joint project of the San Francisco Department of Public Health AIDS Surveillance Office, the Asian American Health Forum, and the Filipino Task Force on AIDS, Northern California, April 1990 (Unpublished).

Green R., "Homeless with HIV", *AIDS Service Provider Association Newsletter*, June 1993.

Grinstead, O.A., Faigeles, B., Dinson, B., & Eversley, R., "Sexual Risk for Human Immunodeficiency Virus Infection Among Women in High-Risk Cities", *Family Planning Perspectives*, 25:252-256-277, 1993.

Guydish, J.R., Abramowitz, A., Woods, W., Black, D.M., & Sorenson, J.L. "Changes in Needle Sharing Behavior Among Intravenous Drug Users: San Francisco, 1986-88". *American Journal of Public Health*, 80(8):995-997, 1990.

Guydish, J., Bucardo, J., Young, M., Woods, V., Grinstead, O., Clark, W. "Evaluating Needle Exchange: Are There Negative Effects?". *AIDS*, 7(6):871-876, 1993.

Hamburg, D.A., Nightingale, E.O., & Takanishi, R. "Facilitating the Transitions of Adolescence". *Journal of the American Medical Association*, 257(24):3405-3406, 1987.

Hammett, T.M., Harrold, L., Gross, M. Epstein, J.D. 1992 Update: HIV/AIDS in Correctional Facilities, Washington, D.C.: U.S. Department of Justice, January 1994.

Hanson, M., Kramer, T.H., Gross, W., Quintan, J., Li, P.W., & Asher, R. "AIDS Awareness and Risk Behaviors Among Dually Disordered Adults". *AIDS Education and Prevention*, 4(1):41-51, 1992.

Haverkos, H.W., "Overview: HIV Infection Among Drug Abusers in the United States and Europe", in Batjes, R.J., & Pickens, R.W. (eds.), Needle Sharing Among Intravenous Drug Abusers: National and International Perspectives, NIDA Research Monograph 80, Department of Health and Human Services Publication Number (ADM) 88-1567, Superintendent of Documents, U.S. Government Printing Office, Washington, DC, 1988.

Haverkos, H.W., "Nitrite Inhalants: History, Epidemiology, and Possible Lints to AIDS", *Environmental Health Perspectives*, 102(10):858-861, 1994.

Hayes, R.B., Kegeles, S.M., & Coates, T.J., "High HIV Risk Taking Among Young Gay Men", *AIDS*, 4(9):901-907, 1990.

Hellinger, F.J. "The Lifetime Cost of Treating a Person with HIV". *Journal of the American Medical Association*, 270(4):474-478, 1993.

Higgins, D.L., Galavotti, C., O'Reilly, K.R., Schnell, D.J., Moore, M., Rugg, & D.L., Johnson, R., "Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors". *JAMA,* 266(17):2419-2429, 1991.

Hispanic Medical Consultants, HIV Prevalence and Sexual Knowledge, Attitudes and Practices Among Migrant Farm Workers: San Diego County, July 1992-June 1993, Escondido, CA., 1993.

Holtgrave, D.R., Valdiserri, R.O., Gerber, A.R., & Hinman, A.R. "Human Immunodeficiency Virus Counseling, Testing, Referral, and Partner Notification Services: A Cost-Benefit Analysis". *Archives of Internal Medicine,* 153:1225-1230, 1993.

Holtgrave, D.R., Valdiserri, R.O., & West, G.A. "Quantitative Economic Evaluations of HIV-Related Prevention and Treatment Services: A Review". (in press) October, 1993.

Horan, P.F., DiClemente, R.J., "HIV Knowledge, Communication, and Risk Behaviors Among White, Chinese-, and Filipino-American Adolescents in a High Prevalence AIDS Epicenter: A Comparative Analysis", *Ethnicity and Disease*, 3:97-105, 1993.

Horsburgh, C.R., Jarvis, J.Q., McArthur, T, Ignacio, T, and Stock, P. "Seroconversion to Human Immunodeficiency Virus in Prison Inmates" *American Journal of Public Health*, 80(2):209-210, 1990.

Ickovics, J.R., Morrill, A.C., Beren, S.E., Walsh, U., & Rodin, J. "Limited Effects of HIV Counseling and Testing for Women: A Prospective Study of Behavioral and Psychological Consequences". *Journal of the American Medical Association*, 272(6):443-448, 1994.

Institute of Health Policy Studies, University of California, San Francisco. HIV Prevention in California: Final Report HIV Education and Prevention Evaluation. Prepared for the California Department of Health Services, Office of AIDS, April, 1993.

Ja, D.Y., Kitano, K.J., & Ebata, A., Report on a Survey of AIDS Knowledge, Attitudes, and Behaviors in San Francisco's Japanese Communities, conducted for the San Francisco Department of Public Health Office of AIDS, Asian American Recovery Services, Inc., San Francisco, CA, May 1990 (Unpublished).

Jemmontt, J.B., Jemmott, L.S., & Fong, G.T. "Reductions in HIV Risk-Associated Sexual Behaviors among Black Male Adolescent: Effects of an AIDS Prevention Intervention". *American Journal of Public Health*, 82(3):372-377, 1992.

Johnson, J.A., Sellew, F., Campbell, A.E., Haskell, E.G., Gay, A.A., & Bell, B.J., "A Program Using Medical Students to Teach High School Students About AIDS", *Journal of Medical Education*, 63(July):522-530, 1988.

Johnson, J., Williams, M., & Kotarba, J., "Proactive and Reactive Strategies for Delivering Community-Based HIV Prevention Services: An Ethnographic Analysis", American Journal of Community Psychology, 18(4) 587-596, 1990.

Joseph, S.C. "A Bridge to Treatment: The Needle Exchange Pilot Program in New York City", *AIDS Education and Prevention*, 1(4):340-345, 1989.

Kastner, T.A., Nathanson, R.S., & Marchetti, A.G. "Epidemiology of HIV Infection in Adults with Developmental Disabilities" in HIV Infection and Developmental Disabilities: A Resource for Service Providers. Allen C. Crocker, Herbert J. Cohen, & Theodore A. Kastner (eds.). Paul H. Brooks, Publishing, Baltimore, 1992.

Keller, M.L. "Why Don't Young Adults Protect Themselves Against Sexual Transmission of HIV? Possible Answers to a Complex Question". *AIDS Education and Prevention*, 5(3);220-233, 1993.

Kelly, J.A., Murphy, D.A., Sikkema, K.J., & Kalichman, S.C., "Psychological Interventions to Prevent HIV Infection Are Urgently Needed: New Priorities for Behavioral Research in the Second Decade of AIDS". *American Psychologist*, 8(10):1023-1034, 1993.

Kelly, J.A., St. Lawrence, J.S., Betts, R., Brasfield, T.L., & Hood, H.V. "A Skills-Training Group Intervention Model to Assist Persons in Reducing Risk Behaviors for HIV Infection". *AIDS Education and Prevention*, 2(1):24-35, 1990.

Kelly, J.A., St. Lawrence, J.S., Stevenson, L.Y., Hauth, A.C., Kalichman, S.C., Diaz, Y.E., Brasfield, T.L, Koob, J.J., & Morgan, M.G. "Community AIDS /HIV Risk Reduction: The Effects of Endorsements by Popular People in Three Cities". *American Journal of Public Health*, 82(11):1483-1489.

Kennedy, M., & Houten, C.V. "Providing AIDS-Related Services to Recently Arrived Immigrant and Refugee Youth". *AIDS Education and Prevention*, Supplement: 83-93, Fall, 1992.

Kipke, M.D., Futterman, D., & Hein, K. "HIV Infection and AIDS During Adolescence". *Medical Clinics of North America*, 74(5):1149-1167, 1990.

Klein, J.D., Slap, G.B., Elster, A.B., & Cohn, S.E. "Adolescents and Access to Health Care". *Bulletin of the New York Academy of Medicine*, 70(3):219-235, 1993.

Klein, J.D., Slap, G.B., Elster, A.B., & Schonberg, S.K. "Access to Health Care for Adolescents: A Position Paper of the Society for Adolescent Medicine". *Journal of Adolescent Health*, 13(2):162-170, 1992.

Konicak-Griffin, D., Nyamathi, A., Vasquez, R., & Russo, A.A. "Risk-Taking Behaviors and AIDS Knowledge: Experiences and Beliefs of Minority Adolescent Mothers". University of California, Los Angeles, School or Nurseing. January, 1994.

Kyes, K.B. "The Effect of A 'Safer Sex' Film as Mediated by Erotophobia and Gender on Attitudes Toward Condoms". *The Journal of Sex Research*, 7(2):297-303, 1990.

Lee, P.R., Moss, A.R. "AIDS Prevention: Is Cost-Benefit Analysis Appropriate?". *Health Policy*, 8:193-196, 1987.

Lemp, G.F., Hirozawa, A.M., Givfartz,D., Nieri, G.N., Anderson, L., Lindgren, M.L., Janssen, R.s. & Katz, M. "Seroprevalence of HIV and Risk Behaviors Among Young Homosexual and Bisexual Men". *Journal of the American Medical Association*, 272(6):449-454, 1994.

Leviton, L.C., Valdiserri, R.O., Lyter, D.W., Callahan, C.M., Kingsley, L.A., Huggins, J., & Rinaldo, C.R. "Preventing HIV Infection in Gay and Bisexual Men: Experimental Evaluation of Attitude Change From Two Risk Reduction Interventions". *AIDS Education and Prevention*, 2(2):95-108, 1990.

Lewis, D.K., & Watters, J.K., "Sexual Risk Behavior Among Heterosexual Intravenous Drug Users: Ethnic and Gender Variation", *AIDS*, 5(1):77-83, 1991.

Lewis, D.K., Watters, J.K., & Case, P., "The Prevalence of High-Risk Sexual Behavior in Male Intravenous Drug Users with Steady Female Partners", *American Journal of Public Health*, 80(4):465-466, 1990.

Lex, B.W., "Male Heroin Addicts and their Female Mates: Impact on Disorder and Recovery", *Journal of Substance Abuse*, 2:147-175, 1990.

Longshore, D., Anglin, M.D., Henson, K.D., & Annon, K. HIV Transmission and Risk Behavior Among Drug Users in Los Angeles County. Paper prepared for the Dept. of Health Services, Los Angeles County, December, 1993.

Luna, G.C., Rotheram-Borus, M.J. "Street Youth and the AIDS Pandemic". *AIDS Education and Prevention*, Supplement:1-13, Fall, 1992.

Lurie, P. & Reingold, A., [Principal Investigators], The Public Health Impact of Needle Exchange Programs in the United States and Abroad, prepared by the School of Public Health, University of California, Berkeley, and the Institute for Health Policy Studies, University of California, San Francisco, Prepared for the U.S. Centers for Disease Control and Prevention, October, 1993. (Copies available by contacting Peter Lurie, M.D., University of California, San Francisco Prevention Services Group, 74 New Montgomery St., Ste. 600, San Francisco, CA, 94105, (415) 597-9213.)

Lustig, S.L. "The AIDS Prevention Magic Show: Avoiding the Tragic with Magic". *Public Health Reports*, 109(2):162-167, 1994.

Marin, B.V. & Marin, G., "Effects of Acculturation on Knowledge of AIDS and HIV Among Hispanics", *Hispanic Journal of Behavioral Sciences*, 12(2):110-121, 1990.

Marin, B.V. & Gomez, C.A., Latinos, HIV Disease and Culture: Strategies for AIDS Prevention, University of California, San Francisco, Center for AIDS Prevention Studies, 1993.

Marin, B.V., Marin, G., Juarez, R.A., & Sorensen, J.L. "Intervention from Family Members as a Strategy for Preventing HIV Transmission among Intravenous Drug Users". *Journal of Community Psychology* 20(1):90-97, 1992.

McCusker, J., Stoddard, A.M, Zapka, J.G., & Lewis, B.F. Behavioral Outcomes of AIDS Education Interventions for Drug Users in Short-Term Treatment. *American Journal of Public Health*, 83(10):1463-1466, 1993.

McCusker, J., Stoddard, A.M, Zapka, J.G., Morrison, C.S., Zorn, M., & Lewis, B.F. "AIDS Education for Drug Abusers: Evaluation of Short-term Effectiveness". *American Journal of Public Health*, 82(4):533-540, 1992.

McKusick, L., Coates, T.J., Morin, S.F., Pollack, L., & Hoff, C. "Longitudinal Predictors of Reductions in Unprotected Anal Intercourse Among Gay Men in San Francisco: the AIDS Behavioral Research Project". *American Journal of Public Health*, 80(8):978-983, 1990.

McKusick, L., Hoff, C.C., Stall, R., & Coates, T.J. "Tailoring AIDS Prevention: Differences in Behavioral Strategies among Heterosexual and Gay Bar Patrons in San Francisco". *AIDS Education and Prevention*,3(1):1-9, 1991.

Mickler, S.E. "Perceptions of Vulnerability: Imact on AIDS-Preventive Behavior Among College Adolescents". *AIDS Education and Prevention*, 5(1):43-53, 1993.

Millstein, S.G., Irvwin, C.E., Adler, NE., Cohn, L.D., Kegeles, S.M. & Dolcini, M.M. "Health-Risk Behaviors and Health Concerns Among Young Adolescents". *Pediatrics*, 3(March):422-428, 1992.

Millstein, S.G., Moscicki, A.B., & Broering, J.M. "Female Adolescents at High, Moderate, and Low Risk of Exposure to HIV: Differences in Knowledge, Beliefs, and Behaviors". *Journal of Adolescent Health*, 15(2):133-141, 1994.

Modan, B., Goldschmidt, R., Rubinstein, E., Vonsover, A., Zin, M., Golan, R., Chetrit, A., Gottlieb-Stematzky, T., "Prevalence of HIV Antibodies in Transsexual and Female Prostitutes", *American Journal of Public Health*, 82(4):590-592, 1992.

Munoz, G., Marks, R.S., Munoz, L., & Lloyd, L., HIV Prevalence and Sexual Knowledge, Attitudes, and Practices Among Migrant Farm Workers: San Diego County, July 1992 - June 1993, Hispanic Medical Consultants, Escondido, CA (Unpublished Report).

Murase, K., Sung, S., & Vuong, V.D., AIDS Knowledge, Attitudes, Beliefs, and Behaviors in Southeast Asian Communities in San Francisco, a study conducted for the San Francisco Department of Public Health Office of AIDS and the Center for Southeast Asian Refugee Resettlement, San Francisco, CA, March 1991 (Unpublished).

Nahmias, S., & Feinstein, C.D., "Screening Strategies to Inhibit the Spread of AIDS". *Socio-Economic Planning Science*, 24(4):249-260, 1990.

National Commission on AIDS. Preventing HIV/AIDS in Adolescents prepublication copy, Washington, DC, June, 1993.

National Commission on AIDS. HIV Disease in Correctional Facilities, Washinton, D.C., 1991.

National Community AIDS Partnership. HIV Prevention and Youth: A Guide for Program Development. Washington, D.C., 1993.

National Conference of State Legislatures. Protecting Our Young People's Future: HIV Prevention for Native Americans: A Roundtable for State Legislators, Tribal Leaders and State Health Officials, May, 1994.

National Institute of Mental Health, Putting Knowledge to Work...HIV Prevention Research and Community Programs, Final Report of the Working Meeting Sponsored by the National Institute of Mental Health, December 1-3, Washington DC, 1994 (Unpublished Final Draft).

National Research Council, AIDS: The Second Decade, Miller, H.J., Turner, C.F., & Moses, L.E. (Eds.), National Academy Press, Washington, DC, 1990.

Needle Exchange Programs: Research Suggests Promise as an AIDS Prevention Strategy", Report to the Chairman, Select Committee on Narcotics Abuse and Control, House of Representatives, United States General Accounting Office, March 1993.

Office of the U.S. Surgeon General, One Voice, One Vision: Recommendations to the Surgeon General to Improve Hispanic/Latino Health, Surgeon General's National Hispanic/Latino Health Initiative, TODOS, June 1993.

Onorato, I.M., Gwinn, M., Dondero, T.J. "Applications of Data from the CDC Family of Surveys". *Public Health Reports*, 109(2):204-211, 1994.

O'Shea, D., & Shatz, E. Caring's 1994 Data Pak for HIV/AIDS and Other Health and Human Care Services , 1994.

Ostrow, D. "Recreational Drugs and Sexual Behavior in the Chicago MACS/CCS Cohort of Homosexually Active Men" *Journal of Substance Abuse*, 5-4,311-325, 1994.

Padian, N.S., Shiboski, S.C., & Jewell, N.P., "The Effect of Number of Exposures on the Risk of Heterosexual HIV Transmission", *The Journal of Infectious Diseases*, 161(May):883-887, 1990.

Pentz, M.A., "Reasons for an integrated approach to adolescent health promotion", in Adolescent Health Promotion: Anticipatory Guidance in the Clinical Setting, Beach, R.K, Ed., American Academy of Pediatrics Annual Meeting proceedings, San Francisco, CA, October 12, 1992.

Perkins, D.O., Leserman, J., Murphy, C., Evans, D.L. "Psychosocial Predictors of High-Risk Sexual Behavior Among HIV-Negative Homosexual Men". *AIDS Education and Prevention*, 5(2):141-152, 1993.

Peterson, J.L., Coates, T.J., Catania, J.A., Middleton, L., Hilliard, B., & Hearst, N. "High-Risk Sexual Behavior and Condom Use among Gay and Bisexual African-American Men. *American Journal of Public Health*, 82(11): 1490-1494, 1992.

Remafedi, G. "Cognitive and Behavioral Adaptations to HIV/AIDS Among Gay and Bisexual Adolescents". *Journal of Adolescent Health*, 15(2): 142-148, 1994.

Rhodes, F., Corby, N.H., Wolitski, R.J., Tashima, N., Crain, C., Yankovich, D.R., & Smith, P.K., "Risk Behaviors and Perceptions of AIDS Among Street Injection Drug Users", *Journal of Drug Education*, 20(4):271-288, 1990.

Rhodes, F., & Wolitski, R. "Effect of Instructional Videotapes on AIDS Knowledge and Attitudes". *Journal of American College Health*, 37:266-271, 1989.

Rickert, VI, Gottleib, A., & Jay, M.S. "A Comparison of Three Clinic-based AIDS Education Programs on Female Adolescents' Knowledge, Attitudes, and Behavior". *Journal of Adolescent Health Care*, 11(4):298-303, 1990.

Rickman, R.L., Lodico, R., DiClemente, R.J., Morris, R., Baker, C., & Huscroft, S. "Sexual Communication is Associated with Condom Use by Sexually Active Incarcerated Adolescents". *Journal of Adolescent Health*, 15: 149-154, 1994.

Romero, G.J., Arguelles, L., Rivero, A.M., "Latinas and HIV Infection/AIDS: Reflections on Impacts, Dilemmas, and Struggles", in Women of Color and the Experience of Health and Illness, Wayne State University Press, 1993.

Rotherman-Borus, M.J., Koopman, C., Haignere, C., & Davies, M. "Reducing HIV Sexual Risk Behaviors among Runaway Adolescents". *Journal of the American Medical Association*, 266(9):1237-1241, 1991.

Rounsely, C.A. "Transsexuals Find Support in the Workplace". *San Francisco Chronicle*, E7, August 3, 1994.

Ruder, A.M., Flam, R., Flatto, D., 7 Curran, A.S. "AIDS Education: Evaluation of School and Worksite Based Presentations". *New York State Journal of Medicine*, 90:129-133, 1990.

Rugg, D.L., O'Reilly, K.R., & Galavotti, C. "AIDS Prevention Evaluation: Conceptual and Methodological Issues". *Evaluation and Program Planning*, 13:79-89, 1990.

San Diego Indian AIDS Task Force, San Diego County Indian Community Assessment "Community Vision", May 1993.

San Francisco Department of Public Health AIDS Office Surveillance Branch, HIV Incidence and Prevalence in San Francisco in 1992: Summary Report from an HIV Consensus Meeting. February 12, 1993.

San Francisco Juvenile Probation Department, Juvenile Probation Commission, 1992 Annual Report. City and County of San Francisco, 1993.

Select Committee on Children, Youth, and Families, A Decade of Denial: Teens and AIDS in America, A Report of the Select Committee on Children, Youth, and Families, U.S. House of Representatives, One Hundred Second Congress, Second Session; 1992.

Siegel, D., DiClemente R., Durbin, M., Krrasnovsky, F., & Saliba, P. "Changes in Junior High School Students' AIDS Related Knowledge Misconceptions, Attitudes, and HIV-prevention Behaviors: Effects of a School-Based Intervention". *AIDS Education and Prevention.* (in press).

Sobsey, Dick, Violence and Abuse in the Lives of People with Disabilities, NY: Paul Brookes Publishing Company, Inc., 1994.

Society for Adolescent Medicine, "Access to Health Care for Adolescents: A Position Paper of the Society for Adolescent Medicine", *Journal of Adolescent Health*, Vol. 13, No. 2, 1992.

Solomon, M.Z., & DeJong, W. "Preventing AIDS and Other STDs through Condom Promotion: A Patient Education Intervention". *American Journal of Public Health*, 79(4):453-458, 1989.

State of California Department of Housing Community Development, Comprehensive Housing Afffordability Strategy for Federal Fiscal Years, 1994 through 1998, Sacramento, CA, 1993.

Stall, R., Bye, L., Catani, J., Frutchey, C., Henne, J., et. al., "A Comparison of Younger and Older Gay Men's HIV Risk Taking Behaviors: The Communications Technologies 1989 Cross-Sectional Survey", *Journal of Acquired Immune Deficiency Syndrome*, 5:682-687, 1992.

Stall, R.D., Coates, T.J., & Hoff, C. "Behavioral Risk Reduction for HIV Infection among Gay and Bisexual Men". *American Psychologist*, 43(11):878-885, 1988.

Special Initiative on AIDS of the American Public Health Association, Women and HIV Disease, American Public Health Association, Washington, D.C., APHA/SIA Report 8, January 1991.

Stall, R., Ekstrand, M., Pollack, L., McKusick, L. & Coates, T.J., "Relapse from Safer Sex: The Next Challenge for AIDS Prevention Efforts", *Journal of Acquired Immune Deficiency Syndrome*, 3(12):1181-1187, 1990.

Stephens, R., Simpson, D., Coyle, S., & McCoy, C., "Comparative Effectiveness of NADR Interventions", Handbook on Risk of AIDS, (Ed. B. Brown and G. Beschner), Greenwood Press, CT., 1993.

Stiffman, A.R., Dore, P., Earls, F., & Cunningham, R. "The Influence of Mental Health Problems on AIDS-Related Risk Behaviors in Young Adults". *The Journal of Nervous and Mental Disease*, 180(5): 314-320, 1992.

Sy, F.S., Richter, D.L., Copello, A.G. "Innovative Educational Strategies and Recommendations for AIDS Prevention and Control". *AIDS Education and Prevention*, 1(1): 53-56, 1989.

Tanner, W.M., & Pollack, R.H. "The Effect of Condom Use and Erotic Instructions on Attitudes Toward Condoms". *The Journal of Sex Research*, 25(4):537-541, 1988.

United States Conference of Mayors, Assessing the HIV Prevention Needs of Gay and Bisexual Men of Color, Washington, DC, June 1993.

United States Department of Health and Human Services, Centers for Disease Control, NCPS AIDS Community Demonstration Projects: What We have Learned, 1985-1990, 1992.

University of California, Berkeley School of Public Health, & Institute for Health Policy Studies, University of California, San Francisco, The Public Health Impact of Needle Exchange Programs in the United States and Abroad, Summary, Conclusions and Recommendations. (Prepared for the Centers for Disease Control and Prevention,) September 1993.

Valdiserri, R.O., Lyter, D.W., Leviton, L.C., Callahan, C.M., Kingsley, L.A., & Rinaldo, C.R. "AIDS Prevention in Homosexual and Bisexual Men: Results of a Randomized Trial Evaluating Two Risk Reduction Interventions". *AIDS*, 3(1):21-26, 1989.

Valdiserri, R.O., West, G.R., Moore, M., Darrow, W.W., & Hinman, A.R. "Structuring HIV Prevention Service Delivery Systems on the Basis of Social Science Theory". *Journal of Community Health*, 17(5)259-269, 1992.

Van Oss Marin, B., Gomez, C.A., & Hearst, N., "Multiple Heterosexual Partners and Condom Use Among Hispanics and Non-Hispanic Whites", *Family Planning Perspectives*, 25(4):170-174, 1993.

Van Oss Marin, B., Gomez, C.A., & Tschann, J.M., "Condom Use Among Hispanic Men with Secondary Female Sexual Partners", *Public Health Reports*, (6):742-750, 1993.

Van Oss Marin, B., Tschann, J.M., Gomez, C.A., & Kegels, S.M., "Acculturation and Gender Differences in Sexual Attitudes and Behaviors: Hispanic vs. Non-Hispanic White Unmarried Adults", *American Journal of Public Health*, 83(12):1759-1761, 1993.

Watters, J., Downing, M., Case, P., Lorvick, J., Cheng, Y., & Fergusson, B., "AIDS Prevention for Intravenous Drug Users in the Community: Street-Based Education and Risk Behavior", *American Journal of Community Psychology*, 18(4) 587-596, 1990.

Watters, J., Guydish, J. "HIV/AIDS Prevention for Drug Users in Natural Settings". (in) Preventing AIDS: Theories and Methods of Behavioral Interventions. R.J. DiClemente & J.L. Peterson (eds.) Plenum Press, New York, 1994.

Wilson, J.W., Marelich, W.D., Ascher, M.S., Kerndt, P., Kizer, K.W., & the California Family of Surveyans and Sentinel Surveillance Consortia. "HIV-1 Sero prevalence Among Women Attending Sexually Transmitted Disease Clinics in California". *The Western Journal of Medicine*, 158(1): 40-43, 1993.

Wingood, G.M. & DiClemente, R.J. "Cultural, Gender, and Psychosocial Influences on HIV-Related Behavior of African-American Female Adolescents: Implications for the Development of Tailored Prevention Programs". *Ethnicity & Disease*, 2:381-388, 1992.

Wolfe, L.R., "Fighting for Women's Lives: Philanthropic Responses to AIDS Preventions, Programs, Policy", Center for Women Policy Studies, Washington, DC, 1992 (Unpublished Report).

World Health Organization, Global Programme on AIDS, Office of Intervention Development and Support, High Risk Behaviour Unit. Making Sex Work Safer: A Guide to HIV/AIDS Prevention Interventions. July, 1993.

Zamichow, N., "AIDS Often Goes Undetected in Women", *Los Angeles Times*, September 22, 1991.

Zeldis, J.B., Jain, S., Kuramoto, I.K., Richards, C., Szama, K., Samuels, S., Holland, P.V., Flynn, N. "Seroepidemiology of Viral Infections Among Intravenous Drug Users in Northern California". *The Western Journal of Medicine*, 156(1): 30-35.

Zimit, G.D., DiClemente, R.J., Lazebnik, R., Anglin, T.M., Ellick, E.M., & Williams, P., "Changes in Adolescents' Knowledge and Attitudes About AIDS Over the Course of the AIDS Epidemic", *Journal of Adolescent Health*, 14:85-90, 1993.

LOCAL NEEDS ASSESSMENTS AND SURVEYS

Bleth, G., Fujikawa, B. HIV Disease Prevention and Treatment Plan. Department of Health, County of Fresno, FY 1991-92.

California Department of Health Service, Office of AIDS. HIV/AIDS in Rural and Less Urbanized Areas in California: Epidemiology, Disease Surveillance, and Resource Allocation. A draft discussion paper prepared for the HIV Comprehensive Care Working Group (Year Four), November, 1993.

Central Valley AIDS Team, Survey of AIDS Related Knowledge Attitudes and Beliefs Among Gay and Bisexual Men in Fresno County, May 1994.

Kahn, J.G., Durbin, M., Franks, P. Draft Report to the Fresno Regional HIV Planning Task Force. Institute for Health Policy Studies and Center for AIDS Prevention Studies, University of California, San Francisco, November, 15, 1990.

Lake County Health Services Department. Countywide High School Survey Results, 1991.

Lake County Health Services Department. HIV Educational Needs Survey: Final Report, 1991.

Lammers, P.A., Aziz, M. Report on Student Drug Use in Humboldt County: Results of the 1992-93 Humboldt County Drug Use Survey, June 1993.

Mendocino County Department of Public Health, Division of Alcohol and Other Drug Programs Community Works Project. 1993 Needs Assessment of Alcohol and Other Drug Problems, August, 1993.

Mendocino County Department of Public Health, Division of Alcohol and Other Drug Programs. 1993 Student Alcohol and Drug Use Survey in Grades 7, 9, and 11, Spring, 1993.

Orange County Health Care Agency, Public Health. HIV Strategic Plan: 1993-1995, 1993.

Orange County HIV Planning Advisory Council, Education and Prevention Committee Countywide Educational Inventory. Survey period July 1, 1992 to June 30, 1993.

The Pacific Wellness Institute, California State University, Chico. Youth Health Survey: 8th and 10th Grade Results, Chico Unified School District, November, December, 1992.

Public and Environmental Health Advisory Board. A Community Response: Partnership Strategies for a Health County. Contra Costa County Health Services Department, January, 1993.

The Regional AIDS Planning and Coordination Committee Education/Prevention Task Force. Report on Regional Education and Prevention Activities, Fall 1993.

The Sacramento AIDS Foundation, & The Center for AIDS Research, Education and Services. HIV 2000: A Planning Guide for HIV Care in Northern California, October, 1990.

San Diego City Schools, School Service Division, Area IV, Student Services Dept. Youth Risk Behavior Survey: (1993), February 22, 1994.

San Diego Youth & Community Services, Inc. HIV & Youth Education Project: Video-Based HIV Prevention Research Project Data Package, unpublished raw data, 1994.

Santa Barbara County HIV/AIDS Coordinating Council, Education Committee. Summary of Current HIV/AIDS Prevention Programs and Needs, draft, December, 1993.

Santa Cruz County Health Services. AIDS Response Planning: Education and Prevention Section, 1994.

Stanislaus County Department of Public Health. Assessment of HIV/AIDS Needs in Stanislaus County, August, 1991

Toomey, K.E., Oberschelp, A.G. and Greenspan, J.R. "Sexually Transmitted Diseases and Native Americans: Trends in Reported Gonorrhea and Syphilis Morbidity, 1984-88". *Public Health Reports*, 104(6):566-572, 1989.

Van Griensven, G. "Risk Factors and Prevalence of HIV Antibodies in Homosexual Men in the Netherlands", *American Journal of Epidemiology*, 125(6):1035-1047, 1987.

United Way of Butte & Glenn Counties. An Evaluation of HIV/AIDS Service Delivery in 15 Northern California Rural Counties.

Ventura County AIDS Education Coordinating Committee. HIV/AIDS Education Survey, May - June, 1992 (Updated April, 1993).

Yolo County AIDS Task Force. Yolo County HIV/AIDS Needs Assessment, 1993.