# Sarasota County HIV Prevention Plan 2009-2011

## Prepared by Sarasota County Health Department and HIV/AIDS Network of Sarasota (HANS)

Sarasota County HIV Prevention Plan 2009-2011

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## Acknowledgements

### The production of this document was made possible by contributions from the following:

**Bill Little, Administrator, Sarasota County Health Department (SCHD)**

**Christine Griffith, Division Director, Epidemiology and Communicable Disease Center (ECDC), SCHD**

**Scott Pritchard, Epidemiologist, SCHD**

**Joan Surso, HIV/AIDS Education and Training Consultant, SCHD**

**Lauren Sporillo, HIV/AIDS Surveillance Officer, SCHD**

**Gail Counts, Area 8, Department of Health, Bureau of HIV/AIDS**

### Community Based Organizations Including:

**ALSO Out Youth (ALSO)**
**American Red Cross**
**Bethesda House, Catholic Charities of Venice**
**Coastal Behavioral Healthcare, Inc. (CBHC)**
**Community AIDS Network, Inc. (CAN)**
**Dollar Dynasty**
**First Step of Sarasota (FSOS)**
**Genesis Health Services (GHS)**
**Manatee County Rural Health Care**
**Multicultural Health Institute (MHI)**
**Planned Parenthood of Southwest and Central Florida (PPSWCF)**
**Positive Health Care**
**Project Challenge of the West Coast**
**Safe Place and Rape Crisis Center (SPARCC)**
**Sarasota Health and Rehabilitation Center**
**School Board of Sarasota County (SCSB)**
**Second Chance Last Opportunity (SCLO)**
**Senior Friendship Center (SFC)**
**Southwest Florida Community AIDS Quilts**
**Suncoast AIDS Theatre Project**
**TideWell Hospice and Palliative Care**
**Trinity Charities**

# Part I: Introduction

## Overview of HIV/AIDS Sarasota Community Planning

HIV/AIDS community planning in Sarasota is an on-going and evolving process whereby state and local HIV/AIDS prevention and care agencies, organizations and government share responsibilities for developing a comprehensive HIV/AIDS prevention and treatment plan with other state/local agencies, community based organizations, and representatives of communities and groups at risk for and/or affected by HIV/AIDS.

## Community Planning in Sarasota County

The HIV/AIDS Network of Sarasota (HANS) is the group that guides HIV/AIDS prevention in Sarasota County, along with the Sarasota County Health Department. Members of HANS are from local community based organizations and government throughout Sarasota County. The primary goals of HANS are to provide a strong and effective network in Sarasota County of community agencies, organizations and persons living with HIV/AIDS and other interested parties to:

- Prevent new HIV/AIDS infections in Sarasota County
- Improve the quality of life for all persons affected and infected with HIV/AIDS In Sarasota County
- Prevent the progression of HIV disease to AIDS in Sarasota County
- Advocate for a responsive community with regard to HIV/AIDS disease in Sarasota County
- Provide Speaker's Bureau to educate our community about HIV and AIDS

The primary task of HANS is to develop a comprehensive HIV prevention plan that includes prioritized populations and a set of prevention activities/interventions for each target population. Target populations are prioritized and prevention activities/interventions chosen based on their ability to prevent new infections. The Centers for Disease Control and Prevention (CDC) and the Florida Department of Health provide evidence- based interventions proven to be effective in changing people's behavior to prevent HIV/AIDS and other sexually transmitted disease (STD).

Key information necessary to develop the comprehensive HIV prevention plan can be found in the epidemiologic profile, community research (surveys, focus groups data, etc.), state DOH reports ("Silence is Death, The Crisis of HIV/AIDS in Florida's Black Communities"; "Out in the Open, The Continuing Crisis of HIV/AIDS Among Florida's Men Who Have Sex with Men"; and "Organizing to Survive, The HIV/AIDS Crisis Among Florida's Women"), and community assessments. After developing and/or reviewing these products, the HANS began the task of prioritizing the target populations using a methodology determined by the Florida Comprehensive HIV/AIDS Planning Network (FCPN). Once target populations were prioritized, HANS determines what intervention or mix of interventions best met the needs of those populations for Sarasota County.

The HANS planning process is on-going with the goals and objectives updated semi-annually. This information assists in the development of the Area 8 Regional HIV/AIDS Council (RHAC) HIV Prevention Plan, revised every three years per FCPN. This county-wide plan is designed to address HIV/AIDS prevention activities and provide a blueprint for how all HIV/AIDS prevention funds are to be used, including federal, state and local, and when possible, private resources. The SCHD works closely with Sarasota County Government (SCG), DOH, RHAC and HANS in area and county planning processes to ensure HIV/AIDS awareness and prevention activities/interventions are appropriate for the community of Sarasota.

All involved recognize the community planning process must be flexible and there is "no one way" to achieve goals outlined in the HIV Prevention Plan. The goals developed in this process are shared decisions with the ultimate goal being to meet the needs of the Sarasota County community

## Sarasota County HANS's HIV/AIDS Prevention Plan Target Population for 2009-2011

The HANS membership HIV Prevention Plan for 2009-2011 has identified the population that needs to be addressed and targeted for HIV testing activities to include:

- Men who have sex with men (MSM)/bi-sexual males of any age/race/ethnicity
- African American males and females
- Individuals over the age of 30 regardless of sex, race, or ethnicity
- Intravenous drug users (IDU) of any age, race, sex, or ethnicity

In addition, the target populations identified per HANS membership that need HIV/AIDS educational awareness activities in the HIV Prevention Plan include:

- At risk youth and young adults between the ages of 13-29 years
- MSM/bi-sexual males of any age, race, ethnicity
- African American male and females
- IDU of any age, sex, race, ethnicity
- High-risk jail inmates regardless of age, sex, race, ethnicity

## Our History

Sarasota County was one of the first counties in Florida to develop a local network of providers, agencies and PLWHA to work together on prevention activities and initiatives as related to HIV/AIDS. The HANS group was formerly known as Sarasota HIV/AIDS Coalition (SHAC) and was started by Dr. Mark Magenheim and a local PLWHA back in 1992.

Today HANS role in our community as related to HIV/AIDS education and prevention is even more difficult what with continued federal, state and local budgetary reductions for community based HIV/AIDS planning, education and prevention services and programs. Our local HANS members fully support the State of Florida, DOH initiatives and

direction of partnerships and collaborations needed to address HIV/AIDS prevention activities and initiatives. These interventions are evidence based and promote risk reducing behaviors for clients served in our community.

HANS members and the SCHD have increased their collaborative efforts and recognize the difficult decisions that need to be made to continue to find funding sources and resources to promote HIV/AIDS education awareness and HIV testing in our community, HANS agrees to partner with DOH, Bureau of HIV/AIDS, CDC, SCG and others as needed to ensure services and programs are evidence based and proven to be effective as to age, sex, race and ethnicity of our residents.

## Our Future

This HIV Prevention Plan is the result of collaboration and commitment of the community stakeholders in Sarasota County who provide HIV/AIDS prevention and patient care services. The priorities for HIV prevention services and recommended strategies and interventions to best meet the needs of the residents and clients were developed together.

State and federal governments must strive to meet the needs of the people. HANS understands and enthusiastically accepts the role as a partner in the design, delivery and evaluation of HIV/AIDS prevention and awareness activities. In order for government, medical and health care communities to be successful in achieving their goals, they must mobilize the people in the communities impacted with HIV/AIDS and others to share the same goals and vision. Services are recommended that originate with those at risk for or living with HIV/AIDS and their families, friends, and churches. It is essential to take responsibility and be vigilant to a continued commitment to end this epidemic, eliminate health disparities and promote the health of all who live, work and play in Sarasota County.

## HIV/AIDS Network of Sarasota (HANS)<br>Mission and Vision Statements

Membership in the HIV/AIDS Network of Sarasota (HANS) is open to any individual, agency or organization who wishes to assist in planning and implementing HIV/AIDS activities and initiatives impacting our Sarasota County.

**Mission Statement of HANS:** The mission of the HIV/AIDS Network of Sarasota (HANS) is to reduce the incidence of HIV and AIDS in the community through education and awareness and improve the quality of life for all persons affected.

**Vision Statement of HANS:** To recognize the HIV/AIDS Network of Sarasota (HANS) for its diversified and collaborative membership as the premier source of public awareness of HIV/AIDS education, prevention, and HIV testing in Sarasota County.

## HANS Goals and Objectives

HANS's members jointly agree to align their goals and objectives with the CDC Advancing HIV Prevention (HPV) strategies as developed in 2003 which include:

- **Goal 1: Make HIV Testing Routine Part of Medical Care**
  Objective: To assist in promoting the message to health care providers in Sarasota County the importance of discussing sexual history with clients and offering HIV screening/testing routinely to clients.

- **Goal 2: Implement New Models for Diagnosing HIV Infections Outside the Medical Setting**
  Objective: To assist in establishing a coordinated effort among Sarasota County HANS members for HIV screening and testing.

- **Goal 3: Prevent New HIV/AIDS Infections**
  Objective: To continue to work with persons diagnosed with HIV/AIDS and their partners to prevent new HIV/AIDS infections in our community.

- **Goal 4: Further Reduce Perinatal Transmission**
  Objective: To continue to work toward decreasing perinatal HIV transmission in our community.

**Additional goals and objectives of HANS agreed upon for 2008-2010 include the following**:

- **Goal 1: Prevention and Education Programs**
  Objective:
  a) To include specific curriculum to address co-factors that impact HIV/AIDS, such as STD's, Hepatitis, substance abuse and others;
  b) To increase risk reduction strategies by promoting safer sex practices through messages of condom efficacy, sexual responsibility and universal precautions;
  c) To unify opportunities and resources to increase our expertise in meeting HANS's strategic plan; and
  d) To increase the promotion, education and implementation of HIV testing throughout Sarasota County.

- **Goal 2: Collaboration and Coordination**
  Objective:
  a) To inform and invite members to participate in mutually advantageous opportunities, such as, training workshops, seminars, conferences and others;
  b) To plan, coordinate strategies for fundraising individual agencies or HANS as a group; and
  c) To present opportunities for dialogue and communication regarding the building of relationships between members.

- **Goal 3: Resources**
  Objective:
  a) To develop a HANS fundraising plan;
  b) To develop and submit a unified proposal to the Department of Health and other potential funding sources.

- **Goal 4: Advocacy and Media**
  Objective:
  a) To increase public awareness of HIV/AIDS pandemic;
  b) To develop strategies to increase the resources and the visibility of HANS.

**Sub -goals of HANS:**

- Ensure representatives of all priority populations are represented by lead agency, organizations or government entities
- Ensure committee structure is representative of all members within HANS (i.e.: World AIDS Day, Prevention/Education, Media/Promotion, Multidisciplinary Patient Care, and others as needed)
- Continue to recruit new members to HANS from other community based organizations and PLWHA in the community
- Update the HANS web site as needed as to new members, educational sessions, and other material, including Spanish translation for all topics
- Continue to build partnerships and collaborations between other Area 8 HIV/AIDS agencies and organizations, including other County Health Departments to share information and resources

**Regional HIV/AIDS Council (RHAC) for Area 8 Goals for 2008-2010**
(Note: HANS will work to align our objectives to address these areas too.)

- Goal 1: Identify individuals who know their HIV status and are not receiving services, for informing the individuals of and enabling the individuals to utilize services.

- Goal 2: Eliminate disparities in accessing services among the affected subpopulations (i.e. youth, sex workers, MSM, etc.).

- Goal 3: Coordinate the provision of services with programs for HIV prevention (including outreach and early intervention).

- Goal 4: Coordinate the provision of services with programs for the prevention and treatment of substance abuse.

- Goal 5: Address adherence initiatives.

- Goal 6: Minority AIDS Initiative (issues of minority access and disparity in the area).

- Goal 7: Program coordination and linkages between Ryan White Parts A, B, C, D, and AIDS Education and Training Centers (AETC).

- Goal 8: Build capacity in your area.

## Role of HANS Members

The following roles represent the key areas of HANS activities and tasks:

- Prioritize HIV/AIDS prevention by target population and geographic areas, and propose/adopt recommended high-risk priority strategies and interventions/initiatives
- Access existing community resources to determine the community's current capability to respond to HIV/AIDS epidemic as to housing, treatment, medications, and other needs
- Identify unmet HIV/AIDS primary, secondary, and tertiary prevention within defined populations, including health disparities according to Healthy People 2010 initiatives
- Identify specific high-risk target population strategies and interventions/initiatives to meet the priority needs of defined populations within Sarasota County
- Develop and periodically update the comprehensive HIV/AIDS Prevention Plan and foster technical assistance to meet the needs of the community

HANS meets the first Monday of each month, except December and committees meet as needed, at least quarterly.

## Sarasota County HIV/AIDS Minority Representatives

The Florida Department of Health (DOH) has implemented the Florida HIV/AIDS Minority Network and its functions are carried out by HIV/AIDS Minority Network Liaisons who are affiliated with HIV/AIDS service organizations or interested persons in the community. Area 8 has a representative whose office is located in Lee County and is invited to attend HANS meetings. Local HANS representatives have been instrumental in developing relationships with local faith-based entities and in working with our African American and Latino populations and the local agencies serving these populations in our county. HANS establishes committees as needed to work specifically with specific populations, like African American, Latino, Multicultural, MSM, IDU or others. They develop surveys and focus group discussions to determine the needs of targeted populations and develop projects to meet the unmet needs. One example of a project developed and offered for parents was to learn how to speak to their youth on topics such as HIV/AIDS, pregnancy, drugs and alcohol abuse.

# Part II: Local Research and Surveillance

## Purpose

The purpose of this section is to present the epidemiology of HIV and AIDS epidemic in Sarasota County. This section provides a clear picture as to the changing faces of HIV/AIDS in our community. The HIV and AIDS data is presented for at-risk populations and shows HIV transmission trends. The data included is the most complete data related to the epidemic and provides information as to who was infected with HIV/AIDS over the past nine years in our community.

The information in this section represents the scientific evidence upon which Sarasota County's HIV Prevention priorities are based. Funding priorities are based on the estimated HIV incidence, as well as prevalence, incidence, and behavioral data for specific populations. Other funding priorities can be found in Part 3: Priority Setting. For more detailed needs of various populations, as well as additional data on co-factors related to HIV, such as homelessness, or drug usage, see Part 4: Community Assessment.

## Overview of this Section

This section presents an overall picture of the epidemic of HIV/AIDS in Sarasota County. The section uses a combination of data from Surveillance and HIV/AIDS Reporting System data to lend key insight into the epidemiological issues in our community as related to this disease. To understand the disparity of HIV/AIDS in different ethnic and racial populations and behaviors of the populations, it is essential to recognize the overlapping nature of demographic data and behavioral issues. This plan places a greater emphasis upon addressing behavioral risk populations as they can be more effectively targeted with prevention and testing interventions. Remember it is not who one is (demographically) but what done does (behavior) that puts one at risk for HIV/AIDS.

Demographic components include:

a. Gender
b. Race/Ethnicity
c. Age

Behavioral risk components include:

a. Men who have sex with men (MSM)
b. Heterosexual women
c. Injecting drug users (IDU)

This information represents the best and most recent data from the Florida Department of Health (DOH) as to our communities HIV/AIDS incidence. Sarasota County has not conducted an in-depth research or analysis of HIV and AIDS specific to injecting drug

users, however we did recently complete a survey among 130 MSM as to their behavioral issues, which is addressed in this section.

## Surveillance

The HIV/AIDS Surveillance Officer and Epidemiologist at the SCHD are members of HANS. The data provided by them to the HANS members/agencies is valuable for planning purposes. Agencies applying for grants contact the HIV/AIDS Surveillance Officer and/or Epidemiologist at the SCHD for guidance on data information and reporting. As agencies evolve in their proposals for grant applications and projects, many contact other departments within the SCHD for assistance such as Disease Intervention Services, Sexually Transmitted Disease, Hepatitis and others.

As data reporting plays a vital role in how funding is awarded at the local, state and federal levels; it becomes imperative for the demographic data to be collected accurately and updated to others in a timely and meaningful manner. Agencies must then determine how to make it meaningful and relevant to their own program goals and objectives. Technical Assistance from both the SCHD and DOH, Bureau of HIV/AIDS are requested via coordinated communications to make sure efforts are not duplicated with limited personnel and resources to conduct the analysis of the data. Today, many agencies, including the SCHD and DOH are being held to more accountability as to the data collected and presented to ensure it is accurate and reflects what is going on in the Sarasota community. There is increased pressure to ensure any interventions funded by local, state and federal funds are conducted with measurable outcomes and the utilization of surveillance data is becoming even more needed.

## Research

Prevention Research was recently conducted in Sarasota County as related to a project within HANS members as to the DOH report “Out in the Open”. A survey tool was developed with the assistance of HANS members and put on the HANS web site and other sites for MSMs to respond to anonymously. The data was tabulated by Community AIDS Network (CAN) representatives and the SCHD Epidemiologist to determine what variables were consistent and how to develop a possible prevention program aimed at assisting the MSM community regardless of race, age or ethnicity to lowering their risk behaviors. Agencies that assisted with this survey included the following:

*ALSO Out Youth (ALSO)*
*Community AIDS Network (CAN)*
*Genesis Health Services (GHS)*
*Multicultural Health Institute (MHI)*
*Sarasota County Health Department (SCHD)*
*Second Chance Last Opportunity (SCLO)*

The MSM survey was placed on the HANS web site and linked to several other web sites in our community. The analysis of the surveys clearly demonstrated the need for developing an evidence based intervention to serve the needs of the MSM population in

our community. HANS is researching various EBI options and will be seeking funding from various sources during the next several years to be able to offer a program for MSM. Initially, Genesis Health Services has started a Support Group for Black and Hispanic MSM in the northern part of the county with the use of community gatekeepers.

When Sarasota County received funding for the DOH for the "Silence is Death" initiative, members of HANS were instrumental in meeting the needs of the African American population in our community with an initiative entitled "Volunteer Gatekeeper" project. Member agencies who lead the way in this project included:

*Community AIDS Network (CAN)*
*DOH, Area 8, Minority AIDS Representative*
*Genesis Health Services (GHS)*
*Multicultural Health Institute (MHI)*
*Sarasota County Health Department (SCHD)*
*Second Chance Last Opportunity (SCLO)*

The Volunteer Gatekeeper project expanded into Manatee County with the support of the Manatee CHD. Today, although no longer funded per DOH, the project continues in both counties and it is being looked at as a lead initiative in the state for recruiting members of the community to become educators and HIV testers to service areas where HANS agency staff have not been able to access.

The three DOH reports have provided much insight into the HIV/AIDS epidemic in Sarasota County. They created a new emphasis on prevention and testing in the community and new members of HANS are learning how to work together in combating this epidemic. Only one agency in Sarasota County receives funding from DOH for Prevention Initiatives, Community AIDS Network. They offer two evidence based interventions, SISTA and VOICES/VOCES and have a memorandum of agreement with several HANS members, including SCHD to ensure referrals are made for high risk clients to receive the benefits of these interventions. CAN has a contract with DOH to provide Rapid Ora Sure HIV testing, note CAN and SCHD are the only providers in Sarasota County to offer Rapid Ora Quick HIV testing in our county.

## Overview of Sarasota County

Sarasota County is one of the most desirable places to live, work, and raise a family. The clean air, sparking white sand beaches, and sunny climate have made it world famous as a center for the good life. Forbes has named Sarasota one of the best places for business and careers, and Money magazine recognized it as the nation's best small city, one of the best places to retire, and one of the cities with the best health care systems. The community offers a variety of recreational and cultural activities for every taste and budget. It is a diverse area with big city amenities and small town ease of living. Business owners and employees enjoy not only the good life but a thriving business climate. Our top-rated schools and motivated workforce contribute to why Sarasota is home to some of the most successful and productive companies in the country.

Each area of Sarasota County has its own personality, and visitors are delighted to find more vacation variety here than expected. The county has a total population of 359,783 per the U.S. Census Bureau 2005 estimates with 47.7% males and 52.3% females. Adjacent counties include Manatee to the north, DeSoto to the east and Charlotte to the south. The median income for a household is $41,957 and median income for a family is $50,111 with 15.0% living below the poverty level.

There are four incorporated cities in the county, Sarasota, North Port, Venice and Longboat Key; along with 23 unincorporated communities. The city of Sarasota, with its active downtown and arts and theater district, has a friendly, small town feel. Longboat Key with manicured beach resorts and world class tennis, golf and dining are to the north. Siesta key with a laid back feel of a tropical island with its sugar sand beach designated as “the whitest, finest beach sand in the world”. The city of Venice is directly located on the gulf. North Port is the fastest rapidly growing municipality in the county with an average age of 41.

## Racial and Ethnic Diversity

The 2006 U.S. Census estimates indicate that the racial make-up of the county is 91% White; 4.5% Black; 1.20% Asian; other 2.40%, see Figure 1. Persons of Hispanic ethnicity represent 6.7% of the population. English is spoken by 90.7%, 5.4% Spanish and 1.3% German and 1.0% French as their first language. The total population of Sarasota County has grown by 16.3% from the U.S. Census Bureau figures for 2000 compared to 2006 estimates. As of 2006 estimates, the Hispanic population has grown to 24,606 and the Black population has grown to 16,500. A significant percent of both the Hispanic and Black population have lower educational levels, lower incomes and lack health insurance as compared with the White population of Sarasota County. All of this data is from the United States Census Data for 2000 and 2005, since the two reports provide slightly different figures and data both have been included.

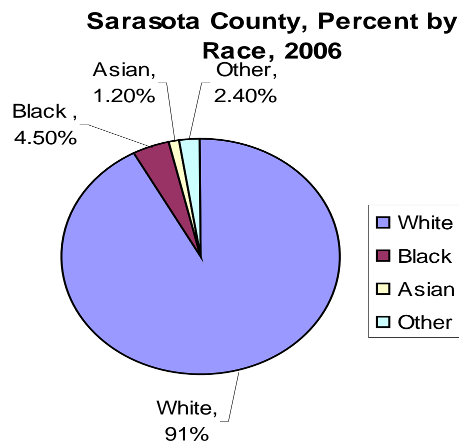


Figure 1. Sarasota County, Percent Population by Race, U.S. Census estimate 2006

## Age and Gender Diversity

Figure 2 demonstrates the age distribution within Sarasota County with 17.1% between the ages of 0 to 9, 16.9% between the ages of 10 to 19, 11.6% between the ages of 20 to 34, 24.4% between the ages of 35 to 54, 29.15% between the ages of 55 to 74, and 17.2% 75 years and older in Sarasota County. The median age is 50 years. For every 100 females there are 90 males and for every 100 females age 18 and over there are 87.30 males. The difference reflects an increase in the number of females in the community.

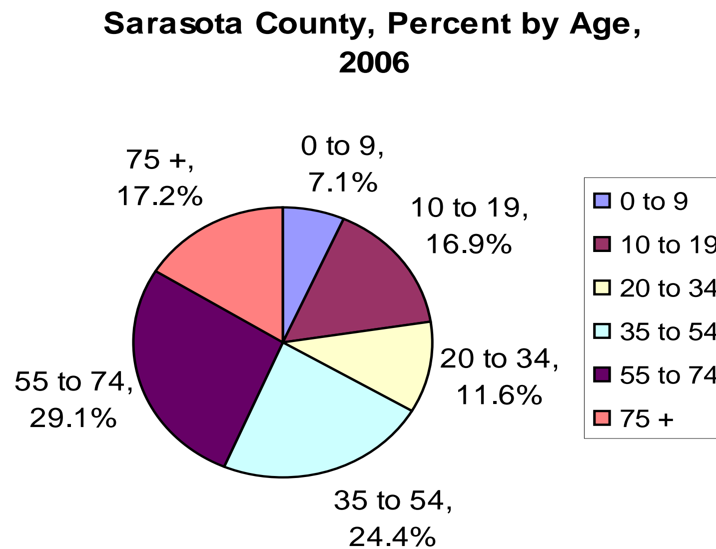


Figure 2. Sarasota County, Percent of Population by Age, U.S. Census estimate, 2006

## Sexual Orientation Diversity

Sarasota County has a growing number of gay and lesbian establishments including hotels/guesthouses, newspapers, bars, restaurants and clubs. There are several gay/lesbian churches in the area and their congregations are growing. The community has an active gay/lesbian population and they sponsor many events, including base ball teams, fundraisers, and web sites with listing of events. The Manasota GLBT (Gay, Lesbian, Bi-Sexual, and Transgender) group is very active. A large number of HIV positives who have self identified their risk factors as having sex with men, and Sarasota ranks 13th out of 67 counties a in the state as to the number of White MSM living with HIV/AIDS .

## HIV and AIDS in Sarasota County: An Overview

Sarasota County has over 1382 people diagnosed with HIV/AIDS since reporting started by DOH in 1988. Unfortunately, Sarasota County is one of the state's largest with disproportionate numbers of persons with HIV/AIDS in the Black and Hispanic population. The report "Organizing to Survive" ranks Sarasota County 21st for white, 10th for black, and 22nd for Hispanic; :"Out in the Open" ranks Sarasota County Men who have sex with men as 9th for white, 6th for black and 6th for Hispanic; and ""Silence is Death" ranks Sarasota County as 13th for white, 19th for black, and 18th for Hispanics living with HIV/AIDS compared to the other 67 counties in the state of Florida (see Table I below).

HIV Prevalence estimate is provided in the figure below. Sarasota County's epidemic affects a smaller proportion of heterosexuals, but a higher proportion of men who have sex with men, intravenous drug users and Black males and females.

The "one in" numbers for our community are for each of the three main ethnic populations of White, Black and Hispanic of Person Living with HIV/AIDS (PLWHA) with the risk factor or being a man having sex with men (MSM) or a female. See Table 1 below:

Table 1. Persons Living with HIV/AIDS "one in" Statement by Sex Race, and MSM

| | **White** | **Black** | **Hispanic** |
|---|---|---|---|
| **Total** | 1 in 743 | 1 in 92 | 1 in 465 |
| **Female** | 1 in 2062 | 1 in 93 | 1 in 1845 |
| **Male** | 1 in 416 | 1 in 82 | 1 in 328 |
| **MSM** | 1 in 47 | 1 in 13 | 1 in 30 |

The HIV epidemic in Sarasota County is disproportionately affecting MSM/ Bi-male as seen in the mode of exposure which represents 52.4% of all PLWHA. Modes of exposure for male PLWHAs include: 68.6% MSM/Bi Male, 6.0% from IDU, 5.7% MSM/IDU, 8.5% heterosexual, 0.5% transfusion, and 0.25% other as of 2007 DOH data. Female modes of transmission identified include: 61.5% heterosexual, 20.1% IDU, 15.5% risk not specified, and 2.9% sex with man who was HIV positive. The HIV/AIDS epidemic has been largely among men who have sex with men and intravenous drug users (IDU) see Table 2.

Table 2. Mode of Exposure for HIV/AIDS for PLWHA in Sarasota County, June 2008

| Mode of Exposure | Male (%) | Female (%) | Total (%) |
|---|---|---|---|
| **MSM** | 410 (68.8) | --- | 410 (53.3) |
| **IDU** | 41 (6.9) | 35 (20.2) | 76 (9.9) |
| **MSM/IDU** | 34 (5.7) | --- | 34 (4.4) |
| **Heterosexual** | 56 (9.4) | 104 (60.1) | 160 (20.8) |
| **Other** | 5 (0.8) | 5 (2.9) | 10(1.3) |
| **Risk Not Specified** | 50 (8.4) | 29(16.8) | 79 (10.3) |
| **Total (%)** | 596 | 173 | 769 |

Figure 3 provides an overview of reported AIDS cases by year from 1988 through 2007 for the county.

In 1993, Sarasota experienced the peak of reported AIDS cases, with 94 reported cases. AIDS case have been declining since the Highly Active Antiretrovial Therapy (HAART) began, in part due to the new and improved HAART medications now available persons infected with HIV/AIS (PLWHA) are living longer, feel healthier, and have an improved quality of life.

The increases in recreational drug use have been associated with increases in high-risk sexual behaviors, particularly among men who have sex with men (MSM). Increases in Sexually Transmitted Disease (STD) in the community have been noted for both Chlamydia and gonorrhea in younger individuals during the past several years. When an individual has an STD they are two to five times more likely of becoming infected with HIV. SCHD is partnering with Sarasota County School Board with a DOH/DOE initiative entitled "Get Real About AIDS" for grades 4-12 and have worked on adopting a manual for approved courses for each grade level. The intention is to make sure youth get the proper facts on HIV/AIDS and STD from their teachers, parents and school health nurses. A student intern with the SCHD has developed a video about "What Youth in Sarasota Think about HIV/AIDS". Upon approval, the video will be used with seminars and other educational programs for parents and youth on telling them the facts of HIV/AIDS.

Unmet mental health and substance abuse treatment needs and fear of legal interventions and economic cost of such programs, have contributed to MSM and transgender from seeking needed services. In summary, there continues to be an epidemic among MSM, particularly gay men and male transgender persons in Sarasota County for all ages, races and ethnic backgrounds. There is only one agency in the county offering any support services for this group, Genesis Health Services (GHS).

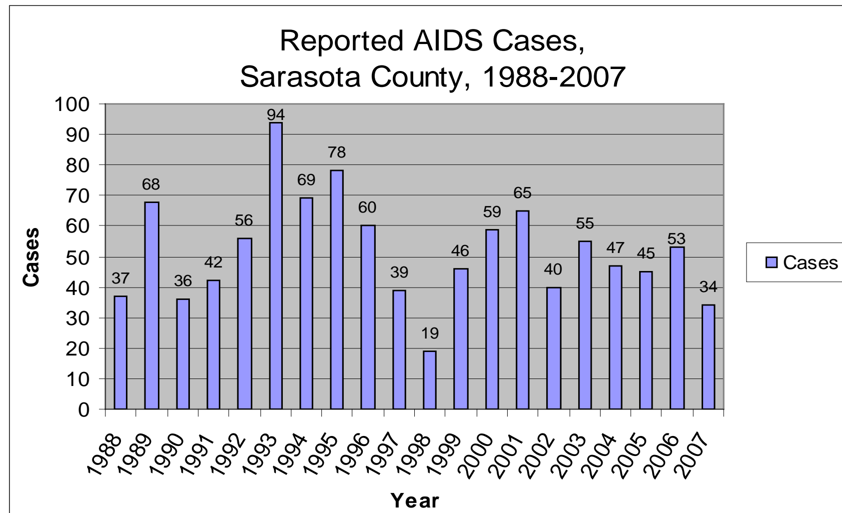


Figure 3. Number of Reported AIDS Cases from 1998 through 2007 in Sarasota County

Figure 4 shows the number of HIV (Regardless of AIDS) cases from 1988 to 2007 for Sarasota County as reported by the Florida DOH. The peak year for reported HIV cases was in 2003 and the number of new cases increased again in 2006-2007. This may be attributed to the number of HIV testing sites and prevention activities offered by agencies like Community AIDS Network (CAN), ALSO Out Youth (ALSO), Planned Parenthood of Southwest and Central Florida (PP), First Step of Sarasota (FSOS), Second Chance Last Opportunity (SCLO), and the SCHD. SCHD and CAN are the only providers of Rapid Ora Sure testing. As of June 2008, there are 304 persons living with HIV; 481 persons living with AIDS for a cumulative total of 769 persons living with HIV/AIDS (PLWHA) in Sarasota County. See Figure 4 and Table 3 below for a detailed look at HIV/AIDS cases in Sarasota County.

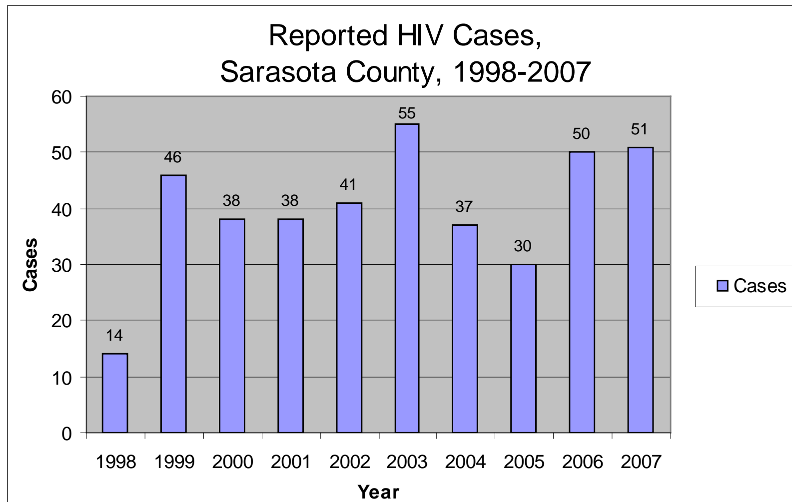


Figure 4. Number of Report HIV Cases from 1998 through 2007 in Sarasota County

Table 3: Cumulative Number of Reported AIDS and HIV Cases in Sarasota County, as of June 2008

| | AIDS | HIV | Total | PLWHA | % Living |
|---|---|---|---|---|---|
| **Total** | 1071 | 311 | 1382 | 769 | 55.6% |
| **Male** | 891 | 229 | 1120 | 596 | 53.2% |
| **Female** | 180 | 82 | 262 | 173 | 66.0% |

## Demographics and HIV/AIDS Data

| **Cumulative AIDS Cases** | | |
|---|---|---|
| Total | Alive # | % Living |
| 1071 | 481 | 44.9% |
| **Cumulative HIV Cases** | | |
| Total | Alive # | % Living |
| 311 | 304 | 97.7% |
| **Grant Total HIV/AIDS Cases** | | |
| Total | Alive # | % Living |
| 1382 | 769 | 55.6% |

### *Gender*

In Sarasota County, men, mostly MSM and females with a history of IDU are disproportionately affected by HIV/AIDS among Whites, Blacks and Hispanics. Men represent 67.5% of the PLWHA. Women represent approximately 22.5% of all newly reported HIV infections. Figure 5 and 6 represent the percent of reported HIV/AIDS by sex for the years 2001-2007.

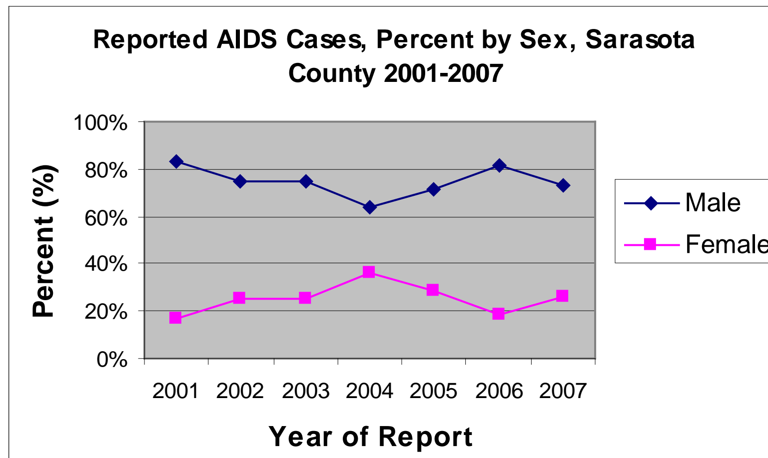


Figure 5. Percent of Reported Cases of AIDS by Sex in Sarasota County from 2001-2007.

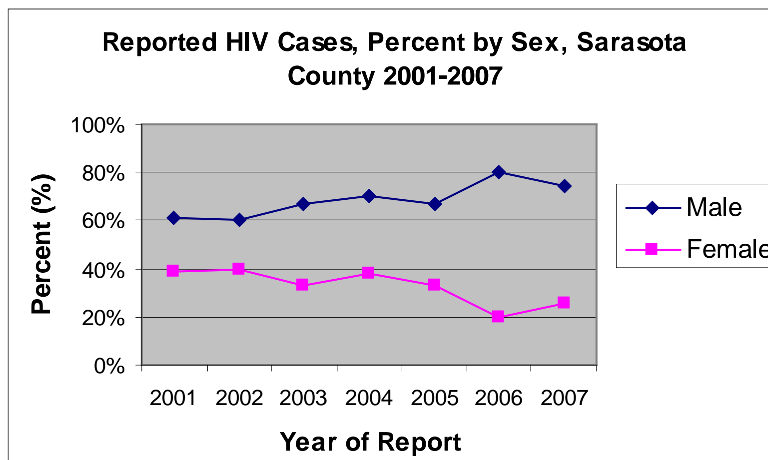


Figure 6. Percent of Reported Cases of HIV by Sex in Sarasota County from 2001-2007.

Table 4. HIV/AIDS cases by Sex, Sarasota County, June 2008

| Diagnosis | Males | Females | Total | M:F Ratio |
|---|---|---|---|---|
| AIDS | 891 | 180 | 1071 | 5.0:1 |
| HIV | 229 | 82 | 311 | 2.8:1 |
| Total | 1120 | 262 | 1382 | 4.3:1 |
| PLWHA | 596 | 173 | 769 | 3.4:1 |

Table 4 details the male to female ratios of reported HIV/AIDS cases as well persons living with HIV/AIDS (PLWHA) in Sarasota County.

The relative increases in male’s cases reflect that a higher proportion of HIV/AIDS infections are being reported in men, mostly within the MSM population even though targeted educational and prevention messages have been in place since the epidemic began in the early 1980’s. This evidence suggests new prevention messages need to be targeted to the MSM since many are no longer listening or practicing safer sex behaviors.

## Race/Ethnicity

Although white males represent the largest racial group of reported HIV/AIDS in Sarasota County, nearly 20% of newly reported male HIV cases are black, a group that represents 3.6% of Sarasota's male population. Nearly half of all female infections are among black women in our community, a group which represent only 3.7% of the female population. All races/ethnic groups in Sarasota County are affected by HIV/AIDS. However, as demonstrated above, blacks are disproportionately affected. Additionally, in 2006-2007, 14.7% of newly reported HIV positives were are among the Hispanic men, a group that makes up 4.2% of our male population,

Table 5 breaks down Sarasota Counties PLWHAs by sex and race. As of June 2008, 66.8% of PLWHAs are white, 24.3% black and 8.8% were Hispanic. White females represent 49.1% of female PLWHA, black females 47.4%, and Hispanic females 3.5%. For males, whites represented 72% of male PLWHA, blacks 17.6%, and Hispanics 10.4%.

Table 5. PLWHA by Race and Sex, Sarasota County, June 2008.

| Race | Male | Female | Total (%) |
|---|---|---|---|
| **Black** | 105 (17.6) | 82 (47.4) | 187 (24.3) |
| **White** | 429 (72) | 85 (49.1) | 514 (66.8) |
| **Hispanic** | 62 (10.4) | 6 (3.5) | 68 (8.8) |
| **Totals** | 596 | 173 | 769 |

Figure 7 demonstrates the percent of reported HIV and AIDS cases by race and ethnicity in Sarasota County since 2001. The racial/ethnic breakdown shows that the percentage of reported AIDS cases that are white has decreased from 60% in 2001 to 50% in 2007 since 2005. Conversely, it has increased from 20% to 35% for blacks and from 2% to 12% for Hispanics, possibly a result of better case finding and testing among minority groups.

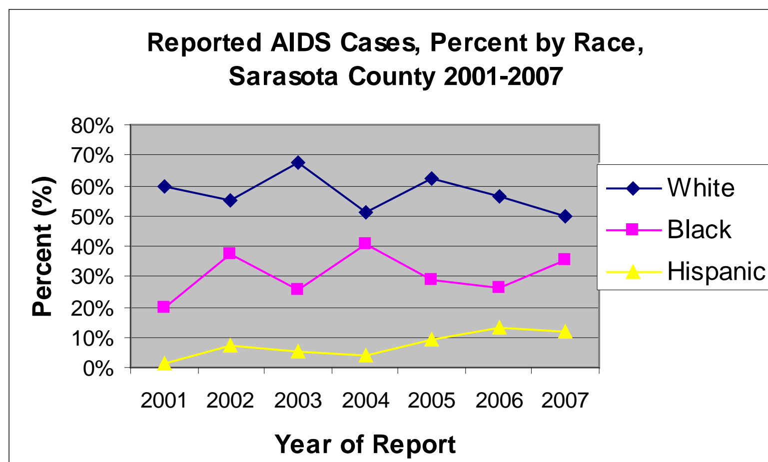


Figure 7. Reported AIDS Cases, Percent by Race in Sarasota County 2001-2007

Figure 8 examines the percent of reported HIV infections by race/ethnicity. This figure shows that the percentage of newly reported HIV cases that are white has remained stable (56% in 2001 vs, 55% in 2007). The percent of newly reported black cases has decreased from 38% to 29% and increased among Hispanics from 5% to 12% in 2007.

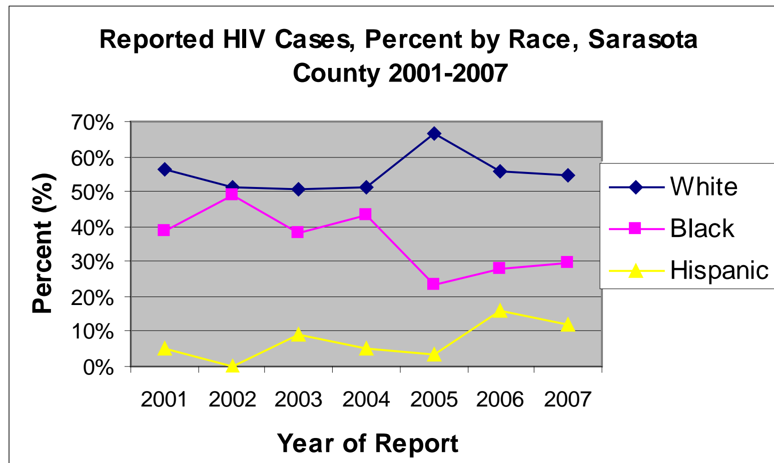


Figure 8. Reported HIV Cases, Percent by Race in Sarasota County 2001-2007

The disparity issues of race/ethnicity can be attributed to several underlying trends//factors:

- Amount of HIV already in the community
- Late diagnosis of HIV or AIDS
- Lack of access to or acceptance of care (screening, diagnosis or quality care)
- Stigma, denial, fee of learning HIV status or disclosing positive HIV status
- Discrimination, homophobia, fear of being gay men, MSM or IDU
- Fear of rejection of family, church, loss of employment
- Poverty, income, unemployment, lack of health insurance, homelessness, other socioeconomic factors associated with risk
- Childhood sexual abuse, increase risky behaviors and HIV infection rates among those who had forced sex
- Incarceration/prison
- Presence of another STD, non-HIV in the community
- Psychosocial health issues, depression, partner violence, low self-esteem can contribute to neglect of HIV prevention for self and others
- Substance usage, crystal meth, cocaine, alcohol and over counter drugs
- HIV/AIDS complacency/treatment optimism, loss of fear of HIV
- Delayed prevention message/burnout, no longer practice safer-sex practices
- Use of internet for dating or arranging anonymous sex with partner
- Language barriers
- Unprotected sex and needle-sharing behaviors, condom usage, other reduction behaviors

## Age

As seen in figure 9, the percentage of reported AIDS cases in the 40-49 age groups has increased the most from 29% in 2001 to 44% in 2007 and decreased in the 30-39 age groups from 40% in 2001 to 24% in 2007. Other age groups are relatively stable. Supporting the evidence that persons are progressing to AIDS later in life, a result of better medical care for HIV infected persons. Figure 10 shows that, although variable from year to year, the percentage of reported HIV cases have also increased in the 40-49 age groups, from 28% in 2001 to 42% in 2007. Based on this data, the age range that we are focusing testing and surveillance efforts on is from 30-50 years of age.

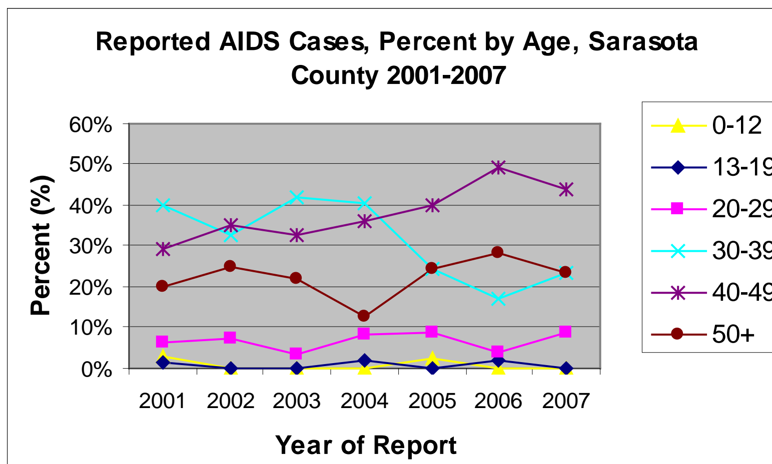


Figure 9. Reported AIDS Cases, Percent by Age in Sarasota County 2001-2007

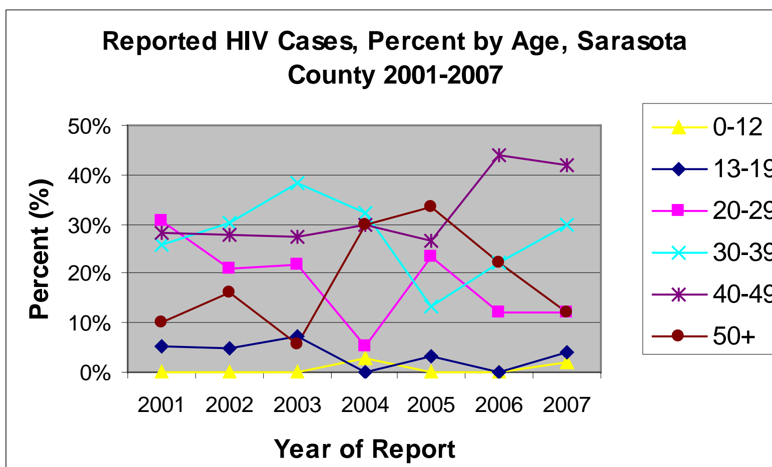


Figure 10. Reported HIV Cases, Percent by Age in Sarasota County 2001-2007

Table 6. Ages, Race, and Ethnicity of Persons living with HIV/AIDS in Sarasota County, June 2008

| Age Range | Black (%) | White (%) | Hispanic (%) | Total (%) |
|---|---|---|---|---|
| **0-12 Yrs** | 3 (1.6) | 4 (0.8) | 0 (0) | 7 (0.9) |
| **13-19 Yrs** | 10 (5.3) | 14 (2.7) | 1 (1.5) | 25 (3.3) |
| **20-29 Yrs** | 38 (20.3) | 58 (11.3) | 13 (19.1) | 109 (14.2) |
| **30-39 Yrs** | 66 (35.3) | 187 (36.4) | 31(45.6) | 284 (36.9) |
| **40-49 Yrs** | 51 (27.3) | 158 (30.7) | 21 (30.9) | 230 (29.9) |
| **50 + Yrs** | 19 (10.2) | 62 (12.1) | 2 (2.9) | 83 (10.8) |
| **Total** | 187 | 514 | 68 | 769 |

## Behavioral Risk Population

The primary risks for transmission for HIV/AIDS that have been identified in Sarasota County are:

1. Men who have sex with men (MSM), all ages, races and ethnic backgrounds
2. African America Heterosexual men and women all ages
3. Age 30 and over for any sex, race and ethnic background
4. Injecting drug users (IDU) all ages, sex, races and ethnic backgrounds

Sarasota County is one of the most highly impacted counties in Florida according to the DOH in there three reports on the incidence of HIV/AIDS in MSM, African American and women in our state as referenced earlier in this report. Below are Sarasota's HIV/AIDS 2007 prevalence rates by race and ethnicity for the general population and for MSMs by race and ethnicity represented by a one-in-statement.

**Sarasota**

*1 in 743 Whites*
*1 in 47 White MSM*
*1 in 92 Blacks*
*1 in 13 Black MSM*
*1 in 465 Hispanics*
*1 in 30 Hispanic MSM*

Table 2 (reprinted): Identified Risk Factors for PLWHA in Sarasota County, June 2008.

| Mode of Exposure | Male (%) | Female (%) | Total (%) |
|---|---|---|---|
| **MSM** | 410 (68.8) | --- | 410 (53.3) |
| **IDU** | 41 (6.9) | 35 (20.2) | 76 (9.9) |
| **MSM/IDU** | 34 (5.7) | --- | 34 (4.4) |
| **Heterosexual** | 56 (9.4) | 104 (60.1) | 160 (20.8) |
| **Other** | 5 (0.8) | 5 (2.9) | 10(1.3) |
| **Risk Not Specified** | 50 (8.4) | 29(16.8) | 79 (10.3) |
| **Total (%)** | 596 | 173 | 769 |

Through 2007 in Sarasota County, 74.5% of adult males diagnosed with HIV indicated MSM or MSM/IDU as their risk factor for HIV transmission. For women, 60.1% of those diagnosed with HIV indicated a risk factor of heterosexual contact.

Sarasota County has remained fairly consistent with the constant risk factor of intravenous drug use (IDU) among all populations as to the spread of HIV/AIDS. IDU is a unique and effective mode of HIV transmission through three distinctly different aspects. First, through the unsafe re-use of needles among multiple individuals, IDU directly exposes participants to contaminated materials. Second, when IDU and other substance abuse occur in conjunction with sexual/social activity, data demonstrates that the potential for risky behavior is dramatically increased. Third, HIV may be transmitted via sexual activity among substance users, or with other non-using individuals. Sarasota experiences IDU in the White, Black and Hispanic population for both men and women. The proportion of PLWHA with IDU identified as risk factors; White males (4.8%), white females (28.2%); black males (11.4%); black females (13.4%); Hispanic males (12.9%); and Hispanic females (0%). This demonstrates a huge difference in the prevalence of IDU between the race and sex among PLWHA and the need for more education/prevention messages as related to HIV transmission.

Drug abuse is increasing in our community and for people 15-44 unintentional poisonings, 97% of which are drug overdoses, were the leading cause of death in 2006. There is a trend across the U.S. to use other non-transvenous substances, like prescription drugs, crystal meth, crack, cocaine, ecstasy, and GHB. There seems to be a growing usage of methamphetamines in association with risky behavior and this presents an HIV prevention challenge for drug users in our community.

## Part 3: Community Assessment

Sarasota County conducted an analysis of what the member agencies in the HANS are receiving in HIV prevention dollars (either from DOH or other sources) to be over $2.5 million dollars annually when considering prevention and treatment dollars from local, state and federal sources. The following is a breakdown per agencies and funding sources in Chart 8 below.

Chart 8: Breakdown of Prevention Dollars per Agency in 2007-2008 in Sarasota County

| Prevention Contracts | Prevention Funding | Prevention Program | Source |
|---|---|---|---|
| Sarasota CHD | $157,012<br><br>$257,205 | Ryan White/ADAP, Emerging Communities<br>AIDS Prevention, Patient Care, Surveillance | State of Florida, DOH |
| Community AIDS Network (CAN) | $173,297 | HIV Prevention and Early Intervention (VOICES/SISTA) | State of Florida, DOH |
| CAN | $47.000 | HIV Prevention and Education | Sarasota CHD & Sarasota County Government (SCG) |
| Planned Parenthood of Southwest and Central Florida (PPSWCF) | $12,000 | HIV Prevention and Education | Sarasota CHD & SCG |
| PPSWCF | $56,000 | HIV Education and Other with PPSWCF, SCHD, and TruVine Initiative | Gulf Coast Community Foundation (?) |
| Second Chance Last Opportunity | $12,000 | HIV Prevention and Education | Sarasota CHD & SCG |
| ALSO Out Youth | $4,000 | HIV Prevention and Education | Sarasota CHD & SCG |
| Sarasota County Housing Opportunity for Persons with AIDS (HOPWA) | $55,025<br><br>$220,098 | CCC, Case Management<br>Direct HOPWA funds | Federal and State |
| Health Planning Council | $25,682<br><br><br>$60,871<br><br>$19,103<br><br>$159,832<br><br>$20,103<br><br>$67,879 | SCHD Ryan White, Part B, Case Management<br>CCC Ryan White, Part B, Case Management<br>SCHD, Ryan White Medical<br>CCC, Ryan White Medical<br>SCHD, Ryan White, Ancillary Services<br>CCC, Ryan White, Ancillary Services | Federal and State |
| AIDS Drug Assistance Program | $1,156,508 | SCHD for PLWHA to obtain medications via ADAP | DOH |
| Grand Total in Dollars | $2,503,612.00 | | |

## Part 4: Priority Setting

### Overview of Priority Population Selection Methodology

The priority setting tool is used by the State of Florida's Bureau of HIV/AIDS Prevention Planning Group and is based upon a four-path part methodology consistent with community feedback and Centers for Disease Control (CDC) and Prevention's Advancing HIV Prevention (AHP) Initiative. The methodology allocates points between four key areas: 1) HIV case data; 2) disproportionate impact; 3) resource disparities; and 4) community planning partnerships.

### Path 1: HIV Case Data

Rational: Priority should be given to those populations where HIV infection is occurring.

CDC requires priority setting to be "data driven". New HIV case data is a stronger indicator of where new infections are occurring versus AIDS case data, but are important and need to be monitored as to trends.

### Path 2:

Rational: Priority should be given to those populations that are disproportionately impacted by HIV.

### Path 3: Resource Disparity

Rational: Every population deserves HIV prevention efforts, and every infection averted is important. When resources are scarce and can't be distributed to every population, an attempt should be made to fill in service gaps for those populations that are receiving a lower share of resources than the disease burden they carry. CDC suggests that the populations with the largest gaps between impact and services are ranked as the highest priority, and populations with the smallest gaps between impact and services are ranked as the lowest.

### Path 4: Community Planning Partnership

Rational: Community planning partnerships consist of people "in the field", like prevention specialists, health planners, community members, behavioral scientists, epidemiologists, and others to invest in making a difference in working together to combat this disease as to the offering of prevention programs, HIV testing and other initiatives in the community. CDC includes subjective categories, such as barriers to accessing services, barriers to providing services, and community input in the priority-setting process. This method values the expertise of community planning partnerships and asks each group to bring their community experience and knowledge to the priority setting process by ranking the populations as they believe they should be ranked in order to best meet local needs.

## Priority Populations

The HIV/AIDS Network of Sarasota (HANS) members and SCHD staff evaluation and comprehensive analysis of HIV/AIDS case data, and community input from HANS members. The results are listed below as to the priority population for targeting HIV testing and HIV education in Sarasota County:

1. White (non-Hispanic) men who have sex with men
2. Black (non-Hispanic) men who have sex with men
3. Hispanic men who have sex with men
4. Black (non-Hispanic) heterosexual men and women
5. White (non-Hispanic) heterosexual men and women
6. Black (non-Hispanic) injecting drug users
7. White (non-Hispanic) injecting drug users
8. Hispanic heterosexual men and women
9. Hispanic injecting drug users

### HIV/AIDS Case Data from 2001 through 2008 (6/1/08)

Chart 9: Transmission Breakdown per Race/Ethnicity in Sarasota County

| Ethnic Groups | Heterosexual | MSM Males Only | IDU Males/Females |
|---|---|---|---|
| White | 83 | 653 | 92 |
| Black | 112 | 67 | 67 |
| Hispanic | 15 | 49 | 10 |
| Total | 210 | 769 | 169 |

Chart 10: Ranking Data by Target Population as to Percentage of HIV/AIDS Transmission in PLWHA in Sarasota County

| Rank | Population | % of Cases |
|---|---|---|
| 1 | White MSM | 76.4% of MSM/ 47.3% total |
| 2 | Black MSM | 36.8% of MSM/ 4.8% total |
| 3 | Hispanic MSM | 6.4% of MSM/ 3.5% total |
| 4 | Black Heterosexual | 53.8% of H/ 8.1% total |
| 5 | White Heterosexual | 31.7% of H/ 2.2% total |
| 6 | Hispanic Heterosexual | 14.4% of H/ 4.8% total |
| 7 | Black IDU | 38.7% of IDU/ 4.8% total |
| 8 | White IDU | 53.25 of IDU/ 6.6% total |
| 9 | Hispanic IDU | 8.1% of IDU/ 4.8% total |
| 10 | Other Risks(including MSM/IDU and not identified) | 12.6% |
| | | Total: 100% |

Chart 11: Prevention Contacts (Includes Counseling/Testing and Providers)

| Ethnic Background | Heterosexual | MSM | IDU Male/Female |
|---|---|---|---|
| White | 83 | 653 | 51/ 41 |
| Black | 95 | 67 | 34/ 33 |
| Hispanic | 15 | 49 | 9/ 1 |
| Total | 193 | 769 | 94/ 75 |

Chart 12: Target Population as to Priorities with HANS Input for Prevention Messages and HIV Testing in Sarasota County

| Population | Rank |
|---|---|
| Black MSM | 1 |
| Hispanic MSM | 2 |
| White MSM | 3 |
| Black Heterosexuals | 4 |
| Hispanic Heterosexuals | 5 |
| White Heterosexuals | 6 |
| Black IDU | 7 |
| Hispanic IDU | 8 |
| White IDU | 9 |

## Part 5: Strategies and Interventions

### Overview of HIV Prevention Interventions

Before moving into this section of the most effective prevention strategies, it is worth discussing what has been learned about effective HIV prevention during the first 25 year of the epidemic of HIV/AIDS.

### Providing Information is not enough

In the earliest stages of the epidemic in the 1980's, it was recognized that HIV was a "Behavioral transmitted disease". Thus early concepts of prevention were built around changing individuals behaviors. In the early days, a belief existed that merely informing people of the presence of a deadly disease, how it was transmitted, and how to protect themselves from it would be sufficient to change behavior. Early prevention efforts were built around this information provision model unfortunately failed, producing little or no significant and sustainable behavioral change.

### Understanding environmental and contextual factors is critical to enabling people to change behavior

Over the next decade, recognition developed that a number of other factors influenced the effectiveness of prevention efforts. In particular, it was recognized that the individual often does not control his or her own behavior. Original models of HIV behavior change

put far too much emphasis on individualistic approaches and failed to consider the social, cultural and economic environment and context in which behaviors occurred. They assumed that individuals could always make informed decisions based on information provided to them by prevention and then act on those decisions. Numerous prevention failures helped to highlight some of the limitations of this approach.

**A more realistic model of behavior change-**
**addressing risk and vulnerability**

The lessons learned over the first two decades of the epidemic have led to a more realistic model of HIV prevention. In the real world, individuals make decisions about risk behaviors not only in response to a variety of factors, but from the information about HIV/AIDS, past experiences, social pressures (peers, family, and church), risk perceptions (MSM/IDU), personal concerns, motivations and individual cultural norms. But in this model, even once individuals have made a decision to take protective measures, such as to use a condom, limit their sexual partners, a number of other factors may stand in the way. Many of these external factors are part of the local environment in which risk behaviors occur or the context in which the risk behaviors are understood. Collectively, they influence an individual's vulnerability to HIV infection, that is, their ability to control and act on the decisions they make on prevention and protective measures.

**Effective prevention works at multiple levels**

In discussing environmental and structural interventions, it is important to address the factors influencing risk and vulnerability components at different levels of development.

- Superstructural: These components address large-scale social and political environments in which behavior takes place. It may require addressing gender or social inequalities, which contribute to elevated risk for women or for marginalized populations such as sex workers and MSM.
- Structural: Prevention components at the structural level address laws or policies at both national and institutional level that interfere with prevention efficacy (i.e.: laws as to IDU, condom ads). They might seek to address operational issues, such as failure to encourage/enforce condom use in brothels or failure to apply universal precautions in medical settings.
- Environmental: These components address the facts in local environment that lower the effusiveness of interventions or encourage risk behavior. They might seek to encourage families to migrate together to worksites instead of encouraging male only migration. Or they might seek to address lack of access to condoms or clean needles in local settings. Or they might try to change social norms regarding condom use.
- Individual: these components seek to influence the individual's decisions and skills regarding prevention measures. They are what most people think of when they hear the term "prevention" but by themselves they are insufficient to produce sustained behavior change.

## Important implications for prevention programs

The more realistic model for prevention presented here has several major implications for effective HIV prevention programs.

- Effective prevention programs must understand and address people's behaviors, the context in which they occur, and the factors influencing them to change or not change their behaviors.
- Effective prevention programs address not only risk, but also vulnerability.
- Effective prevent must involve and grow out of the community whose behaviors they seek to change. Only when those engaging in risk behaviors are involved in the design and implementation of prevention efforts are those efforts likely to adequately reflect an understanding of the local environment and context of risk and vulnerability.
- Effective prevention efforts must involve multiple partners and multiple components to address the multitude of environmental and contextual factors influencing risk and vulnerability. They must be multicultural in nature and involve multiple components working in multiple levels.

## Lessons from the first two decades of HIV prevention

A number of important conclusions need to be examined from the first two decades of HIV prevention.

Real prevention is complex; there is no single right prevention message for every one. This means there is no single prevention approach that can work within every population. It means that simplistic approaches like providing information alone, while easily understood, are likely to prove ineffective.

Effective prevention takes time, behaviors are not changed over night, and they were not developed over night. Putting the components into place to address the multiple factors influencing risk and vulnerability requires careful planning, time, effort and resources. Moving prevention efforts form a small pilot project to a national scale takes time to build capacity, time to address the changes required, and time for the efforts to have an impact.

Prevention must be planned for the long term since there is no cure in the foreseeable future with this HIV epidemic. Staying in a “crisis” mode, which promotes “quick and dirty” but less effective prevention efforts, and ignoring the need to undertake more comprehensive multicultural/multiple level interventions efforts to address other contributing factors, will result in far less effective future prevention efforts.

## The Science of HIV Prevention

Scientific reviews consistently identify the fundamental elements of effective HIV prevention programs. To be an effective HIV prevention program/project you must have the following components in the design, implementation and evaluation of the project/program:

- Based on sound science, using evidence or principles derived from behavioral and social science research;
- Clearly defined target audiences, focused on reducing specific risk behaviors, and designed to address strategic public health goals and objectives;
- Involve the target audience in intervention design, implementation and evaluation;
- Culturally and developmentally appropriate, speaking the language of the target audience and taking into account their social and cultural backgrounds;
- Deliver specific messages and provide specific risk reduction steps in terms the target audience understands;
- Focus on more than just education, actively address skills and motivations, and barriers for change to occur;
- Sustain and reinforce over the lifetime of the high-risk target audience/population, with prevention interventions and messages repeatedly reinforced;
- Sufficient resources to ensure adequate delivery of interventions and messages to as many members of each target audience as possible, and to ensure that effective interventions are sustained over time;
- Provide access to prevention technology to ensure that behavioral and biomedical interventions are supported by access to needed tools and services as voluntary counseling and testing, condoms, and timely screening and treatment of other STDs; and
- HIV prevention programs are best planned and implemented at the local level.

Despite the many successes in fighting the war on HIV/AIDS, further progress must be taken to fight this disease and it requires a major new effort to combat the spread of infections via a national strategic plan. Sustaining and building on early successes and adapting programs to keep pace with an evolving disease calls for commitment, adequate resources, and sustained leadership from affected communities. Working in partnership, organizations and individuals can accomplish the following:

- Provide prevention and hope for people living with HIV/AIDS;
- Educate others as to the risk factors associated with HIV/AIDS; and
- Identify other new interventions, treatments and prevention messages.

## Behavioral Change Theories and Effective HIV/AIDS Interventions

Behavior change is a process that many theorists have mapped and analyzed and behavior change communication has its roots in theories that have evolved over the last several decades and continue to evolve. Behavior change of individuals, communities, organizations, and institutions is fundamental to reducing risk and vulnerability to HIV/AIDS. There are stages of change to look at when developing and implementing a new behavioral intervention. Attention must be given to the following steps an individual moves through in order for a change in their behavior to occur:

- Pre-contemplation unaware
- Contemplation aware and concerned and knowledgeable
- Preparation motivated to change
- Action tries new behavior
- Maintenance sustains new behavior

CDC has implemented Diffusion Evidence Based Interventions (DEBI) and Evidence Based Interventions (EBI) as the best approach for local communities to take in educating target audiences on ways to reduce their high-risk behaviors as associated with HIV/AIDS and other STDs. CDC in the late 1990's reviewed behavioral intervention literature and made recommendations about what interventions had evidence of reducing sex and drug injection risk behaviors. They developed a "Compendium of HIV Prevention Interventions with Evidence of Effectiveness" in 1999 and updated it in 2005. CDC recognizes the broad array of evidence based interventions (EBI) for various diverse subpopulations at risk for acquiring or transmitting HIV/AIDS. A wide range of HIV behavioral interventions exist that vary in many factors, such as their theoretical foundation, targeted risk groups, manner of delivery, content, length, and intensity. They vary in terms of how they have been evaluated to determine their efficacy as well as the type and strength of the evidence available from prior evaluation. CDC has been able to develop a framework for classifying HIV behavioral interventions, called the Tiers of Evidence. To date, this framework focuses on classifying individual and group level interventions and does not include community level (CLI). For more information on DEBI/EBI refer to the CDC web site at http://www.cdc.gov/hiv/topics/research/prs/prs_rep_debi.htm

Community based interventions seek to change attitudes, norms, and values of an entire community/target population as well as social and environmental context of risk behaviors of the target population/community. Examples of community level interventions include:

- Holistic Health Recovery Program (HHRP)
- Popular Opinion Leader (POL)
- Community PROMISE
- MPowerment
- Real AIDS Prevention Program (RAPP)
- Group level interventions

Group level interventions seek to change individual behavior within the context of a group setting. Examples of group level interventions include:

- Healthy Relationships (HR)
- Many Men, Many Voices (3MV)
- Safety Counts
- SISTA
- Street Smart
- Together Learning Choices (TLC)
- VOICES/VOCES

**Tiers of Evidence Framework**

CDC encourages all HIV prevention partners, including health departments and community based organizations to move toward Evidence Based Interventions (EBI) practices by identifying and selecting EBI HIV behavioral interventions for programmatic implementation and to guide agencies delivering locally developed interventions on how to build measures of outcome and evidence into their local programs. CDC encourages adopting interventions that have been shown to prevent HIV, by reducing HIV/STD incidence, reducing sex or drug risk behaviors, or increasing HIV related protective behaviors. The EBI selected by our local agencies and the health department meet the prevention needs of the target population for our local community. Our local CBO that do not offer EBI are beginning to understand the need to develop evaluation methods to help them better demonstrate the efficacy of their programs for the target audience. This type of evaluation process includes program evaluation, process evaluation, outcome monitoring, and to make improvements as needed. The Tiers of Evidence framework is a conceptual framework that provides a multi-tiered system for classifying all HIV behavioral interventions based on the type and level of evidence for reducing HIV risk. The framework serves the purposes:

1) Clarify the spectrum of interventions that may exist with various degrees of efficacy or evidence that the intervention brings about risk behavioral change;
2) Describes how CDC designates evidence based interventions (Tiers I and II) identified in the research literature, and
3) Distinguishes between those interventions that have been identified in the research realm as being efficacious (Tiers I and II) and those locally developed interventions that may be currently implemented in the prevention program field.

Tiers I and II comprise Evidence Based Interventions (EBI), because they are based on direct, high-quality, empirical evidence that demonstrates a reduction in HIV/STD incidence or reduced HIV related risk behaviors. Tiers III and IV comprise the Theory Based Interventions (TBI) which are based on sound behavioral science theory, but do not have sufficient empirical evidence to satisfy CDC criteria for EBI. These interventions do have empirical evidence in the form of process data or outcome monitoring data. The lowest category in the Tiers of Evidence program is “Unevaluated Interventions” (UI), which represents all other interventions that may still exist but have never really been evaluated. Tiers I are best evidence based interventions based on HIV behavioral interventions practices while Tier II is promising evidence based on level of study quality and strength in findings.

Chart 13 below shows Sarasota Community Based Organizations and the Sarasota CHD as to offering different types of EBI:

Chart 13: Types of EBI Offered in Sarasota County

| Agency | Evidence Based Intervention | Target Audience |
|---|---|---|
| Community AIDS Network (CAN) | VOICES/VOCES and SISTA (Tier I) | African American males and females |
| Sarasota CHD | Partnership for Health (PfH) (Tier I) | HIV positive and high risk HIV negative clients |
| Planned Parenthood of Southwest and Central Florida (PPSWCF) | SOURCE Teen Theater productions (UI) | Youth/Teens on risks of HIV/AIDS/STD |
| Genesis Health Services and Multicultural Health Institute (GHS/MHI) | Volunteer Community Gatekeepers (UI) | Target high risk negative African Americans and Hispanics |
| Project Unity | Brother-to-Brother (Tier I) | African American MSM/Bi-Sexual Males |
| Project Unity | Focus on Kids (Tier I) | Youth all races |

## Part 6: Other Significant Issues

### Mental Illness and HIV/AIDS

Patients with severe mental illness may be at higher risk for HIV infections than the general population. Seroprevalence studies in New York City among severely ill psychiatric patients have found rates of HIV infection ranging from 4.0% to 19.0%. In most of these studies, women were as likely as men to be infected, and blacks had higher rates of infection than non-blacks. Psychiatric patients often demonstrate poor judgment and impulsive behavior when selecting a sexual partner and hyper sexuality may be a symptom of certain psychiatric illnesses. Patients may lack the social skills or access to condoms necessary to practice safer sex. While illegal drug use is common among psychiatric patients, only a small number report any recent IV drug use. Many report having sex with intravenous drug users. To design and offer successful interventions with mentally ill patients requires offering help in a supportive, non-judgmental, and positive environment. For patients to avoid high-risk behavior, they need information and skills, including: specific knowledge, coping skills, and emotional awareness. For those patients who use substances, they need extra support in resisting peer pressure to use drugs if they live in an environment where they are exposed to drugs daily. It is often difficult for mentally ill patients to establish new peer groups in the face of continued pressure to use drugs and they need assistance in recognizing, labeling, and controlling their emotional responses.

## Domestic Violence

There are a variety of ways that domestic violence may put victims at risk of contracting HIV/A*DS:*

- Often victims are not able to negotiate safer sex practices
- Abusers may rape or sexually assault victims, making it unlikely that the abuser will use a condom
- Abusive partners may engage in unprotected sex outside their relationship with the victim
- Abusers may prevent their victims from receiving medical care

Safe Rape and Crisis Center (SPARCC) is a local non-profit agency providing domestic abuse services for men and women residing in our community and they are a member agency of HANS.

## Drugs and HIV/AIDS

Addressing the complex interconnection between HIV infections and drug use continues to be a serious public health challenge through out the United States. The destructive connection manifests itself in three ways: (1) behavioral affects induced by drug use; (2) behavioral aspects associated with the need for the drug, and (3) sero epidemiological aspects associated with the equipment used to take the drug. Both injected and non-injected drugs have affects on the user which lead to high-risk sexual behaviors. Most drugs, including alcohol, reduce inhibitions and impair judgment, which often leads to multiple sexual partners and riskier sexual activity. Often dependence on drugs leads to additional behavioral effects which contribute to increased risk of HIV infection such as prostitution and domestic violence. In Sarasota county HIV transmission in women is high as a result of intravenous drug usage, where 25% cases identify IDU as risk factor for HIV transmission. For people living with HIV, drug use can lead to missed anti-retroviral medications; this can lead to increased chances of failure in treatment and resistance to medications. Mixing recreational drugs with anti-retroviral drugs can be dangerous, and can cause serious side effects or overdoses.

A high degree of con-morbidity exists with individuals infected with HIV and other infectious diseases including hepatitis C (HCV), hepatitis B (HBV), tuberculosis (TB) and other Sexually Transmitted Diseases (STD), including syphilis, Chlamydia, gonorrhea, and genital herpes. HCV, HBV, and HIV/AIDS are highly prevalent among IDUs and often occur with HIV; HBV is also common among drug users. HCV is highly transmissible through blood-borne exposure. Studies have found that people who inject drugs, within three years of infecting, most IDU contract HCV. Chronic HCV and HIV and treatment during the acute phase of HCV infection present certain challenges, and it is now recommended to begin HCV treatment prior to starting HIV anti-retroviral treatment.

TB as a co-infection with HIV is on the rise in the U.S. TB infections in Sarasota County have increased during the past year. If an individual has HIV and TB it is important to treat the active TB since they may be contagious during this stage to others. HIV infection severely impairs the immune system, so people infected with both HIV and latent TB are at increased risk of developing active TB disease and becoming highly infectious, thereby increasing the risk of further TB transmission. Effective treatment of HIV and TB can reduce TB/HIV associated disease and risk of transmission to others.

## Part 7: Conclusion and Recommendations:

### People of Color and HIV/AIDS (African Americans and Hispanics)

1) HANS members need to work with local churches and develop educational and HIV testing to be offered in the local churches to the congregation as non-threatening, non-judgmental ways.
2) Need to educate men and women in these two target populations as to the risk factors associated with HIV and other STD as to their sexual behaviors and assist them in developing safer sex practices that can be easily implemented.
3) Begin to break down the barriers to obtaining early medical treatment and staying in care/treatment.
4) Work with the youth to better educate them as to the risk factors with HIV and STD and providing them with facts to stay healthy and lead healthier lifestyles.
5) Work with local media to offer educational and media campaigns designed and targeted at this high risk target population.
6) Work with local domestic abuse/crisis centers to offer HIV testing on site and educate staff on HIV/AIDS and STD.
7) Develop EBI that target this population and designed to meet the needs of those served with incentives provided when complete the intervention.
8) Work with youth to make sure they are aware of HIV/STD and protecting themselves since one in five young women have an STD nationally.
9) Talk to men of risks they place their families with practice of having sex with men and unprotected. Need to do more education with this group of men but difficult to locate due to denial of MSM status.
10) Providing educational seminars to parents on how to talk with their children on HIV, STD, and substance usage.

### Substance Abuse and Usage

1) Educate drug users on HIV, STD and HCV as to risk factors.
2) Work with local Substance Abuse providers to train staff, including mental health counselors on HIV/AIDS. Develop educational program for mental health counselors and what they need to know when counseling HIV positive clients.
3) Work with substance abuse providers to offer HIV testing on site (i.e.: Rapid Ora Quick method of choice).

## Target Population as to Zip Codes for HIV/AIDS Education and Testing in Sarasota County

According to the HIV data from 2007 Chart 14 shows the following zip codes with the highest reported incidence of persons living with HIV/AIDS in Sarasota County as of 2007 per DOH:

Chart 14: Zip Codes with the Highest Percentage of PLWHA in Sarasota County

| Zip Code | Number of PLWHA | Ranked Order |
|---|---|---|
| 34234 | 185 | 1 |
| 34237 | 69 | 2 |
| 34236 | 67 | 3 |
| 34231 | 50 | 4 (Tie) |
| 34232 | 50 | 4 (tie) |