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National Alliance of State and Territorial AIDS Directors

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Focus on Reaching Specific Populations at Risk

This month, NASTAD turns the focus of its *Bulletin* to several populations with specific risk behaviors. These populations are often thought of as “hard to reach,” because the behaviors and socio-cultural contexts that place them at risk are difficult to address. But in many ways, labeling populations as hard to reach is not helpful, because naming a population or behavior “hard to reach” may further stigmatize a group of people who are already stigmatized in one or more ways. ¹ This can also inadvertently provide an excuse for not doing work with these populations.

One reason people use the term “hard to reach” is that many of these populations may be hidden or impacted by multiple, very difficult socio-economic factors. At the same time, a concentration of the epidemic within these groups can have a significant impact. Yet data for these populations is often scarce. ² For these groups, who are often also isolated from traditional mechanisms for prevention and care services, information and attention is critical.

Thus, a focus on hard to reach has been useful as a way to refocus attention on populations impacted by HIV who may be overlooked or inadequately addressed. What the following profiles have in common is not how they seek to further separate and stigmatize various groups, but that they are creating conditions, programs or information that will help to make it easier for people who need HIV services to get HIV services.

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Quantifying HIV Epidemiologic Data For Hard To Reach Populations

By Jim Kent, Senior Epidemiologist, Public Health – Seattle and King County

The following profile from Seattle and King County provides an example of how epidemiology data was applied and used for identifying populations that have been thought of as hard to reach. On November 6, 2005, in a special supplement (Supplement B Volume 17), AIDS Education and Prevention published 11 articles on how the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA) and local health departments use epidemiologic data and other health related data to set priorities for program objectives and resource allocation for HIV prevention and care.

Epidemiologists want to provide data to address every question. Often, however, the question is about a group with only limited information available. Transgender persons and foreign-born persons are two hard to reach populations that local community planning groups (CPGs) asked epidemiologists at Public Health – Seattle and King County to further describe during the prioritization process.

There were several problems with providing these data, including inadequate definition, poor data collection efforts, and no historical data to establish baseline data. While there may be limited data available on hard to reach populations, it is important to critically approach the problem. What data are already available in the HIV/AIDS Reporting System (HARS)? Can a fresh look uncover new perspectives? What other data are available, through Adult Spectrum of Disease (ASD), Sexually Transmitted Disease (STD) databases, or local studies? Can the existing data be validated, corrected, or completed? Could better data be available through implementing revised data collection protocols? Could a better description be provided in a year if certain steps are implemented now? Two examples used by Seattle and King County Public Health are outlined below.

Transgenders

The only solid local data was a needs assessment that identified high self-reported HIV prevalence rates among the 70 transgender persons who participated. However, there was no supporting data on the size of the total transgender population, nor of the total size of the HIV-infected population. Although transgender information was occasionally volunteered on case report forms, this was not routinely collected and only a handful of anecdotal cases were documented. Epidemiologists therefore concluded that high individual risk did not prove the entire transgender population to be a high priority prevention population.

As a result of the concerns stated by the CPG, Public Health agreed to begin directly requesting transgender information for prospective surveillance efforts. Separate questions for sex at birth and current gender were prospectively added to the HIV/AIDS Case Report form. In addition all HARS comment fields were reviewed to identify any possible mention of transgender identity. Providers were contacted to clarify any question about the information.

After 12 months of collecting information on transgender persons, epidemiology was able to draft a Fact Sheet on the transgender population. The report and fact sheet are expected to be available later this spring. Although the total number of documented cases is still small, we now can describe gender identity, age, race, residence, and date of diagnosis for this population.

Foreign-born Persons

In response to the original CPG request for a description of the HIV epidemic among foreign-born persons, epidemiology was able to provide local Census data counts of persons born in other countries, by race. In addition, the country of birth has always been collected on the HIV/AIDS case report form. Preliminary analyses showed no recent increase among all foreign-born persons, but variations by race. The data suggested that cases increased substantially among foreign-born Blacks while remaining stable among native-born Blacks. In addition, these cases contributed toward the increase among heterosexually-acquired infections.

These important findings needed to be validated. For example, perhaps ascertainment of origin has improved over time and accounts for the apparent increase. We reviewed cases missing origin, and reviewed death records, online electronic medical records, and ASD to ultimately obtain a country of birth for 95 percent of total cases. Very few cases missing country of birth were among Blacks or heterosexual transmission cases.

Secondary analyses showed substantial increases over time in the total proportion of cases occurring among foreign-born Blacks. In addition, the transmission profile among foreign-born Blacks was dramatically different than among native-born Blacks.¹ Therefore epidemiology proposed foreign-born Blacks as a priority population for prevention planning. Prevention funds were allocated for interventions. One successful intervention for the past two years has been an international soccer tournament² with on-site counseling, testing, and education.

For more information, contact [Jim Kent](#) at (206) 205-6121.

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Addressing HIV/AIDS among Transgender Populations in Virginia

By Elaine Martin, Director of Community Services, Division of Disease Prevention, Virginia Department of Health

Virginia's interest in addressing the HIV prevention needs of transgender populations stemmed from the community planning process. In 2001, the Virginia HIV Community Planning Committee (HCPC) set new priority populations. While information from national studies and articles indicated that transgender persons were at increased risk for HIV for a variety of reasons, no local data existed. The community planning group (CPG) was unable to incorporate transgender persons into its formula for determining priority populations. Instead, the CPG designated transgender persons as a "population of special interest" and in 2002, the HCPC selected transgender persons as its next research focus.

The Virginia Department of Health (VDH) and the Virginia HCPC have a long history of collaboration with Virginia Commonwealth University's Community Health Research Initiative (CHRI) and has conducted extensive research, needs assessments and population-focused studies with CHRI. In 2003, the CPG, VDH, CHRI and interested community members formed the Virginia Transgender Taskforce. The taskforce established a "Transgender Health Initiative" to improve the capacity of health care providers through training, develop a resource and referral guide for transgender health services, and support research into the risk behaviors, health care access and HIV prevention and care needs of transgender persons in Virginia.

In January of 2004, the first statewide Transgender Health Initiative Training was conducted for 100 HIV prevention and care providers including case managers, outreach specialists, social workers, nurses and health educators. The goal of the two-day meeting was to increase providers' competence in offering effective and sensitive services. In March and April 2004, CHRI held a series of focus groups with 48 transgender individuals to assess risk factors driving HIV infection among transgender persons, and hear their experience in accessing medical care.

In the spring of 2004, VDH issued a state-funded Request for Proposals to support a demonstration site for transgender HIV Prevention Services. The Fan Free Clinic in Richmond, VA was funded to conduct a transgender clinic. Clients receive a mental health assessment, primary medical care, HIV and STD screening and hormone therapy. The hormone therapy acts as a draw to bring people into care who previously have not accessed services. State funds are not used to pay for hormones. A local focus group showed that individuals were willing to pay for their hormones if they could access them legally with a prescription. The clinic is staffed by a nurse practitioner and a licensed counselor. A transgender staff person manages the clinic, registers clients and guides them through the system. In addition to clinical services, the Fan Free Clinic provides HIV prevention education as part of the project. The clinic adapted the VOICES curriculum by developing a new video featuring transgender people. Since the clinic began operation, they have seen 55 clients. Twenty-seven had existing

HIV infection, several of whom were not in care, and nine percent were newly diagnosed through the clinic and have been referred for HIV prevention case management and other support services.

In November 2005, CHRI and the Transgender Taskforce launched the next phase of its research with the Transgender Health Initiative Survey (THIS). THIS is currently in the data collection stage. The survey addresses the HIV prevention, HIV care and overall health care needs of the transgender community in Virginia, and includes questions regarding health status, ability to access health care, violence, substance abuse, housing, employment, and HIV/AIDS. Participants must self-identify as transgender and be a Virginia resident. Participants receive \$15 for completing the survey which can be accessed on-line or completed on paper. Data collection is expected to continue at least through April 2006.

In December 2005, VDH hosted the second Transgender Health Initiative Training for 80 participants. Several noted national speakers on transgender issues conducted this training which was more in depth than the original workshop. The second day of training focused on current transgender research and models for HIV prevention and care including the Tom Waddell Clinic, the Mazzoni Clinic and the local Fan Free Clinic model.

Finally, in February 2006, the Transgender Resource and Referral List was posted on the VDH Division of Disease Prevention website. Although the provider list is small, VDH anticipates that it will grow as the department works to increase the comfort level and expertise of providers, and is able to identify new providers. The next task is to finalize a provider brochure for assessing HIV risks of transgender clients.

For more information, contact [Elaine Martin](#) at (804) 864-7962.

Building Capacity to Address HIV/AIDS in Native American Communities

Native American communities are extremely diverse, with diverse local circumstances and needs. NASTAD produced a Native American Report in 2004 to frame many of the issues health departments need to be aware of when working with Native American communities to address HIV/AIDS in these communities in their jurisdictions. NASTAD is now supporting peer networking among health departments on this issue, and is seeking input and advice from a broad group of stakeholders and experts on HIV/AIDS in Native American communities, including partners funded by CDC to provide technical and capacity building assistance. The following profile by these CDC-funded CBA providers is part of our ongoing efforts to promote dialogue and raise the issues surrounding HIV/AIDS prevention in Native American communities. For more information about NASTAD's activities in this area, please contact [Federico Gutierrez](#) or [Lynne Greabell](#).

Native American Capacity Building Assistance

By Charlene Worley, National Native American AIDS Prevention Center Pamela Thurman Jumper, Center for Applied Studies in American Ethnicity; Michelle Sabori, Inter Tribal Council of Arizona.

Very often, we believe ourselves to be "culturally competent" in HIV/AIDS work. However, we might be surprised to find that we often aren't as culturally attuned as we would like to be. Yet, the importance of cultural competency cannot be overstated with a topic as sensitive as HIV/AIDS. The lack of awareness of cultural differences can create problems for both providers and clients that can impact the access to and quality of prevention and health care. While it is true that, as people, there is much that we have in common, there are fundamental differences that must be acknowledged related to national, ethnic, and cultural identities and experiences. These differences often determine how one seeks care and communicates symptoms and may influence the ways that one reacts and responds to medical education and intervention, as well as how care is delivered. Differences may also influence the expectation that provider and client have of each other. To be culturally competent is to have the knowledge, skills and abilities to effectively work with diverse communities and people. For example, for HIV/AIDS prevention to be effective and successful among American Indian, Alaska Native and Native Hawaiian populations, the unique needs, histories, and socioeconomic contexts of these populations must be deliberately assessed and addressed.

AIDS has steadily increased becoming the ninth leading killer of Native people between the ages of 15 and 44. Surveillance data collected through June 2005, shows that there are still increases in AIDS cases in the American Indian/Alaska Native and Asian/Pacific Islander populations. Despite the work that has been done related to HIV/AIDS, there are major challenges in the prevention of HIV/AIDS in Native communities.

The CDC has funded three Capacity Building Assistance (CBA) providers to provide tailored assistance to Native organizations, health departments, and organization/tribes serving Native people: the National Native American AIDS

Prevention Center (NNAAPC), the Center for Applied Studies in American Ethnicity (formerly identified as the Tri-Ethnic Center) (CASAE), and the Inter Tribal Council of Arizona (ITCA). All services are free and easily accessible.

The National Native American AIDS Prevention Center CBA program provides services in two areas of HIV prevention - organizational development and HIV prevention programming. Organizational development CBA is focused on ensuring that Native-serving organizations have the internal systems in place to support an HIV program. Some examples of assistance include: development of policies and procedures (i.e. Universal Precautions for HIV Counseling and Testing programs), strategic planning for board and staff members, human resource management, fiscal management, strategic fund development, and executive coaching. Prevention programming CBA focuses on helping staff to integrate the needs, beliefs, and principle of Native communities into HIV prevention activities. CBA is provided to organizations with varying degrees of exposure to Native communities and with different levels of familiarity with the CDC's evidence-based HIV interventions (www.effectiveinterventions.org). CBA is also provided to health departments and other agencies with Native constituents on culturally competent ways to access and work with Native communities. Capacity-building assistance is provided through one-on-one consultations, site visits, regional trainings, and clearinghouse information. For more information on this program and other services, contact NNAAPC at (510) 444-2051.

The Center for Applied Studies in American Ethnicity (CASAE, formerly identified as the Tri- Ethnic Center) provides CBA for strengthening community access to and utilization of HIV prevention services, using the highly successful Community Readiness Model (CRM) to improve the capacity of Native serving organizations in the development of strategies consistent with readiness levels. Strategies consistent with readiness are cost effective and have a much higher potential of success in increasing access to and utilization of HIV prevention and risk reduction and avoidance services. Community Readiness has been successfully applied to the development of building cultural competence by various groups. Many Native communities have already embraced CRM and have applied it successfully to other social concerns. Tribes have utilized the model for prevention of: suicide, drug use, partner violence, child abuse and a variety of other concerns. A CR assessment serves as a "community diagnostic" for intervention that sets the foundation for developing strategies to mobilize a community toward HIV/AIDS prevention while gaining the involvement and investment of other organizations, leaders, and community members, thereby increasing capacity to strengthen program efforts, make services more accessible, responsive, and consumer driven. When services are consumer driven, they have a higher potential for utilization. Community Readiness CBA will provide any or all of the following: CR materials (training manual, presentation script, Power Point slide show), a readiness assessment/report/diagnostic, workshop/training, strategy development for intervention and social marketing, and training in participatory evaluation. (<http://www.triethniccenter.colostate.edu/HivAidsPrevention/> or (970) 491-0251).

The Inter Tribal Council of Arizona (ITCA) is a tribal organization whose mission is to support leaders of tribal governments in Arizona and throughout the nation by increasing self-reliance and self-determination. ITCA's National STD/HIV/AIDS Prevention Program (NSHAPP).was established in 1989 to address the increasing disparity of HIV/AIDS among American Indian tribes and provides tailored CBA across all CDC regions to CBOs, state health departments, community planning groups (CPGs), tribal health consortia and coalitions, and individual planning group members to achieve and ensure parity, inclusion and representation (PIR) of American Indian/Alaskan Native/Native Hawaiians (AI/AN/NH's) in HIV community planning through orientation, skills building for active participation, leadership development and consensus building, among others. Training is also provided to local CPG's and state health departments on general HIV community planning concepts and procedures, cultural competency and how to recruit and retain AI/AN/NH CPG members. For more information or to request CBA, contact ITCA at (602) 258-ITCA or visit the ITCA website at www.itcaonline.com (http://www.itcaonline.com/program_hiv.html).

For more information on the CBA available for American Indian/Alaska Native/Native Hawaiians, visit : joint factsheet: <http://ewebs.realtimesites.net/ds-Southwestern/sout-j-2/ImagesCust/1067269050-06-10-2004-11-42-15l.pdf>.

Addressing the Needs of Migrant Workers: Strategies from California

By Matthew Facer, Epidemiologic Studies Section, Office of AIDS California Department of Health Services

According to the U.S. Custom and Border Protection agency, over 85 million individuals cross the U.S./Mexico border through Southern California annually, making this the largest port of entry along the U.S./Mexico border. Of the 85 million, 97 percent of those entering the U.S. cross the border through the use of either a passenger vehicle (more than 67 million) or simply cross the border through customs by foot (more than 17 million).¹ These numbers include migrant workers and their families, who disperse throughout both rural and urban areas of California, serving as a critical source of labor.

Migrant workers and their families face multiple challenges that directly impact health and wellness, including poor working

and living conditions, barriers in accessing adequate health care, and sexual risk behavioral practices that may increase exposure to HIV/AIDS and/or other STD's.²

The state of California has taken steps to address the needs of this population through programmatic components designed to not only directly serve migrant communities but also attempt to get a better understanding about this population through the increase of surveillance activities. The following four projects reflect past and/or ongoing efforts by the state to address the multiple and complex needs of this population.

The California-Mexico Epidemiological Surveillance Pilot (CMESP) Project

Funded by the Universitywide AIDS Research Program of the University of California Office of the President, the CMESP project is a collaborative project with the California Policy Research Center, the California Department of Health Services, the federal Secretariat of Health of Mexico, and the CDC. The goals of the pilot among communities of Mexican migrants and recent U.S. immigrants of Mexican descent are:

1. To jointly develop a bilateral epidemiological surveillance system to provide improved monitoring of behavioral, medical, environmental, and service trends and changes;
2. To assess the burden and trends of HIV/STD/TB disease and other health conditions; and
3. To evaluate the impact of disease prevention (particularly HIV/STD/TB), through health care programs, behavior interventions, and linkage to care strategies.

HIV Testing Survey (HITS 2002) among Migrant/Seasonal Farm Workers

The Office of AIDS, in collaboration with CDC, the Community Medical Centers, Inc., and the counties of San Joaquin, Solano, and Yolo, conducted an anonymous cross-sectional study among migrant/seasonal farm workers. The purpose of the HIV Testing Survey (HITS) was to monitor HIV testing patterns and to assess why at-risk individuals seek or delay HIV testing and what factors influence their decisions. California interviewed 300 individuals recruited from venues such as migrant camps, employment fairs, health fairs, local festivities, and community dances. Results of the survey will assist in developing specific interventions and prevention programs to help migrant/seasonal farm workers overcome barriers to HIV testing and will assess knowledge and issues surrounding state policies for HIV surveillance. Preparation of the state report is ongoing and expected to be complete by June 2005.

A second module of this study addresses the implementation of the Simplified Epidemiological Surveillance System (SESS) in rural areas in California and Mexico. The SESS combines syndromic assessment with community outreach methods and referrals and has proven to be a successful system in rural areas in Mexico. A third module addresses the periodic sampling of targeted populations in urban and rural sites for behavioral surveillance and disease prevalence through interview and serologic and urine testing.

Study of Latino Day Laborers in the Agricultural Sector – Monterey and San Francisco

Several studies of Mexican migrant workers have indicated that the majority of these workers do not access HIV testing services. These studies have largely been quantitative in nature. Relatively few studies provide an in-depth assessment of this population's perceptions of HIV risk and barriers to HIV testing, which is critical to effectively encouraging a desired behavior. A qualitative assessment that would provide for a more comprehensive understanding of HIV-related behaviors of this population was desired. To this end, the Office of AIDS conducted a cross-sectional survey of Latino migrant workers who were at least 18 years old between July 2004 and March 2005. The sample consisted of 126 laborers from San Francisco and 125 workers from the agricultural sector in Monterey County.

The study consisted of an interview conducted by bilingual, trained outreach workers from a standardized questionnaire and oral specimen collection that was tested for HIV antibody via Orasure. The questionnaire obtained information related to HIV/AIDS such as sexual and drug-using behavior, medical history (including HIV testing history), current access to health care, knowledge of HIV, and reasons for not seeking HIV testing. In addition, the questionnaire obtained information on demographics, English language usage, and migration patterns. Dissemination of study results will begin in 2006.

Health Assessment Survey of Urban Latino Migrant Workers

Between April and December 2003, the Office of AIDS conducted a health assessment survey among 291 urban Latino migrant workers in the East Bay Area. This cross-sectional study was designed to examine the sexual beliefs and behaviors of these individuals and their access to health care. Each participant was interviewed using a standardized questionnaire. Specific study objectives include:

1. Examining the sexual beliefs and behaviors of urban Latino migrant workers;
2. Examining their knowledge and practice of methods to prevent sexually transmitted disease infection;
3. Assessing the effects of migration on changes in sexuality and sexual practices; and
4. Examining health care access and utilization.

The above studies have been designed to assist public health officials understand risk behavior practices that are intertwined in culture. Critical to the success of interventions is having an understanding of the community one wishes to target and collaborations with federal and indigenous partners has helped the Office of AIDS build this understanding.

For more information, contact Matthew Facer at: (916) 449-5835 or via e-mail: MFacer@dhs.ca.gov.

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Prevention in Rural Communities

Every state has some areas that they deem rural. While some states are primarily rural in nature, the nature of its "ruralness" will depend on several local factors. What this means for HIV/AIDS and viral hepatitis prevention is that the populations at risk have different characteristics in different regions. While recent analyses have found that the "rate of new AIDS diagnoses in 2000 was lower for rural areas than for suburban or urban areas,"¹ many reports confirm the higher rates of AIDS in the largely rural Southeast and Mississippi Delta Region ^{2,3}, particularly impacting African Americans and Latinos.⁴ Other research suggests that while the proportion of the epidemic in non-metropolitan areas (population less than 50,000) to metropolitan areas has remained relatively constant throughout the epidemic small changes in the impact of HIV/AIDS in rural areas can have a significant impact ⁵ and there is a need for more data on emerging populations at risk for HIV/AIDS in rural areas.⁶

Two of the main reasons that prevention in rural areas is particularly challenging is the relative dearth of available and accessible services and providers juxtaposed with the additional barriers impacting the risk of rural residents for HIV, STDs and viral hepatitis. In the rural South, African Americans at risk for HIV/AIDS, particularly gay men and men who have sex with men, face significant stigma caused by persistent racism and homophobia. As Lichtenstein's review of the literature states, "men in the rural Deep South fear being labeled as homosexual. This fear is more pronounced for African-Americans, especially in rural communities where homophobia intersects with religiosity and with cultural constructions of a dominant heterosexual masculinity."⁷ Stigma is also a factor in rural areas in other parts of the country such as the Midwest and "frontier" states. Dreisbach and colleagues found that in rural Colorado, "conservative values marginalize non-conforming behaviors such as homosexuality, drug use, and sex outside marriage," including within specific racial/ethnic populations.⁸

Perhaps one of the more chilling aspects of the challenges to working on HIV/AIDS and other STDs in rural areas is the impact on providers of prevention services. In their paper, Dreisbach and colleagues concluded that the "current HIV prevention policy and rural structural challenges have inadvertently interacted to demoralize rural prevention specialists and weaken the capacity for early detection of HIV infection in rural Colorado."⁹

Yet despite these challenges, rural HIV/AIDS prevention providers are responding with innovative and more integrated

approaches to dealing with these challenges. Two of these approaches from Wyoming and Mississippi are profiled below.

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Wyoming's Internet-Based Program for Gay Men

In Wyoming, the large geographic areas and the fact that there are no other venues in which to locate prevention services (e. g., gay bars), caused researchers at the University of Wyoming, working with the health department HIV/AIDS program, to develop an online assessment of rural gay men (<http://www.wrapp.net/>) through their Wyoming Rural AIDS Prevention Projects (WRAPP) program. Qualitative interviews were conducted with forty men to determine their needs and identify the issues gay men are facing. Of the forty men surveyed in the initial needs assessment, 67.5 percent identified as gay and 32.5 percent identified as bisexual. Of these forty men, only 10.7 percent were living with a partner at the time of the survey and all of the men had been tested for HIV. Almost 67 percent of those surveyed said they always used a condom with casual partners and 50 percent of the men surveyed said they would have sex with a man they didn't know. One reason this is so important is that most of Wyoming's prevention efforts have been focused on gay identified men who have sex with men.

Funded by the National Institute of Mental Health, the assessment was used to help create a series of internet-based interventions: 1.) a knowledge intervention with basic HIV prevention information provided through online peer conversations; 2.) a context based intervention with ways to stay safe when meeting men; and 3.) a situation/partner based intervention focused on condom communications with casual or new partners. The program is based on Social Learning theory and WRAPP researcher Margaret Legaretta says she believes the most important aspect of the intervention is the tailoring to individuals needs. "We ask the men a series of questions through out the intervention and based on the feedback we are receiving, the path of the intervention changes. Several studies have shown that a boxed intervention doesn't work well. It takes a little tailoring to an individual to get them not only involved but to get them thinking about their own circumstances."

WRAPP places information about its program on internet banners on sites such as www.gay.com <<http://www.gay.com/>>. Their needs assessment confirmed this particular site as a frequent destination for gay men in Wyoming. The assessment also said that other means to promote messages, such as word of mouth, were not as effective in rural states that have a dearth of gay venues for this to take place. Currently in the fifth year of a five-year project, the interventions on the WRAPP site have been available for one and a half years. The researchers are now getting outcome data and finding they are reaching not only Wyoming gay men, but also men around the world as they have developed a truly international reach.

As with any internet intervention, WRAPP is tracking how it is being used. Legaretta estimates that they have had hundreds of thousands of hits, but what is more important is the number of registered users they have. While they are still checking out the fraudulent accounts from the good ones, they have 1400 registered accounts. Their information on rates of completion of the interventions is not yet complete, and data collection on these is still underway.

The health department has used the information from WRAPP as a resource for information on men who have sex with men in Wyoming, information on their needs and behaviors. They found that the work done by local researchers has led to more culturally competent and trusted products, whereas outside researchers assumed an implied rapport and credibility that did not automatically confer in a conservative, closed environment like Wyoming.

“A lot of states are looking at internet interventions--what makes this one different is the programmed learning models that someone can do at their own pace and in the privacy of their computer,” says Rob Johnston, HIV Prevention Coordinator in the Wyoming HIV/AIDS/Hepatitis Program. Legaretta added, “from my perspective, the key lesson I have learned is that presentation of the material makes a large difference. You have to find a way to draw men in, not only to keep them interested and coming back, but to also help them gain the information that is useful and valuable to them. That is why tailoring to individual needs as much as possible is important in any intervention whether it be internet or a more traditional venue.” While the project is currently in the fifth of a five year funding grant from the NIMH, WRAPP is currently exploring several options for further supporting and expanding their internet-based programs for rural Wyoming gay men.

For more information on WRAPP, visit their website or contact Margaret Legaretta at WRAPP: Marg@uwyo.edu, or Rob Johnston at the Wyoming Department of Health: rjohns11@state.wy.us.

Mississippi’s Mobile Medical Clinic

Mississippi is another rural state, but one with a much different epidemic and population than Wyoming. A program Mississippi has found useful in reaching those at risk for HIV in rural Mississippi, in fact throughout much of this largely rural state, is its Mobile Medical Clinic. In conjunction with their syphilis elimination efforts, Mississippi petitioned CDC for funding to purchase a mobile medical unit to provide HIV testing and syphilis screening, paired with screening for other critical health problems, within the communities hardest hit by HIV and syphilis in Mississippi. The clinic was first used in Mississippi’s largest urban environment, Jackson, although even there, it doesn’t take long to reach a rural setting. Mississippi put the clinic on the road in 2001 and they have tested over 9,500 people and detected a total of 33 new HIV infections, 163 new syphilis cases, 236 chlamydial infections and 48 gonococcal infections.

To ensure that the clinic is not identified solely as the “VD” van, as well as to screen for other health problems that affect communities that are also at high risk for HIV, the clinic offers glucose, blood pressure and cholesterol screening as incentives to board the clinic where they can learn about screenings for HIV and other STDs. Mississippi primarily targets areas where people are at highest risk for HIV and syphilis, specifically focusing on African Americans. By offering the screening for other diseases, Mississippi gave people a reason to be in the clinic for the HIV and STD screening, while at the same time helping to identify critical health problems that occasionally required immediate attention at local hospitals. A unique memorandum of agreement between the health department and local providers is set up so that providers of care for diabetes and high blood pressure and cholesterol will accept and follow any patients the clinic identifies during screenings in their area. In addition to blood pressure, body mass index, cholesterol and glucose screenings, based on community requests we have partnered with various public and private programs and health care providers to perform clinical breast exams, PAP smears, PSA screening, digital rectal exams, and dental sealant applications in youth (through school systems).

The health department does not take the mobile clinic into a community without first arranging for a local sponsoring organization, like a church or community representative, to ensure that there is support in the community for their presence. It is critical that the community knows that the clinic is there by the invitation of the local sponsoring entity. Where the clinic sets up shop depends on the locality. In some areas, the clinic works near meat processing plants, in others, it’s another community venue. But in any event, the key aspect is that the clinic is located where the people are. According to STD/HIV Director Craig Thompson, “people appreciate that these services come to them.”

Another key feature critical to the success of the clinic is that it operates on virtually a 24/7 basis. It often runs on nights and weekends, and has become, Thompson says, “an easily identifiable and trusted facility in the community at times when they are most able to use it.” The most people the clinic has screened in a day is 500. At this point, the clinic uses serologic rather than rapid testing technologies because the venue is not conducive to rapid test use, and because, as Thompson says, “until there is a rapid oral test for syphilis, Mississippi will continue to use serologic tests – to lose control of syphilis is

tantamount to the beginning of the loss of control of HIV – they go hand in hand here.”

After Katrina, the clinic was loaned out to the Gulf Coast region to use as a county health department. The clinic was recently returned to its original use and is back on the road reaching out to communities across Mississippi. Thompson says that “screening in low-income African Americans communities casts a net capable of detecting HIV infections – we believe this more traditional public health approach is responsible for the continued decline in incident HIV disease in Mississippi.”

For more information on this program contact Craig W. Thompson, Director, STD/HIV Bureau: craig.thompson@msdh.state.ms.us.

Online Resources for Community Outreach to Injection Drug Users

www.cdc.gov/outreach/

CDC recently unveiled a new website focused on outreach to injection drug users (IDUs): <http://www.cdc.gov/outreach/>. A key feature of the site is the easy access to a wide array of program materials – operations manuals, slide sets, forms – from actual outreach programs, so that others can gauge what they are doing and not “reinvent the wheel” so to speak. CDC intends the site to be dynamic, continually updated and improved as people use and provide feedback on the site.

Outreach is a particularly useful prevention strategy for reaching IDUs. The major tenet of outreach is that the services are made available where the clients are in the community. Effective outreach helps people understand their risk, make behavior changes, and bring them into a continuum of prevention and care services. Considerable information and materials on outreach were gathered as the CDC-supported IDU technical assistance (TA) was developed through the Academy for Educational Development (AED). The outreach site was created as a companion to their www.cdc.gov/idu/ site to support increased peer networking and sharing.

Yet in the course of this IDU TA work, CDC found that many programs were still struggling with how to support targeted outreach for IDUs. CDC’s Advancing HIV Prevention (AHP) has emphasized improved targeting of effective prevention services, including HIV testing and behavioral interventions. To respond, many programs like the one in Texas (see profile below), now only fund outreach which recruits IDUs into effective behavioral interventions. Much of the movement in this direction is to ensure that outreach is tied to evidence-based interventions.

The diverse models and approaches to outreach for IDUs found in developing its IDU TA prompted CDC to create the website. An early version of the site was previewed at the 2005 National HIV Prevention Conference, and the site went live in October 2005. Visit the outreach website at: www.cdc.gov/outreach/.

For more information, contact Danni Lentine, MPH, Public Health Analyst at CDC. NASTAD thanks Danni and T. Stephen Jones for their assistance with this article.

Prevention Outreach and Recruitment in Texas

In 2003, the Texas Department of State Health Services (TDSHS) changed the way they fund HIV/AIDS prevention outreach. Prior to 2003, Texas funded outreach as a stand-alone intervention. While contractors had specific objectives for outreach contacts, outreach was not tied to recruitment into other interventions. In 2003, Texas modified their RFP contracts for local health departments and CBOs to require funded programs to provide evidence-based interventions (EBIs). This meant that outreach would no longer be funded as an intervention on its own and had to be done only as a method to recruit individuals into partner counseling/partner elicitation (PCPE), prevention case management (PCM), or an EBI.

To support this change, the health department invited current providers and potential applicants to a presentation about the changes in the RFP. In the presentations, they emphasized the critical role of outreach as a method to recruit individuals into these interventions and stressed targeting those populations at highest risk, as identified by the community planning groups in Texas. The presentation also emphasized that while providers may see fewer individuals overall, they will have a greater impact on those they do contact.

The RFP for 2003 HIV Prevention Contracts specifically said that, "Outreach strategies must include building rapport with community members who may later be referred to more intensive programs, identifying barriers affecting service delivery, and identifying lifestyles and behaviors of the target populations through conducting a community assessment." Contractor budgets encouraged agencies to purchase incentives (in Texas contracts they are tangible reinforcements) for use during outreach as a way to encourage recruitment to PCPE, PCM and EBIs. DSHS gave agencies one-time funds in 2003 for start-up needs such as tangible reinforcements or staff attendance at the Texas Outreach Workers Conference. (Link to the 2006 Street Outreach Conference at: <http://www.hivconnection.org/calendar/index.html>, or the 2005 Conference <http://www.hivconnection.org/services/conferences/index.html>).

Texas now requires process objectives for all funded outreach. Agencies must report on the number of outreach contacts by target population, and the health department provides a standardized format. Technical assistance and training is provided by TDSHS staff, as well as peers from experienced agencies and through a Recruitment Technical Assistance Bulletin. Texas also revised its prevention monitoring tool to fit the new interventions and expectations: <http://www.tdh.state.tx.us/hivstd/fieldops/page2.htm>.

Texas has learned several lessons through the process of changing their RFPs. While change is difficult, it is important to start the process early, set clear expectations from the beginning, and use consistent language in RFPs, site visit tools, program guidance. Making sure that health department staff know and understand the change is also critical as is providing technical assistance to support the process.

NASTAD thanks Tony Schmitt, Manager, and Jenny McFarlane, Team Leader, HIV/STD Prevention Services Group in the Texas Department of State Health Services for their assistance with this story. For more information, visit: www.tdh.state.tx.us/hivstd.

Adolescent and School Based Health: Incorporating Youth in HIV Prevention and Community Planning

Involving youth in programming planning and decision making is a fundamental concept for achieving appropriate and sound programming. Many agencies such as the International Planned Parenthood Federation (IPPF), United Nations Children's Fund (UNICEF), and the World Health Organization (WHO) have identified this programmatic strategy as one of the most important guiding principles in working with youth. The IPPF Task Force on Youth, for example, strongly urges meaningful implementation of youth involvement, arguing that tokenism is not acceptable.¹

Feedback from an informal NASTAD survey of eight health departments in January 2006 identified "bringing youth to the table" and developing "meaningful youth involvement" in their planning processes and programs as common concerns. The benefits of youth involvement for building credibility and ownership among youth, as well as for helping adults better understand and value young people's perspectives and contributions, continue to lead HIV prevention programs to explore new methods to engage youth. Following is an update on the Pennsylvania Young Adult Roundtables, which NASTAD has profiled in past years.

Profile of the Pennsylvania Young Adult Roundtables

By Michael D. Shankle, University of Pittsburgh, Pennsylvania Prevention Project. Joseph Pease, Director, Division of HIV/AIDS, Pennsylvania Department of Health

Beginning with four statewide groups in 1995, Pennsylvania's Young Adult Roundtables have been designed to provide young people aged 13 to 24, parity, inclusion and representation in our state's HIV prevention community planning process. Each of the current six groups is comprised of 15–20 "high-risk" young adults from diverse communities across the state. Each Roundtable group meets five times during the year for three hours in order to discuss and to provide important HIV prevention needs assessment information to the Pennsylvania HIV Prevention Community Planning Committee. The objectives of the Roundtables emanate from project participants, Community Planning Groups (CPG) and Department of Health (DOH) member feedback and include:

- a. Giving voice to young adults in statewide HIV prevention planning;
- b. Having participants evaluate HIV prevention materials that target young people;
- c. Having participants interact with local leaders and AIDS service organizations;
- d. Promoting awareness of and sensitivity toward young people living with HIV;
- e. Disseminating accurate information about HIV/AIDS to high-risk young people;
- f. Providing the group with local HIV peer education training opportunities;
- g. Creating a safe forum in which HIV prevention issues can be openly discussed; and
- h. Developing a web page for communication among youth in various cities.

The Pennsylvania Young Adult Roundtable Executive Committee, consisting of two elected representatives and one alternate representative from each of the six groups, provides a conduit through which four young people are elected by their peers to be sitting members of the Pennsylvania HIV Prevention Community Planning Committee. The Executive Committee meets a minimum of two times per year for 8-10 hours to develop consensus related to the HIV prevention needs of young people in Pennsylvania. The Executive Committee and Roundtables have produced the HIV Prevention Consensus Statement, which identifies needs and under-served target populations, youth-focused interventions and evaluation strategies for current programs available to young people.

The composition of the Roundtables attempts to reflect the AIDS epidemic among young people in our state, as we best understand it from current, available data (primary and surrogate). Therefore, with each passing year and with feedback from Roundtable members, Planning Committee members, DOH staff and needs assessment data, Roundtable composition changes. Certain groups of young people, by virtue of their demographic or behavioral characteristics (typically young men who have sex with men (MSM) and young people in recovery from injection drug use), have been challenging to recruit and/or retain. And recruitment of young people living with HIV/AIDS has been an insurmountable challenge. At the same time, we have gotten more even distribution of Roundtable representation by sex. The age range for recruitment of certain populations such as young MSM is extended (usually to 21) in order to accommodate the special environmental and personal factors that effect these young people. In addition, the increasing average age of Roundtable members was the deciding factor in terminating some of the Roundtables.

While it is important to consider needs assessment information from the widest variety of high-risk young people, particular groups of young people such as runaways are not compatible with the structured organization of the Roundtables, which requires ongoing contact by University of Pittsburgh staff with members and their regular attendance at meetings. Needs assessment information from such groups of young people is better obtained through focus groups, key informant interviews and other methods of inquiry.

Because Roundtable members are recruited using convenience sampling, it is important to note that the opinions of Roundtable members, both individually and collectively, though compelling and essential to the community planning process, do not represent all young people in Pennsylvania. However, it is noteworthy that the opinions and recommendations in the Roundtable HIV Prevention Consensus Statement are consistent with national perspectives on young people published by SIECUS, Advocates For Youth, Planned Parenthood, and the Kaiser Family Foundation.

For more information visit <http://www.stophiv.com/yart/about.htm>.

Reference:

1. Senderowitz, Judith. "Involving Youth in Reproductive Health Projects". FOCUS on Young Adults, September 1998. Retrieved February 2006 from: <http://pf.convio.com/pf/pubs/focus/RPPS-Papers/involvingyouth.pdf#search='youth%20involvement%20in%20HIV%20evaluation%20and%20planning>.

Resources:

Innovation Center for Community and Youth Involvement: <http://www.theinnovationcenter.org/>

Youth Involvement in Prevention Programming. Advocates for Youth. Revised Edition, August 2001: <http://www.advocatesforyouth.org/publications/iag/involvement.pdf>

Youth Involvement in the Community Planning Process. NASTAD. July 2001: http://www.nastad.org/documents/public/pub_prevention/2001720YouthofColotTARReport.pdf#search='youth%20involvement%2C%20hiv%20planning%2C%20nastad'

Capacity Building Calendar

Information on CDC-sponsored Capacity Building Assistance trainings for [March-May](#) is now available.

Meeting and Planning Calendar

March 22-24, 2006

"Keeping it Real: Street-Level Intervention Strategies for Addiction, HIV/AIDS and Hepatitis" Conference, Newark, Delaware. Sponsored by the Central East ATTC and the Delaware Department of Health and Social Services, Division of Substance Abuse and Mental Health. For more information, visit the [conference website](#).

April 30-May 4, 2006

17th International Conference on the Reduction of Drug Related Harm, Vancouver, BC, Canada. For more information, visit the [conference website](#).

May 2-6, 2006

"Embracing Our Traditions, Values and Teaching: Native People of North America HIV/AIDS Conference," Anchorage, AK. Presented by Inter-Tribal Council of Michigan, Inc. Currently accepting abstracts on Research, Mental Health, Prevention, Special Populations and Stigma, Spiritual Issues and Leadership, and Treatment, Care and Support. For more information, visit the [conference website](#).

May 8-11, 2006

National STD Prevention Conference, Jacksonville, FL. "Beyond The Hidden Epidemic: Evolution or Revolution?" For more information, visit the [conference website](#).

May 19, 2006

National Asian and Pacific Islander HIV/AIDS Awareness Day. For more information, visit the [event website](#).

May 25-28, 2006

"HIV/AIDS 2006: The Social Work Response." Eighteenth Annual National Conference on Social Work and HIV/AIDS, Miami, FL. Sponsored by the Boston College Graduate School of Social Work. For more information, contact [Vincent Lynch](#) at (617) 552-4038.

June 4-7, 2006

HIV Prevention Leadership Summit (HPLS), Dallas, TX. For more information, visit the [conference website](#).

June 22-25, 2006

A National Symposium: Global Health Care Justice, Hiram, OH. For more information, visit the [conference website](#).

June 27, 2006

National HIV Testing Day. Sponsored by the National Association of People With AIDS. For more information, visit the [event website](#).

August 13-18, 2006

XVI International AIDS Conference, Toronto, Canada. Abstract submissions due February 22, 2006. For more information, visit the [conference website](#).

September 12-14, 2006

CDC's 2006 National Health Promotion Conference: Innovations in Health Promotion: New Avenues for Collaboration, Atlanta, GA. For more information, visit the [conference website](#).

September 24-26, 2006

United States Conference on AIDS (USCA), Hollywood, CA. For more information, visit the [conference website](#).

October 15, 2006

National Latino HIV/AIDS Awareness Day. For more information, visit the [event website](#).

November 4-8, 2006

"Public Health and Human Rights," American Public Health Association's 134th Annual Meeting, Boston, MA. For more information, visit the [conference website](#).

November 8 – 12, 2006

Sixth National Harm Reduction Conference, Oakland, CA. For more information, visit the [conference website](#).

December 1, 2006

World AIDS Day. For more information, visit the [event website](#).

If you have an idea or program relative to any of these topics that you would like to include in the *Bulletin*, please contact [Nyedra Booker](#) (202/434-8090). The NASTAD *HIV Prevention Bulletin* is written and edited by NASTAD staff and participants of community planning and prevention efforts around the country.

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LET US KNOW WHAT YOU THINK! NASTAD welcomes feedback to issues presented in our newsletter. To submit commentary, please e-mail us at NASTAD@NASTAD.org.

Visit our Webpage! Electronic versions of the *Bulletin* are posted along with other information on both NASTAD's prevention and care projects.

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