



Sonoma County HIV Prevention Plan 2008 -2011

Developed by
Sonoma County
Department of Health Services
Prevention and Planning Division

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1. EXECUTIVE SUMMARY

It's been over twenty-five years since the HIV epidemic began and while there is much success to celebrate, new challenges have emerged, demanding that we look at HIV disease differently and adjust our response to the changing epidemic at policy, systems, community, and personal levels.

No longer is infection with HIV considered a terminal condition. For many, HIV medications are readily available, and have allowed people to live longer and healthier lives. However, since medicines are allowing people with AIDS to live longer, AIDS prevalence (the number of people living with AIDS) in Sonoma County continues to rise¹. In addition, a decrease in new AIDS cases means an increase in HIV prevalence (number of people living with HIV). People infected with HIV are living longer before acquiring AIDS and the illnesses associated with the diagnosis. This increase in HIV prevalence represents a growing burden on prevention and treatment services for persons with AIDS, and strains the resources available to take care of the growing HIV+ population. We must now think in terms of the prevention and treatment of a Chronic Disease and adjust both our prevention and treatment strategies accordingly.

As with many chronic conditions, people can live with HIV for longer periods without knowing that they are infected. Evidence suggests that the majority of new infections are caused by persons who are unaware of their HIV status². This presents a double threat: individuals who are unaware of their status are less likely to engage in risk reduction behaviors and are therefore more likely to transmit HIV; and, because they are not testing they do not seek treatment or services until their condition advances. Early treatment can improve the chances that a person with HIV will delay the onset of AIDS – resulting in a longer healthier life for the individual and lessening the burden of costly treatment on the system of care.

The shifts in the epidemic, along with changes at the national and state levels require a reassessment and refocus of local HIV-prevention activities. Improving access to testing and providing prevention and care services for persons infected with HIV will lead to reductions in HIV-associated morbidity and mortality and will also work to reduce new infections. Prevention efforts must ensure that those with HIV have access to current information on risk reduction; primary care and support services; and, resources and support for their partners. But prevention strategies must extend further to address the full range of emerging behaviors that put individuals at risk for infection.

An increase in recreational drug use has been associated with increases in high-risk sexual behavior, particularly among men who have sex with men (MSM). In addition, the number of people with HIV/AIDS presenting with co-occurring issues including alcohol or other drug addiction, mental illness, tuberculosis, Hepatitis B/C, and other sexually transmitted diseases is also growing. Prevention efforts in each of these areas must endeavor to become more integrated if we hope to curb the growing infection rates.

¹ Epidemiology of HIV/AIDS in Sonoma County, Annual Report June 2007, Department of Health Services, Public Health Division

² HIV Prevention (AHP): New Strategies for a Changing Epidemic, Centers for Disease Control, 2005

Finally, as is true for communities across the nation, we are seeing increasing risk among women, youth, and people of color. In the 42 U.S. states with confidential name-based HIV infection reporting, women (adults and adolescents) accounted for 30% of new HIV infections in 2004³. Half of all new HIV infections are believed to occur in people under the age of 25⁴. As young people (13-24) begin to engage in high-risk behaviors including unprotected sex and drug use, their risk for HIV infection. In 2002, the rate of new HIV or AIDS diagnosis among Latinos in Sonoma County surpassed the rate among White, non-Latinos and has remained higher through 2006. Since 2000, however, the highest rate of new HIV/AIDS cases has been among non-White, non-Latino persons.

In order to address the disparities in access to health care and HIV prevention information and services we must work within communities of color to expand the reach of prevention services; increase opportunities for diagnosing and treating HIV; develop new, effective prevention interventions; and mobilize broader community action.

Sonoma County HIV Prevention efforts will work toward reducing new infections by focusing on the behaviors and/or conditions that present the greatest risk for transmission of HIV. Primary goals of the HIV Prevention Plan include:

- ❖ Providing education and awareness of risk reduction strategies to persons with co-occurring conditions of mental illness and alcohol and/or other drug addiction;
- ❖ Reducing barriers to early diagnosis of HIV infection among persons with co-occurring conditions of mental illness and alcohol and/or other drug addiction;
- ❖ Eliminating racial and economic disparities in the delivery of HIV related prevention and support services;
- ❖ Improving awareness of HIV status through increased knowledge of risk and widespread testing;
- ❖ Connecting those testing positive for HIV/AIDS with primary care and/or HIV/AIDS treatment and prevention services as early as possible; and,
- ❖ Facilitating access to quality medical care, treatment, and ongoing prevention services for those diagnosed with HIV and their partners.

Assuring that prevention services are responsive and proactive with respect to the changing nature of the HIV/AIDS epidemic will drive the direction of Sonoma County Prevention efforts through 2011.

³ [Centers for Disease Control and Prevention \(CDC\). HIV/AIDS Surveillance Report, 2004. Vol. 16. Atlanta: US Department of Health and Human Services; 2005.](#)

⁴ [National Office of Aids Policy. Youth and HIV/AIDS 2000: A New American Agenda](#)

2. HIV EPIDEMIOLOGIC PROFILE

Description of Sonoma County

Sonoma County, a largely rural county with the majority of its population living in nine incorporated cities, is located north of San Francisco. Bordering the Pacific Ocean yet stretching inland to include redwood forests and rolling hills, county residents enjoy remarkable scenic beauty and a mild climate.

Sonoma County has the 17th largest population of California counties in 2004 with nearly half a million residents⁵. The largest growing segments of the population are persons age 65-84 and Latinos⁶. Despite being one of the wealthiest counties in California, approximately 20% of White non-Latino households and nearly half of Latino households had annual incomes less than \$30,000 in 2001⁷. Further, Sonoma County is nationally ranked as one of the least affordable communities nationwide⁸.

At the end of 2004, we estimate that 1,987 persons were living with HIV or AIDS in Sonoma County (between 1,856 and 2,118). This figure is based on a national estimate that assumes that 24-27% of persons who are HIV positive are unaware of their infection⁹. Given the estimated total population in 2004 are 479,824; the prevalence of HIV in Sonoma County is 0.4%.

Recent studies indicate that persons unaware of their HIV status significantly contribute to the ongoing epidemic of HIV. Of the estimated 70 new infections in Sonoma County in 2004, 54% of these cases likely acquired their infection from an HIV positive unaware person (Table 1). This scenario is the driving force behind the 2006 CDC directive to expand HIV testing¹⁰.

Table 1 – Estimates of Prevalence and New Infections in Sonoma County, 2004

Prevalence ¹¹	N	%
Diagnosed PLWHA	1490	75
Undiagnosed PLWHA	497	25
Total PLWHA	1987	100
Estimated Contribution to New Infections ¹²	N	%
Diagnosed PLWHA	32	46
Undiagnosed PLWHA	38	54
Total New Infections	70	100

5 State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, CA, May 2004.

6 Sonoma County Department of Health Services. Sonoma County Health Profile, December 2005.

7 Ibid.

8 Ibid.

9 Glynn M, Rhodes P. Estimated HIV prevalence in the United States at the end of 2003. National HIV Prevention Conference; June 2005; Atlanta. Abstract 595

10 Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 2006;55(No. RR-14):1-17.

11 Glynn M, Rhodes P. What is really happening with HIV trends in the United States? Modeling the national epidemic. National HIV Prevention Conference. June 2005. Atlanta [abstract T1-B11-13].

12 Marks G, Crepaz N, Janssen R. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS. 2006. 20: 1447-1450.

HIV and AIDS in the World, US, and California

The number of persons currently living with HIV or AIDS continues to rise around the world (Table 2). Certain regions, such as East Asia, Eastern Europe, and Central Asia, are experiencing a dramatic increase in newly diagnosed cases¹³. Of particular concern is the increasing proportion of women and children affected by HIV and AIDS. In some countries, over fifty percent of persons living with HIV disease are women. In the United States, this proportion is twenty-seven percent and growing larger each year¹⁴.

Table 2 – Global, national and State HIV/AIDS Estimates (Pediatric and Adult)

People living with HIV/AIDS	
Worldwide ¹⁵	39.5 million (34.1-47.1 million)
Adults	37.2 million (32.1-44.5 million)
Women	17.7 million (15.1-20.9 million)
Children under 15 years	2.3 million (1.7-3.5 million)
United States ¹⁶	1.1 million (1.0-1.2 million)
California ¹⁷	151,000
New Infections per Year	
Worldwide ¹⁸	4.3 million (3.6-6.6 million)
United States ¹⁹	40,000
California ²⁰	7,888 (6,788-8,988)

¹³ UNAIDS (2004). 2004 AIDS Epidemic Update. Geneva, UNAIDS.

¹⁴ Centers for Disease Control and Prevention. A glance at the HIV/AIDS Epidemic. Atlanta: US Department of Health and Human Services, Center for Disease Control and Prevention; 2005.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Glynn M, Rhodes P. Estimated HIV prevalence in the United States at the end of 2003. National HIV Prevention Conference; June 2005; Atlanta. Abstract 595.

¹⁸ Centers for Disease Control and Prevention. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. MMWR 2006;55(No. RR-14):1-17.

¹⁹ Glynn M, Rhodes P. What is really happening with HIV trends in the United States? Modeling the national epidemic. National HIV Prevention Conference. June 2005. Atlanta [abstract T1-B11-13].

²⁰ Marks G, Crepaz N, Janssen R. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS. 2006. 20: 1447-1450.

In California, Sonoma County has the seventh highest prevalence of persons living with AIDS of all 58 counties (Table 3).

Table 3 – Leading Prevalence^{21,22} of AIDS Cases by County, California, 1981 – 2006

County	Prevalence per 100,000*	Persons living with AIDS
San Francisco	1,108	8,852
Marin	249	632
Los Angeles	213	21,774
San Diego	201	6,159
Alameda	197	2,974
Solano	182	771
Sonoma	171	820
Riverside	148	2,900
Kern	138	1,074
Orange	114	3,517

* Prevalence based on county of first diagnosis

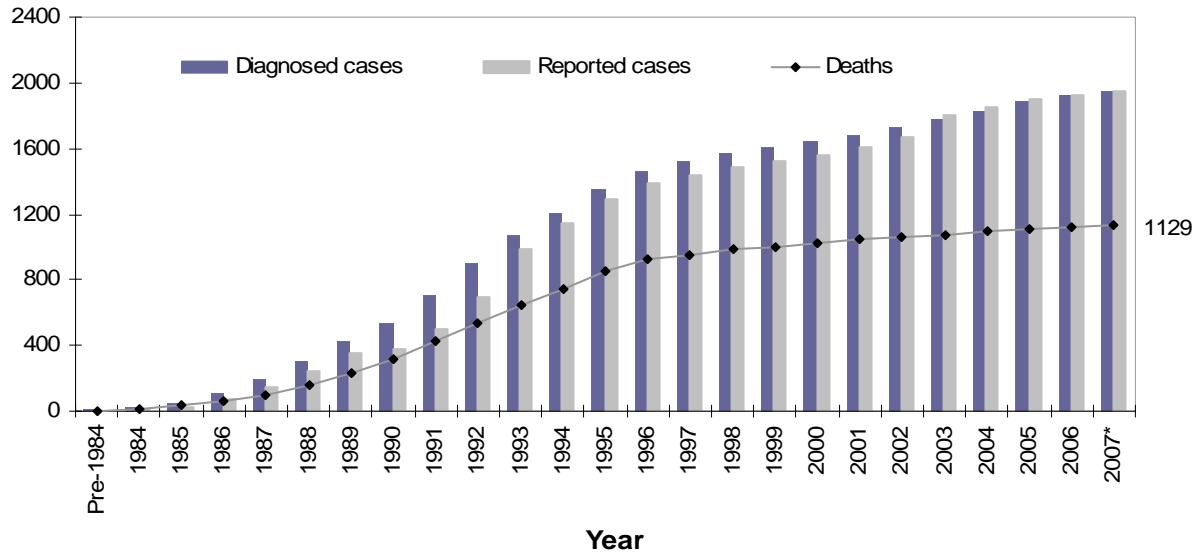
AIDS in Sonoma County

The HIV and AIDS case information in this section reflects data from the HIV/AIDS Reporting System. This database only includes HIV and AIDS cases that were diagnosed in Sonoma County. Those people living with HIV/AIDS that currently live in Sonoma County but were diagnosed with HIV or AIDS in another county are not included in the tables and graphs in this section.

²¹ California Department of Health Services, Office on AIDS. AIDS Reporting System Surveillance Report for California- June 30, 2006.

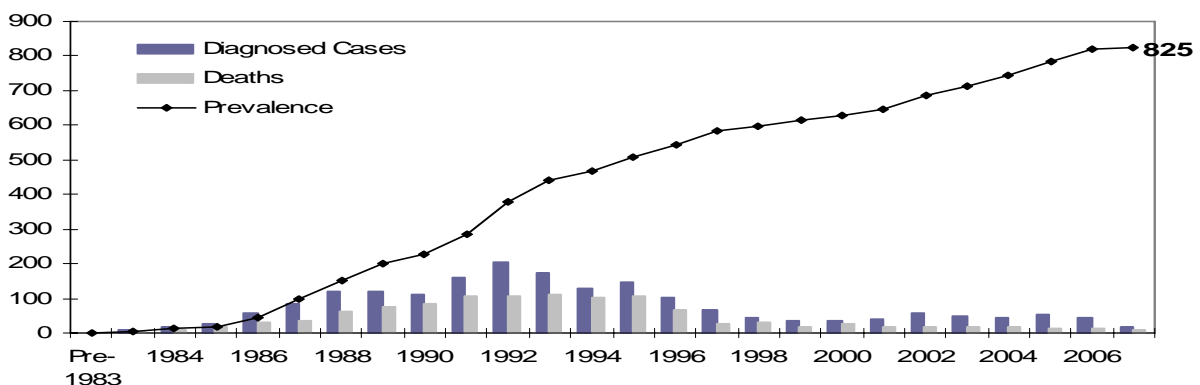
²² State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000-2050*. Sacramento, CA, May 2004.

Figure 1 - Cumulative AIDS Cases by Year Reported, Year of Diagnosis, and Year of Death
Sonoma County, 1981 through June, 2006



From January 1, 1981 through June 30, 2007, 1,946 Sonoma County residents have been reported with AIDS (Figure 1). Of these cases, 1,129 have died, resulting in a case fatality ratio of 58.8% over the course of the epidemic. While the number of newly diagnosed cases has declined since 1992, the total number of persons living with AIDS has steadily increased over time (Figure 2). The decline in the number of newly diagnosed AIDS cases is partially due to better management of HIV causing a delay in conversion to AIDS. Currently, there are 825 persons living with AIDS who were diagnosed in Sonoma County.

Figure 2 – AIDS Cases by Year of Diagnosis, Year of Death, and Prevalence
Sonoma County 1981 through June 2007



Race/Ethnicity

The cumulative incidence rate (CIR) by race/ethnicity estimates the rate at which a particular race or ethnic group is being diagnosed with AIDS (Table 4). The Other/Unknown classification of race/ethnicity includes Asian/Pacific Islanders (n=15), American Indian/ Alaska Natives (n=14), Multi-Race (n=13) and unknown (n=3). These groups were combined into one category because the number of cases for any one of these groups alone was too small to calculate a statistically reliable CIR.

Table 4- Cumulative Incidence Rates* of AIDS by Race/ Ethnicity

Sonoma County, 1981 through June 2007

Race/Ethnicity	Cumulative Incidence Rate	95% Confidence Intervals
White	474.7	(452.1, 497.3)
Latino	166.6	(141.1, 192.0)
African American	706.6	(520.5, 892.7)
Other/ Unknown	117.6	(83.2, 151.9)
Total	390.1	(372.8, 407.4)

*Rates per 100,000 population and not age-adjusted

Source: Sonoma County HIV/AIDS Reporting System

The highest CIR was seen for African Americans, followed by Whites. However, it is important to note that the fewer cases of AIDS in African Americans (n=55) compared to Whites (n=1682) and Latinos (n=164) may result in a less accurate representation of the CIR for African Americans. Latinos and the Other/Unknown groups had a significantly lower CIR than Whites or African Americans.

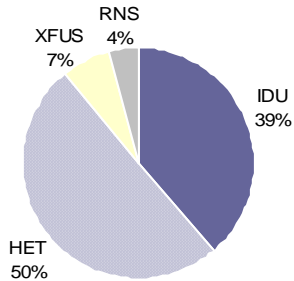
Exposure Category

A hierarchical index following The Centers for Disease Control and Prevention guidelines is used to describe how each AIDS patient acquired the virus. If a patient has more than one possible exposure category, excepting men who have sex with men and use injection drugs, the response closest to the top of the hierarchy is selected. In the following graph, each AIDS patient is represented by one response even though the patient may have reported multiple modes of exposure.

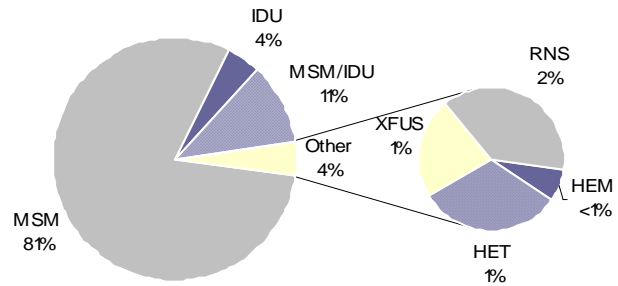
Figure 3 - Percent of Adult AIDS Cases by Exposure Category and Gender

Sonoma County 1981 through June 2007

Females (N=119)



Males (N=1825)



MSM – Men who have sex with men
HET – Heterosexual contact
XFUS – Blood transfusion, blood components or tissue

RNS – Risk not reported
IDU – Injecting drug use

The majority of male AIDS cases reported sex with another man (MSM) as the primary exposure category (81%, Figure 3). Note that if a man with AIDS reported ever having sex with a man between 1977 and his first HIV-positive test, he was placed in this category regardless of his sexual orientation. The majority of females reported heterosexual contact (HET, 50%) or injecting drug use (IDU, 39%) as primary exposures. These proportions are similar to all of California, where the majority (74%) of male AIDS cases were also in the report IDU exposure²³.

Age at Diagnosis

When diagnosed with AIDS, women are significantly younger than men (38 vs. 41 years, p=0.03 T-test with unequal variances). Among males, the largest proportion is diagnosed with AIDS between ages 30 and 39 (39%), followed by 40-49 (35%, Table 5). In comparison, among females, the largest proportion is diagnosed between ages 30 and 39 (42%), followed by ages 40 to 49 (22%, Table 5).

²³ UNAIDS (2004). *2004 AIDS Epidemic Update*. Geneva, UNAIDS.

Table 5 – Age at Diagnosis for Adult and Adolescent AIDS Cases

Sonoma County 1981 through June 2007

	Males		Females	
	N	%	N	%
13-19	2	<1	1	1
20-29	182	10	24	20
30-39	712	39	50	42
40-49	647	35	26	22
50-59	219	12	10	8
60+	66	4	8	7
Total	1828		119	

Persons Living with AIDS and HIV

As of June 30, 2006, there are at least 1,230 persons living with HIV disease in Sonoma County (825 AIDS, 405 HIV, non-AIDS). Due to the limitations in data collection, this number is not a true reflection of the local burden of HIV and AIDS, and only represents persons diagnosed with HIV or AIDS in Sonoma County. Additionally, an unknown number are unaware of their HIV status and are not reflected in the data. It is estimated that at the end of 2004, there were actually between 1,931 and 2,202 persons living with HIV disease in Sonoma County. This figure is based on a national estimate that assumes that 24-27% of persons who are HIV positive are unaware of their infection²⁴.

The number of Sonoma County residents who were older than 12 years at the time of AIDS or HIV diagnosis and who had no reported date of death as of June 30, 2007 was used to calculate the number of adults/adolescents living with HIV or AIDS. Some deaths may not have been reported (and not included in this data) especially if the person died outside the county. The data in this section includes persons with both AIDS and HIV non-AIDS.

²⁴ Centers for Disease Control and Prevention. *A glance at the HIV/AIDS Epidemic*. Atlanta: US Department of Health and Human Services, Center for Disease Control and Prevention; 2005.

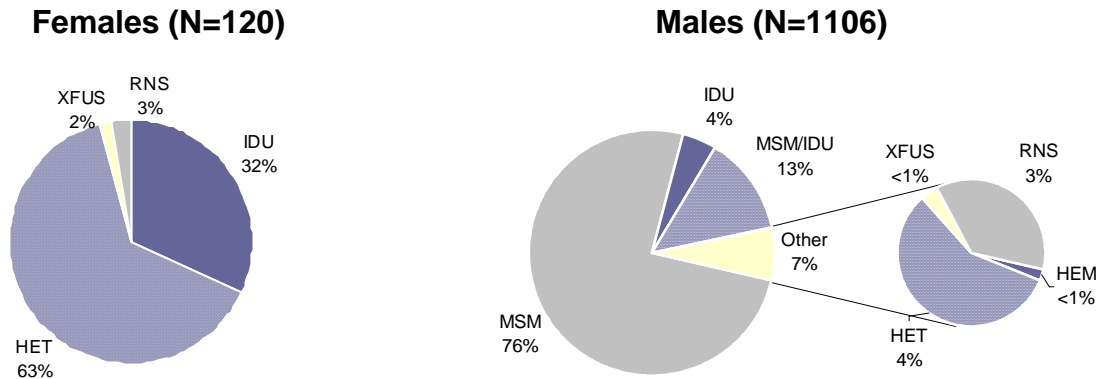
Table 6 – Demographic Characteristics of Adults living with HIV or AIDS
 Sonoma County – June 30, 2007

	Persons living with HIV/AIDS		Sonoma County Population >12	
	N	%	N	%
Diagnosis				
HIV	405	33	--	--
AIDS	825	67	--	--
Gender				
Male	1,109	90	247,708	50
Female	121	10	251,160	50
Race/Ethnicity				
White	983	80	354,342	71
Latino	149	12	98,461	20
Asian/Pacific Isld	18	2	20,732	4
African American	47	4	7,784	2
Amer Ind/Alaska Nat	11	1	6,282	1
Multi-Race	8	1	11,267	2
Unknown	2	<1	--	--
Current Age (as of 12/31/05)				
13-19	5	<1	49,153	10
20-29	54	4	69,242	14
30-39	187	15	58,427	12
40-49	506	41	73,924	15
50-59	355	29	76,613	15
60+	123	10	96,307	19

The majority of persons currently living with HIV or AIDS are male and report White race. Compared to the Sonoma County population, males overall and White and African American persons represent a larger proportion of cases of HIV and AIDS (Table 6).

Figure 4 - Percent of Adults Living with HIV Disease by Exposure Category and Gender

Sonoma County, 1981 through June 2007



The majority of males living with HIV or AIDS report sex with a man with or without intravenous drug use as their primary exposure, whereas females report heterosexual sex or intravenous drug use as the primary exposure (Figure 4). Compared to all AIDS cases, persons currently living with HIV or AIDS include a higher proportion of heterosexual exposures, particularly females (63%, Figure 3 vs. 50%, Figure 4).

Persons Recently Diagnosed with HIV/AIDS

Cases over Time

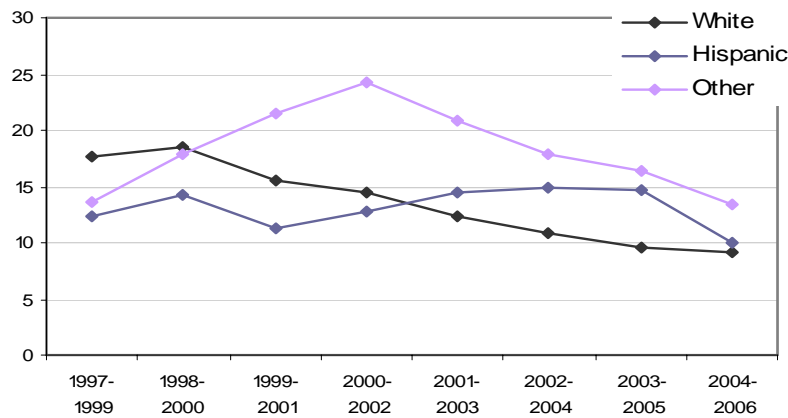
Since 1992, the peak of the AIDS epidemic in Sonoma County with 203 cases, the number of newly diagnosed AIDS cases by year has dropped dramatically. Between 1998 and 2006, an average of 45 AIDS cases were diagnosed each year (range 36 in 1999; 56 in 2002).

In 2006 there were 46 new AIDS cases and 29 new HIV cases reported to Sonoma County Public Health. Of the 46 AIDS cases, 32 were conversions (prior diagnosis of HIV to AIDS) and the remaining 14 were first reported as simultaneous diagnoses of HIV and AIDS. Since January 1, 2007, 17 new AIDS cases and 12 new HIV cases have been reported. Of the new AIDS cases, 13 were conversions and the remaining 4 were co-diagnoses of HIV and AIDS.

To evaluate trends over time, incident cases are evaluated by date of first positive HIV test, regardless of current AIDS status.

Race/Ethnicity

Figure 5 – Rate of HIV/AIDS cases by Race/Ethnicity by Date of First Positive Test, Sonoma County 1997 - 2006



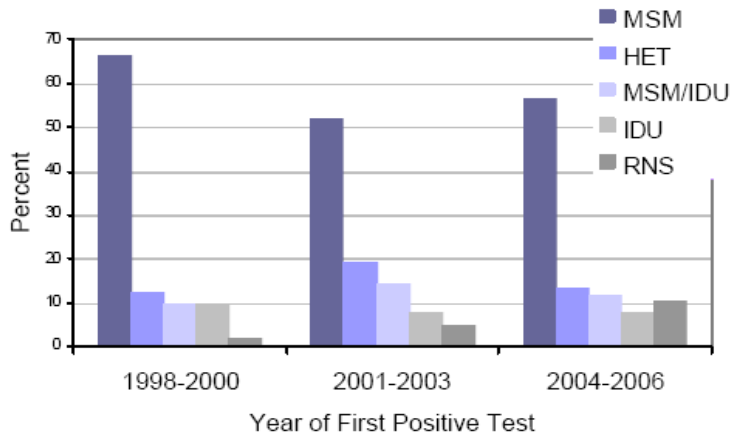
The rate of new diagnoses of HIV or AIDS varies by race and ethnicity (Figure 5).

In 2002, the rate of new HIV or AIDS diagnosis among Latinos surpassed the rate among White, non-Latinos and has remained higher through 2006. Since 2000, however, the highest rate of new HIV/AIDS cases has been among non-White, non-Latino persons.

Prior to 2000, White, non-Latinos accounted for over 80% of all new diagnoses of HIV or AIDS. Since 2000, this has decreased to an average of 70% of new cases, with the Latinos accounting for approximately 20% of new diagnoses and other non-Latino non-Whites accounting for the remaining 10%.

Figure 6 – HIV/AIDS cases by Mode of Exposure and Year of First Positive Test

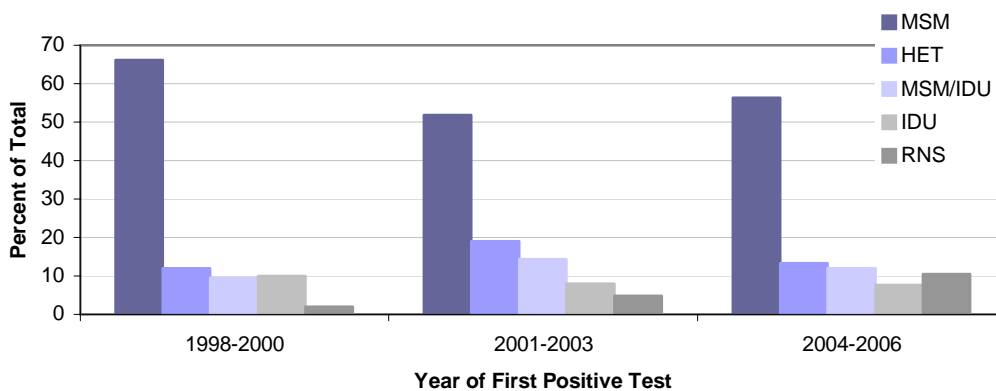
Sonoma County, 1998 –2006



The proportion of individuals identifying heterosexual sex as a primary risk factor has increased over the years from 11% of all new diagnoses in 1998-00 to as high as 19% of new diagnoses in 2001-03 (Figure 6).

In contrast, the proportion of men reporting sex with another man as a primary risk factor has decreased. In addition to the proportion, the yearly number of newly diagnosed MSM has decreased by half from 59 cases in 2000 to 28 cases in 2006

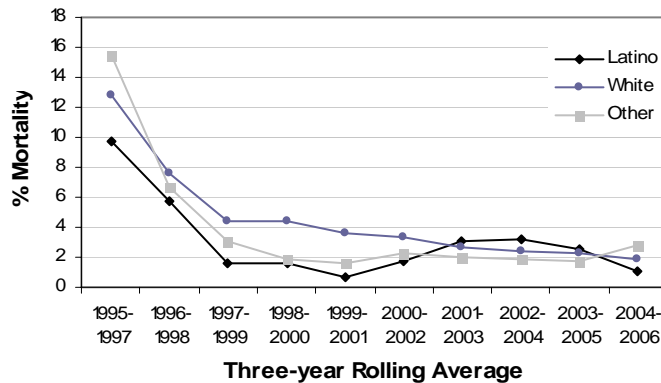
Table 7 – HIV/AIDS cases by Mode of Exposure and Year of First Positive Test Sonoma County, 1998 – 2006



Mortality

Figure 7- Crude Mortality Rate* by Race and Ethnicity

Sonoma County, 1995 –2006



*Percent per year, Annual deaths per 100 person-years

The mortality rate for AIDS has decreased significantly over time (Figure 7). Although all groups have less than four percent mortality, Latinos and other non-Whites have had a slightly higher rate in recent years.

The primary reason for the decrease in mortality is successful disease management using highly active anti-retroviral therapy²⁵. The higher mortality rate in Latinos may reflect late entry to care or difficulty accessing adequate medical resources.

Groups of Special Interest

There are several community groups or segments that are of special interest because of disproportionate impact, modes of transmission, increasing risk, and/or issues with access to prevention and treatment services. As we move forward with the design and development of prevention strategies we must take into consideration the unique challenges of these groups and ensure that our efforts attempt to address them.

²⁵ Palella FJ Jr, Delaney KM, Moorman AC. Et al. Declining morbidity and mortality among patients with advanced human immunodeficiency virus infection. *N Eng J Med.* 1998;338(13):853-60.

Special Interest: Latinos and Mexican-born Persons

The Latino population in Sonoma County is increasing, currently representing 20% of the total 2007 population, compared to 14% in 1995^{26,27}. Half of Sonoma County Latinos are foreign born, the majority of these born in Mexico²⁸. As a group, Latinos face significant challenges to receiving medical care; approximately 20% are uninsured and 30% are living in poverty (0-99% FPL)²⁹.

Latinos continue to be disproportionately affected by the HIV/AIDS epidemic. While 14% of the US population is Latino, Latinos account for approximately 19% of newly diagnosed AIDS cases nationwide in 2005³⁰. A sub-group of concern is recent immigrants from Mexico. These individuals are a particularly vulnerable population, and may be at increased risk for HIV infection while facing multi-factorial barriers to social services and health care³¹.

Since 1981, 210 Latinos have been diagnosed with AIDS or HIV in Sonoma County. While the total number of new cases per year has declined overall, the number of new Latino cases has remained relatively constant, averaging about 11 cases per year since 2001. This represents approximately 20% of all new diagnoses of HIV and AIDS.

The most commonly reported mode of exposure for persons with HIV or AIDS is men having sex with men (MSM), followed by MSM who also inject drugs (MSM/IDU), intravenous drug use (IDU) only, and heterosexual exposure (HET). For Latinos, MSM remains the most common exposure; however, the proportion of MSM is lower than that in non-Latinos (64% vs. 74%, respectively, Figure 8). Other risk factors, notably heterosexual sex and unknown other exposure (RNS), account for a larger proportion of Latino cases than that of non-Latino cases (Figure 8).

²⁶ San Francisco AIDS Foundation. HIV/AIDS Facts and Figures: A Quarterly Report. San Francisco, CA, December 2004.

²⁷ UNAIDS (2004). *2004 AIDS Epidemic Update*. Geneva, UNAIDS.

²⁸ Centers for Disease Control and Prevention. *A glance at the HIV/AIDS Epidemic*. Atlanta: US Department of Health and Human Services, Center for Disease Control and Prevention; 2005.

²⁹ San Francisco AIDS Foundation. HIV/AIDS Facts and Figures: A Quarterly Report. San Francisco, CA, December 2004.

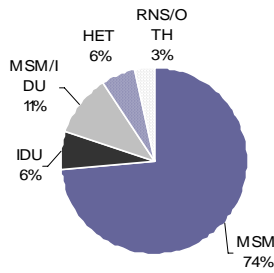
³⁰ California Department of Health Services, Office on AIDS. AIDS Reporting System Surveillance Report for California- June 30, 2006.

³¹ State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000-2050*. Sacramento, CA, May 2004.

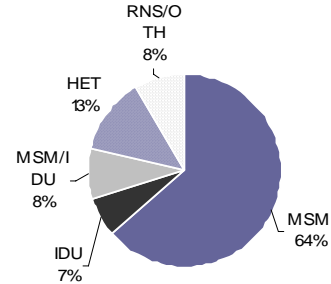
Figure 8 - Percent of Adults* Diagnosed with HIV or AIDS by Exposure Category and Ethnicity

Sonoma County, 1981 through June 2007

Non-Latino (N=2358)



Latino (N=206)

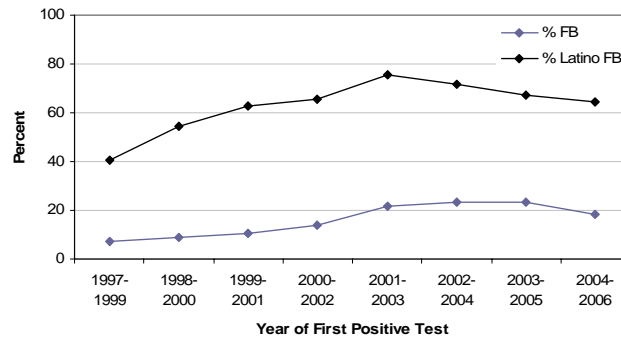


*Fourteen pediatric cases were excluded from these figures. A contributing factor to the proportion of heterosexual exposure as a risk factor among Latinos may be the larger proportion of female cases. 11% of all Latino HIV/AIDS cases are female, compared to only 7% of non-Latino cases.

Foreign-born Cases

Figure 9 – Percent of Foreign-born Cases among New Diagnoses of HIV/AIDS, All Cases and Latinos

Sonoma County 1997 - 2006



Persons born in other countries comprise a significant proportion of persons newly diagnosed with HIV or AIDS. Since 1997, the proportion of new HIV or AIDS diagnoses reporting a foreign birth country has increased over time (Figure 9). This is even more pronounced among Latinos where over 60% of new diagnoses report a

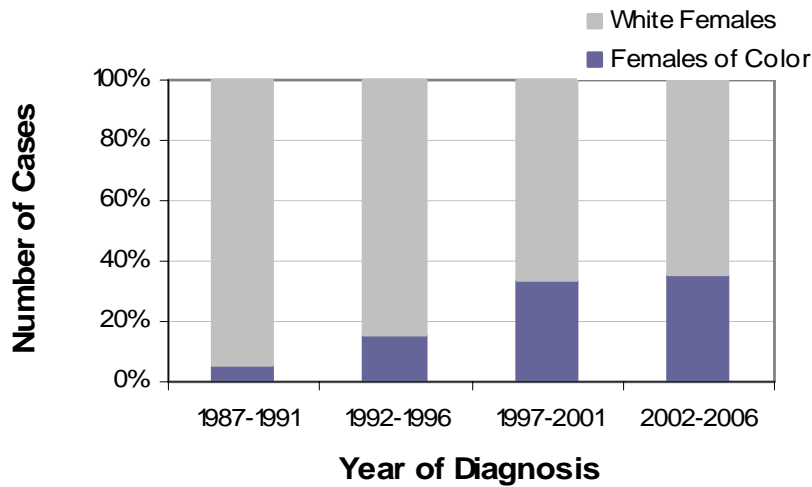
non-US birth country (Mexico 91%, Central or South America 9%). This proportion has also increased over time from 40% in 1997-99 to 64% in 2004-2006. Mexican-born males are more likely to report MSM and MSM/IDU exposure compared to Latinos not born in Mexico (76% vs. 84%, respectively). Mexican-born women are less likely to report IDU as a primary risk factor compared to Latinos not born in Mexico (11% vs. 20% respectively).

Special Interest: Women with Unidentified Risk

Since 1981, 170 women have been diagnosed with HIV or AIDS in Sonoma County (125 AIDS, 45 HIV). Of these, 124 are currently living with HIV disease. The proportion of women among persons newly diagnosed with HIV or AIDS averages about 13% of new cases per year (range, 6% 2005, 22%, 2004). The primary reported risk factors for women living with HIV or AIDS are heterosexual sex (62%), followed by injection drug use (31%).

Figure 10 – Female AIDS cases by Race/Ethnicity

Sonoma County, 1987-2006



Factors affecting HIV rates among women include increased risk of transmission during vaginal intercourse and lack of awareness of their male partners' past or current risk behavior³². While the overall numbers of women diagnosed with AIDS continues to decline, women of color account for an increasing proportion of these cases, 33% between 2002 and 2006 (Figure 10). AIDS affects women of all ages (Table 8). Compared to all women with AIDS, women recently diagnosed with HIV or AIDS more frequently report heterosexual exposure (70% vs. 50%). A growing

³² California Department of Health Services, Office on AIDS. AIDS Reporting System Surveillance Report for California- June 30, 2006.

segment of newly diagnosed cases are heterosexual women over 45 years of age. The proportion of new cases diagnosed among women over 45 has steadily increased from 8% in 1998-2000 to 29% in 2001-03 to 47% in 2004-06.

Table 8 – Female AIDS cases by Mode of Infection and Age Group

Sonoma County, Jan 1985 – Jun 2007

	<13	13-19	20-29	30-39	40-49	50-59	60+	Total
HET	0	1	14	20	14	8	3	60
IDU	0	0	8	27	10	1	0	46
Transfusion/Blood disorder	0	0	0	2	0	1	5	8
Maternal Exposure	5	0	0	0	0	0	0	6
Pediatric Transfusion	1	0	0	0	0	0	0	1
Risk not Specified	0	0	2	1	2	0	0	5
Total	6	1	24	50	26	10	8	125

Special Interest: Pediatric Cases

The majority of the pediatric AIDS cases reported in Sonoma County from 1981-2005 were children of mothers with or at risk for HIV infection. No new pediatric AIDS cases have been reported in Sonoma County since 1994. All of the pediatric HIV cases reported in Sonoma County from 1981-2005 were in the exposure category of a mother with or at risk for HIV infection (N=4). There have been no new pediatric HIV cases reported in Sonoma County since 2000.

HIV COFACTORS

In addition to primary risks such as sharing needles and having unprotected sex, it is important to consider other cofactors in HIV prevention planning and implementation. A cofactor can increase susceptibility to HIV infection in two ways: (1) the cofactor can increase the likelihood of engaging in a risk behavior (e.g., low self-esteem, sex work); or (2) the cofactor can increase the likelihood of contracting HIV if exposed (e.g., presence of an STD).

Late Entry to Care

Persons are considered to have late entry to care if their AIDS diagnosis occurred at the same time or within three months as their first HIV diagnosis. It is possible that these persons were aware of their previous diagnosis of HIV, but were not reported to the County until their AIDS diagnosis. Further study is needed to evaluate whether these persons are truly late entry.

Forty-three percent of persons diagnosed with AIDS since January of 2003 appear to have late entry to care. These cases are primarily White (58%) and Latino (32%),

and the majority is male (82%). Latinos are nearly one and a half times more often late entry to care compared to non-Latinos, although this association is not statistically significant (RR 1.4, 95%CI [01.05, 1.95]). The reported risk factors for all late-to-care cases are men who have sex with men (47%), heterosexual sex (20%), and intravenous drug use (18%, IDU and MSM/IDU combined).

Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) continue to be a problem in Sonoma County. Current rates of nearly all STDs are increasing in Sonoma County. In addition to complications from the diseases themselves, STDs can increase the risk of HIV transmission.

The presence of a sexually transmitted disease (STD) other than HIV, such as Gonorrhea, rectal Gonorrhea, Syphilis, Chlamydia, or Hepatitis B or C may indicate risk for HIV infection because they are transmitted in the same way (e.g., via sex, or, in the case of Hepatitis B and C, needle sharing). In addition, many STDs can facilitate the transmission of HIV. Sexually transmitted diseases (STDs) continue to be a problem in Sonoma County. Current rates of nearly all STDs are increasing in Sonoma County.

The rate of Chlamydia has been steadily increasing from a rate of 81.7 new cases per 100,000 population in 1999 to 165 new cases per 100,000 population in 2005. In 2005, women 20-24 years old had the highest incidence rate of Chlamydia. People of color, particularly Latinos and African Americans, are disproportionately affected by Chlamydia.

The upward trend in the rate of Gonorrhea infections began in 1999, increasing to a rate of 37 cases per 100,000 persons in 2005. Both women and men 20-24 years old have the highest incidence rates of Gonorrhea.

In Sonoma County, the increase in primary and secondary Syphilis cases has primarily been in males. This trend is similar to California, where outbreaks of Syphilis have occurred among MSM³³. All cases reported in Sonoma County since 2003 were in males and, in 2005, the majority of cases have been aged 35-44.

Substance Use

Using alcohol or other drugs during sex may affect a person's ability to make decisions about condom use, when to have sex, or whether to use clean needles. Data from national surveys estimate that 7.9% of persons older than 12 years report use of any illicit drug in the past month³⁴. In Sonoma County, this translates to over 32,000 persons in 2004. An even larger segment of the population, 9.4%, is estimated to either depend on or abuse illicit drugs or alcohol. (38,586 persons)³⁵. Among MSM tested in Sonoma County between January 2004 and December 2007, over two thirds (78%) reported using alcohol. Considerable numbers also reported the use of marijuana (34%), cocaine (13%), and amphetamine (21%).

³³ California Department of Health Services. *Sexually Transmitted Diseases in California 2003*. June 2005.

³⁴ Substance Abuse and Mental Health Services Administration. (2005). *Results from the 2004 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-28, DHHS Publication No. SMA 05-4062). Rockville, MD.

³⁵ Ibid.

Methamphetamine Use

The use of methamphetamines contributes to risky sexual behavior that facilitates the transmission of sexually transmitted diseases, including HIV. A recent study of non-IDU MSM in San Francisco found that nearly one quarter of those recently infected reported amphetamine use in the past twelve months³⁶. Overall, researchers estimated that the annual incidence of HIV infection among MSM who use amphetamines was three times higher than nonusers³⁷.

In addition to the affect methamphetamines have on behavior, there are numerous negative health consequences. For persons already infected with HIV, methamphetamine use may decrease the effectiveness of antiretroviral therapy³⁸ causing the individual's viral load to increase, which in turn causes both a worsening of disease and increased likelihood of transmission.

In California's publicly monitored drug-treatment programs, the percent of individual clients reporting a primary methamphetamine problem has increased from 26.5 in FY 2001-02 to 31.5 in FY 2003-04³⁹. Among Californians who enter public treatment, methamphetamine has recently surpassed heroin and alcohol as the most commonly reported primary drug of choice⁴⁰.

In Sonoma County, methamphetamine as a primary drug of choice is even more common, and overall treatment admissions for methamphetamine use have increased by 85% between 2000 and 2004⁴¹. In FY 2003-04, methamphetamine was listed as the primary drug of choice for 41% of persons entering publicly monitored treatment, an increase of 2% from FY 2001-02⁴². For persons between 18 and 30, this proportion is even greater, with 43% of men and 64% of women reporting methamphetamine as their primary drug of choice⁴³.

Poverty and Homelessness

Health and disease are not equally distributed in society. Low socioeconomic status is one of the most consistent determinants of poor health status. Impoverished communities experience higher morbidity and mortality rates for most major chronic diseases and infections, including HIV infection. Lack of access to health services, social and physical environments unsupportive of healthy behavior, injection drug use and other substance use, commercial sex work, multiple sex partners, sex with partners who are high-risk, low perception of risk, and the prioritization of immediate needs such as maintaining food, housing, and income over issues such as HIV, are

³⁶ Buchacz K et al. Amphetamine use is associated with increased HIV incidence among men who have sex with men in San Francisco. *AIDS* 2005;19:1423-4.

³⁷ Ibid.

³⁸ Ellis RJ, Chiders ME, Cherner M, Lazzaretto D, et al. Increase human immunodeficiency virus loads in active methamphetamine users are explained by reduced effectiveness of antiretroviral therapy. *Journal of Infectious Disease*. 2003; 188(12):1820.

³⁹ State of California, Department of Alcohol and Drug Programs, *Fact Sheet: Facts and Figures on Methamphetamine*. Sacramento, CA, August, 2005.

⁴⁰ Ibid.

⁴¹ Sonoma County Department of Health Services, *Sonoma County Methamphetamine Profile, Report to the Board of Supervisors*. July 2006.

⁴² Sonoma County Department of Health Services, AODS Division, Primary Drug of Choice, State and County Comparison, 2001/2002 to 2004/2005

⁴³ Ibid.

some factors associated with poverty that may contribute to increased HIV risk. These conditions provide a context for understanding why poor people are at increased risk for HIV infection, they should draw attention to the larger social and political responsibility of addressing the root causes of poverty.

Those who are homeless may face additional challenges. Many are vulnerable to abuse and crime, suffer from mental health conditions, and/or engage in high-risk behaviors in order to secure money, food, a place to stay or drugs. A recent point-in-time count of the county's homeless population found 2,232 homeless men, women and children on a given night in 2005⁴⁴. National estimates indicate that at least 1.5% of the total population experiences homelessness in any given year (~7,232 Sonoma County residents)⁴⁵.

Mental Health

Mental health stressors may be episodic or chronic conditions, including anxiety, depression, schizophrenia, and bipolar disorder. Stresses on mental health functioning influence thought and decision-making processes, can hinder physical functioning, and can increase risk for HIV infection.

Mental health issues must be addressed in the context of HIV prevention, and HIV prevention must be addressed in the context of providing comprehensive mental health services. Low-self esteem, anxiety, depression, sexual abuse, or post-traumatic stress disorder can impact an individual's ability to make decisions about high-risk sexual or drug use behaviors thereby increasing the chances of HIV transmission. Mental health issues affect people from all racial/ethnic backgrounds and socioeconomic status. However, people with few financial and social resources may experience more serious consequences from having a mental health issue, including homelessness and poverty.

BEHAVIORAL RISK GROUPS

The previous section of this plan presented epidemiological data, general information on HIV cofactors, and behavioral risk groups in order to begin to assess the scope of prevention need in Sonoma County. This section provides more detail on the behavioral and cofactor data for Sonoma county populations at risk for HIV and looks at barriers to early diagnosis of HIV and access to quality medical care, treatment, and ongoing prevention services. Finally, it presents the strategic recommendations resulting from the assessment process.

In characterizing persons most at risk for acquiring or transmitting HIV, the Prevention Planning Group (PPG) reviewed the available epidemiological data and identified the following seven behavioral risk groups (BRGs):

⁴⁴ Sonoma County Task Force on the Homeless. *Homeless in Sonoma County – The 2005 Point-in-Time Count*.

⁴⁵ Department of Housing and Urban Development

Behavioral Risk Groups:

1. HIV negative substance users including Intravenous drug users (IDUs), and men who have sex with men (MSM)
2. HIV positive individuals who use drugs and do not practice safe sex
3. HIV negative men who have sex with men and women, and men with multiple partners
4. HIV negative young MSM
5. HIV negative women at sexual risk with special focus on women of color
6. HIV negative non-gay identified men who have sex with men and women
7. HIV positive individuals who do not access HIV treatment and support services

Understanding the nature and level of HIV risk behavior in Sonoma County is important in assessing the need for HIV prevention and related services. This section summarizes the key HIV risk behaviors for each of the identified Behavioral Risk Groups (BRGs) in order to begin to assess the scope of HIV prevention needs and presents recommended strategic approaches for addressing these needs.

HIV negative substance users including intravenous drug users (IDUs), and men who have sex with men (MSM)

Historically, the concern about drug abuse and HIV has focused on injection drug use and needle sharing. However, we now understand that the abuse of alcohol and other drugs impacts risk more broadly because of the behaviors it engenders. Drug and alcohol intoxication affect judgment and can lead to risky sexual behaviors that put people in danger of contracting or transmitting HIV. In addition, substance abuse may facilitate the progression of HIV infections by further compromising the immune system. Reducing risk by addressing alcohol and other substance abuse is widely recognized as a best practice. In fact, the **National Institute of Drug Abuse has established that drug abuse treatment *is* HIV prevention.** This plan proposes that strategies that focus not only on the reduction of sexual risk behaviors, but also on the facilitation of mental health and substance abuse treatment when indicated:

- ❖ Internet-based outreach that offers safer sex information and other messages that encourage the use of harm reduction strategies on sites where men seek partners;
- ❖ Development of systems to refer substance users to substance abuse treatment programs and/or services, with follow-up and monitoring components to track participation/completion rates;
- ❖ Provide education, skills development, and support for injection drug users and/or substance users to plan for safer sex prior to drug use;

- ❖ Work through existing social networks and peer leaders to increase the use of syringe exchange services and other safe drug use practices by injection drug users;
- ❖ Provide support and education to increase readiness for individuals not ready to enter treatment;
- ❖ Provide health promotion programs for substance users to increase condom use with partners outside of their primary relationship; and/or
- ❖ Develop/improve systems to promote appropriate referral to mental health treatment, track clients' referral completion and support their ongoing participation in mental health services.

HIV positive individuals who use drugs and do not practice safe sex

Drug use can impair judgment, resulting in high risk behaviors such as needle sharing, unprotected sex, failure to disclose HIV status, and/or sex with multiple or anonymous partners. The use of methamphetamine as a sexual enhancement compounds risk. Research suggests that the risk of becoming infected with HIV doubles or triples for MSM who use amphetamines compared to MSM who do not use. With the potential for higher-risk sexual behavior when using methamphetamine, the opportunity for HIV transmission increases.

Several studies of MSM indicate that those who use methamphetamine are 2-3 times more likely than non-users to engage in unprotected anal sex, have condoms break or slip off, acquire a sexually transmitted disease, or become infected with HIV⁴⁶. And these risks are not confined to regular users but are shared by those who report occasional use as well⁴⁷. And, even when accounting for specific risky sexual behavior like unprotected anal sex with HIV+ partners, HIV- men using stimulants were twice as likely to become infected as non-users,⁴⁸.

The link between methamphetamine use and increased HIV/STD risk is not specific to MSM. Studies also show high levels of HIV risk behavior among heterosexuals. In one study, 86% of users reported engaging in "marathon sex" while high on meth. More than a third reported injecting, and of those, 47% had shared and/or borrowed needles⁴⁹.

For those who are HIV+ the negative consequences of methamphetamine use can be considerable. Drug therapies may increase the potential for adverse reactions or overdose. Methamphetamine may also interfere with a person's ability to stick to

⁴⁶ CDC. Methamphetamine use and HIV risk behaviors among heterosexual men—preliminary results from five Northern California counties. *Morbidity and Mortality Weekly Report*. 2006;55:273-277.

⁴⁷ Colfax G, Vittinghoff E, Husnik MJ, et al. Substance use and sexual risk: a participant- and episode level analysis among a cohort of men who have sex with men. *American Journal of Epidemiology*. 2004;159:1002-1012.

⁴⁸ Koblin BA, Husnik MJ, Colfax G, et al. Risk factors for HIV infection among men who have sex with men. *AIDS*. 2006;20:731-739.

⁴⁹ Semple SJ, Patterson TL, Grant I. The context of sexual risk behavior among heterosexual methamphetamine users. *Addictive Behavior*. 2004;29:807-810.

their medical regimes (taking their medications), and may impact overall health by increasing dehydration, sleeplessness and weight loss⁵⁰.

Again, it is imperative that substance abuse treatment is recognized as an HIV risk reduction strategy and that prevention activities for this behavioral risk group include:

- ❖ Targeted prevention to provide appropriate referrals and support for participation in substance treatment programs/services including those addressing the unique issues related to use of methamphetamine;
- ❖ Support the use of condoms with secondary partners to reduce risk of all STDs;
- ❖ Provide safer sex information and interventions that encourage the use of harm reduction strategies on websites where men seek partners;
- ❖ Referral to substance abuse treatment programs and/or services - with follow-up and monitoring components to track participation/completion rates;
- ❖ Increasing the use of harm reduction strategies among IDUs and other substance users such as: planning for safer sex prior to using alcohol and other drugs, and use of condoms with all partners outside of primary relationship, etc.
- ❖ Work to increase the use of syringe exchange services and other safe drug use practices by injection drug users;
- ❖ Promote utilization of drug treatment services by providing information, education, and ongoing support to substance users who are not taking advantage of existing programs/services.

HIV negative men who have sex with men and women, and men with multiple partners

Individuals who engage in sex with multiple partners, regardless of gender and/or sexual orientation are at increased risk for HIV and other STDs, and are more likely to infect others. Men who have sex with both men and women but do not identify as gay or bisexual will not likely be reached through strategies designed to target the broader MSM community. Stigma, fear, denial and homophobia often prevent disclosure and reduce the chances that these individuals will initiate risk reduction behaviors with any of their sex partners (primary or otherwise). Individuals who are unaware of their own HIV status or their risk for infection are less likely to access information and/or prevention services (such as testing).

Many California counties, including Sonoma, have a large number of undocumented residents who frequently travel back and forth across the Mexican/U.S. border. Migrant populations, including day laborers and agricultural workers may experience HIV risk as a result of being without their spouse for long periods of time, increasing the possibility that they will have unprotected sex with female sex workers or engage in survival sex with both men and women. Female partners are then at increased

⁵⁰ New York State Department of Health AIDS Institute. Methamphetamine and HIV: basic facts for service providers. March 2006. www.nyhealth.gov/diseases/aids/harm_reduction/crystalmeth/

risk as well. Condom use will not be initiated, as this would be seen as inferring infidelity.

Prevention efforts that focus on increasing the awareness of the need to protect against STDs including HIV will make prevention messages and strategies more palatable in among those for whom stigma and lack of knowledge may persist. Efforts to encourage the use of risk reduction strategies to promote overall sexual health and wellbeing will be a focus of interventions targeting these harder to reach individuals. Prevention strategies will promote personal risk assessment, routine STD/HIV testing, and condom use as risk reduction strategies. Interventions will also strive to be culturally relevant and appropriate. In some cultures it is less likely that multiple partners and/or HIV infection will be disclosed. Teaching harm reduction skills in a culturally appropriate manner is crucial and strategies will include:

- ❖ Health promotion programs to promote condom use with partners outside of the primary relationship;
- ❖ Facilitation of the development of systems, policies, and protocols among health care providers that promote the integration of HIV risk reduction and safer sex information as a part of routine STD examination/counseling;
- ❖ Building provider (inc. medical providers) capacity to deliver culturally appropriate harm reduction info and education to Latino clients; and/or,
- ❖ Education and support to make culturally appropriate HIV education and information on prevention/harm reduction strategies more widely available & easily accessible to Latinos.

HIV negative young MSM to support safer sex behaviors and provide risk reduction tools and information.

High rates of sexual activity, initiation of sex at an early age, multiple sexual partners, and low condom use rates put young MSM at increased risk for HIV. The start-up or increase in use of “party drugs” (such as methamphetamine) increased risk.

Further, evidence suggests that the young MSM perceive the consequences of HIV infection and/or the impact of HIV/AIDS on overall wellbeing to be less significant than older MSM who lived through the early phases of the epidemic. The advent of HAART (Highly Active Antiretroviral Therapy) has perpetuated the belief that HIV can be easily treated and does not pose a considerable health threat. Successful interventions/strategies must target relevant behaviors and take advantage of the popular tech culture to provide risk reduction interventions including:

- ❖ Internet based health promotion programs to support safer sex and provide tools for behavior change to young MSM to practice safer sex.

HIV negative women at sexual risk especially with a special focus on monolingual/bi-lingual Spanish speakers

Women who are unaware of either their partners HIV status or their partner's high-risk behaviors, including multiple sex partners and/or drug use, are at increased risk for infection because they are less likely to employ risk reduction strategies. Women are less likely to introduce risk reduction strategies into a relationship that is presumed to be monogamous.

Women who have recently immigrated to the area present a number of unique risks. The newly emigrated often experience economic instability, lack access to health care and social services, lack information, are isolated, and do not speak the language. Any one of these conditions could serve as a barrier to services but when combined with a lack of access to linguistically and culturally appropriate HIV information and prevention messages they constitute a particularly vulnerable segment of our immigrant population. In addition, many undocumented immigrants fear deportation and may therefore delay treatment or fail to access health care until they are very ill.

Sonoma County epidemiology data indicates an increase in the incidence of HIV among women who have no identified risk – particularly Latinas. Strategies that provide culturally appropriate HIV messages within the context of a broader health promotion message have been shown to be effective at addressing the disparities in access to HIV prevention information and primary health care. Best practices include:

- ❖ Internet based health promotion programs to support safer sex and provide tools for behavior change to young MSM to practice safer sex;
- ❖ Collaboration with STD clinics to implement protocols that include HIV test and information for those at risk for STDs; and/or
- ❖ Health promotion programs that include HIV education with HPV vaccine information;
- ❖ Outreach to women to increase awareness of risk and harm reduction strategies including:
- ❖ Potential for unknown partner status (partners not tested and therefore do not know status, past/current multiple partners, etc.); and,
- ❖ Harm reduction strategies (such as oral sex as safer if condom use with partners is non-negotiable, risk assessment, negotiation skills, etc.).

HIV negative non-gay identified men who have sex with men and women

Men who have sex with men and women but do not identify as gay/bisexual are less likely to access information and resources targeted at the mainstream MSM community. Messages aimed at reducing risk among male sex partners are less effective at successfully reaching/impacting this segment of the MSM population. For MSM who do not gay identify, sex with men tends to be opportunistic and therefore hinders advance planning for risk reduction – such as carrying condoms. Further risk is presented to the female sex partners of MSM who are not gay/bisexual. Women are often not aware of their partners increased risk for HIV infection. Men

are not likely to disclose and female partners are not likely to inquire about risk. Female sex partners do not perceive risk and therefore do not take action to reduce their own risk. Prevention efforts should focus on changing attitudes and awareness about reducing risk of all sexually transmitted disease infections (including HIV) among all who have/or have had multiple sex partners. Proven strategies include:

- ❖ Work with health care provider agencies/organizations to develop and implement protocols that integrate HIV harm reduction information in routine STD education and testing;
- ❖ Support for using condoms for sex with other partners outside primary relationship and safer sex from all STDs.

HIV positive individuals who do not access HIV treatment and support services

HIV positive individuals who are not aware of their HIV status delay their access to services and treatment increasing the risk of their condition advancing to AIDS. There is great value to the individual and the service system in identifying infection early. In addition, there are those who are aware of their status and for a number of reasons do not take advantage of available services. Barriers may include: lack of awareness of services; lack of insurance coverage; transportation issues; language barriers; mental health issues; inability to navigate service systems; and/or competing health and social needs. Best practices include:

- ❖ Outreach and education to target audience via support groups;
- ❖ Development of community leaders/advocates that are able to outreach to HIV positive individuals with prevention messages; and/or
- ❖ Mentoring programs to promote information exchange and increase awareness and utilization of available HIV treatment and support services.

3. COMMUNITY RESOURCE ASSESSMENT

Identification of unmet need or priority focus began with an assessment of existing resources and services. A broad spectrum of HIV/AIDS prevention and care services are available in Sonoma County. These services combine to increase community awareness of the risks associated with transmission of HIV; build knowledge and skill with regard to risk reduction strategies; provide professional education and training; strengthen support networks; improve knowledge of HIV status through testing and prevention counseling; and, facilitate connection to primary care and services for those with HIV/AIDS and their partners.

Local HIV prevention programs are funded through the State of California Office of AIDS, County general funds, various Titles of the Ryan White CARE Act, private and corporate foundations and private contributions. However, HIV prevention activities also occur as part of many other programs. For example, HIV prevention activities may be included in substance use counseling, communicable disease prevention, the criminal justice system, medical care, and population-specific community health promotion efforts. It is also important to acknowledge the significant numbers of volunteers that contribute to addressing HIV and AIDS in Sonoma County. Without the support of these dedicated professionals, consumers, and residents the services described in the next section along with numerous events and local initiatives would not be possible.

CURRENT COMMUNITY RESOURCES TO ADDRESS NEEDS

HIV PREVENTION & EDUCATION SERVICES

The Department of Health Services administers HIV prevention funds through a network of community-based agencies to reach the following behavioral risk groups: Gay/Bisexual men (including young men and substance users); Men who have sex with men and women who don't identify as Gay/Bisexual; Injection drug users (including Gay/Bisexual men, incarcerated individuals, and sex industry workers); HIV positive individuals (including Gay/Bisexual men, injection drug users and heterosexuals); and, Latinos/Latinas (including women who are unaware of their risk).

Funded strategies include: community mobilization, social marketing, targeted prevention activities, peer education (Promotores), enhanced outreach and group education. In calendar year 2006, 5,890 contacts with clients were provided to people at risk for HIV in Sonoma County.

HIV TESTING AND COUNSELING PROGRAMS

The Sonoma County Department of Health Services offers anonymous and confidential HIV Antibody Testing at various locations in the county, and works to enhance coordination of HIV testing and outreach with other community partners.

NIGHT – The State Office of AIDS funds Neighborhood Interventions Geared to High-Risk Testing, (NIGHT) which is a county-wide mobile testing program designed to reach high-risk individuals by bringing the services into clients' neighborhoods and other areas where clients typically congregate. Target populations include men who have sex with women (MSW), IDUs and substance users (SUs) and their partners. Special efforts are also made to identify at risk Latinos, African Americans, and women of childbearing age from the above risk groups. The interventions include risk screening, risk reduction counseling, HIV education, condom distribution, sexual responsibility kits and education materials.

Partner Counseling and Referral Services (PCRS) – PCRS is an array of confidential services available to HIV positive persons and their sex and/or needle-sharing partners. For the HIV positive individual client this (voluntary) service is professional assistance with the notification of HIV exposure to all relevant partners and a personalized risk reduction plan that include behavioral strategies and biological motivators to minimize the likelihood of further exposure of or transmission to uninfected partners. For the partners, these services include information on HIV infection and risk reduction techniques, (voluntary) HIV counseling and testing and referrals to other important services such as support groups, domestic violence resources, legal assistance and other services.

HIV Testing in the Criminal Justice System – The County provides HIV testing at both the Main and North County Detention facilities.

Routine Testing in Public Health Clinics – All County funded primary care clinics have implemented a policy of offering HIV/STD testing as a routine part of ongoing primary care services.

HEALTH EDUCATION AND PROMOTION

❖ **Promotores de Salud** – St. Joseph's Health System operates a program of community-based lay health & wellness promoters/educators) who serve as a cultural bridge and a vital link in working with Hispanic/Latino families at a grassroots level, providing linkages and social supports in the community to develop preventive strategies to address health issues. With training and resources, members of the community very successfully link themselves, and their community, with available health care services and educate others about health issues and healthy community/quality of life issues.

❖

- ❖ **DAAC School-Based Substance Abuse Programs** – In conjunction with the Sonoma County Office of Education and the Santa Rosa City Schools, the Drug Abuse Alternatives Center (DAAC) offers programs and services for adolescents with alcohol and other drug problems. Services include outreach, education and prevention efforts, assessment, individual, family and group counseling and health services, including HIV and Hepatitis C education, testing, and counseling. DAAC has been providing alcohol and other drug abuse services since 1969, HIV services since 1986 and HCV (Hepatitis C Virus) services since 1999.
- ❖ **Sunburst Projects** – Sunburst Projects helps primarily low-income HIV/AIDS affected family members and children from minority populations. Sunburst provides ongoing family support services that help educate, strengthen, and empower families with children impacted by HIV/AIDS, including: Camp Sunburst, respite childcare services, mental health services, support groups, family-centered case management, and HIV/AIDS prevention and education.

SYRINGE EXCHANGE/HARM REDUCTION PROGRAMS

- ❖ **Pharmacy-Based Syringe Sales** – In September 2004, Governor Schwarzenegger signed Senate Bill (SB) 1159, allowing individuals in California to purchase up to 10 hypodermic needles and syringes without a prescription from pharmacists who have registered with the local health department. The intent of this public health initiative is to reduce the spread of blood borne pathogens and infectious diseases such as HIV and Hepatitis C through contaminated needles. On September 27, 2005, the Sonoma County Board of Supervisors authorized the Department of Health Services to implement a local Disease Prevention Demonstration Project, allowing pharmacies to furnish or sell hypodermic needles and syringes without a prescription as permitted under State law (SB1159). As of January 1, 2006, the following pharmacies are currently registered to sell needles in Sonoma County: Dollar Drug and Lark Drugs.
- ❖ **DAAC Needle Exchange Program** – Also known as the Sonoma County Hepatitis/HIV/AIDS Risk Reduction Project (S.H.A.R.P.), the program supplies a clean syringe for each retrieved used one. Services are offered free and on an anonymous basis. Other services include education, risk reduction materials, HIV and HCV testing.
- ❖ **Perinatal HIV Transmission Prevention** -- In October 2003, Governor Gray Davis signed Assembly Bill 1676 into law. This required medical care providers to screen every pregnant woman in California for HIV as part of the standard prenatal test panel. Additionally, providers are required to explain the purpose of the HIV test and to ensure the right of the woman to refuse the test. Nationally, the 2006 revised CDC guidelines for HIV testing recommends HIV screening as

part of the normal panel of prenatal tests, with repeat screening in the third trimester in areas with elevated rates of HIV infection.

SERVICES FOR PERSONS LIVING WITH HIV/AIDS (PLWHA)

- ❖ **Kaiser Permanente** – A national health maintenance organization (HMO) with a regional hospital and clinical services based in Santa Rosa. The program offers coordinated HIV primary medical care services, including nutritional and pharmaceutical counseling and HIV support groups. Serves Kaiser Health Plan members.
- ❖ **The Center for HIV Prevention & Care** – Since 1987, the Center for HIV Prevention and Care has provided comprehensive primary care to persons living with HIV disease, including: outreach, HIV screening, risk education and prevention counseling, anonymous and confidential HIV counseling and testing, comprehensive primary care services, treatment adherence counseling, access to clinical drug trials, nutritional counseling, mental health care, referral services, and case management. (*Ryan White CARE Act Titles I and II-Funded HIV Primary Care Services*)
- ❖ **West County Health Centers** – The West County Health Centers (consisting of the Russian River and Occidental Area Health Centers) provides comprehensive, quality and accessible health care services to the communities of Western Sonoma County. Services include HIV primary care, HIV self-management programs, mental health support groups and dental care. (*Ryan White CARE Act Titles I and II-Funded HIV Primary Care Services*)
- ❖ The Part C Early Intervention Services (EIS) Program funds comprehensive **Primary Health Care** for recently diagnosed individuals living with HIV disease. Part C services include, among others, risk-reduction counseling on prevention, antibody testing, medical evaluation, and clinical care, as well as case management to ensure access to services and continuity of care for HIV-infected clients. HRSA, which is responsible for administering funding through the Ryan White CARE Act, currently funds 2 Part C EIS programs in Sonoma County. (*Ryan White CARE Act Part C-Funded HIV Early Intervention Services*)
 - West County Health Centers
 - The Center for HIV Prevention & Care
- ❖ The **Circles of Support Network** is a collaboration of AIDS and healthcare service providers that serve HIV positive women, children, youth, and affected family members. Program services provided include: outreach, case finding, primary and HIV specialty medical care, case management and care coordination, mental health, nutritional counseling, psychosocial support services, respite childcare, health education and access to research, primary prevention, oral health, transportation, emergency financial assistance, housing

search assistance, benefits counseling, and translation. The Center for HIV Prevention & Care serves as both a service provider and as the fiscal agent for the program. (*Ryan White CARE Act Part D-Funded Services to HIV+ Women, Children and Families*)

- ❖ **Bridge Program** – The Bridge Program seeks to prevent further transmission of HIV within communities of color by linking and successfully engaging HIV-infected individuals in comprehensive HIV care, treatment and prevention services. Bridge Project clients are located via street outreach, emergency and urgent care facilities, referrals from HIV counseling and testing sites, referrals from EIP (Early Intervention Program) staff, and referrals from private physicians and/or service providers in community-based organizations. The Bridge Project is funded through a combination of state General Funds and California’s High Risk Initiative funds. (*Special State and Nationally Funded Projects*)
- ❖ **OPTIONS** – Clinical providers at the Center for HIV Prevention & Care address safer behavior with HIV positive patients through the OPTIONS Project, funded through the Ryan White CARE Act Special Projects of National Significance (SPNS). The program is a clinician-initiated HIV risk reduction intervention designed to address risky sexual and drug use behaviors among HIV positive patients. (*Special State and Nationally Funded Projects*)
- ❖ **Learning Immune Function Enhancement (L.I.F.E.)** – The L.I.F.E. program is a series of meetings designed to increase self-knowledge about HIV disease and the immune system, improve skills for staying healthy, and impart a sense of purpose and control over life. Participants explore the psychosocial cofactors that are known to influence risk behaviour, immune function, and adherence to health routines. The program is provided through the Center for HIV Prevention & Care. And led by facilitators trained through the Shanti L.I.F.E. Program of San Francisco.
- ❖ **“Positive Connections”** – This is an ongoing, semi-monthly social & educational forum for those living with HIV in Sonoma County. Supported through the Center for HIV Prevention & Care, the group is open to anyone with HIV, and may be attended on a drop-in basis. The focus is on discussing life issues to empower participants with skills and tools to re-imagine their futures, nurture self-esteem, promote greater independence, and realize personal satisfaction.
- ❖ **Project Reconnect**– Developed by the Sonoma County Commission on AIDS, the Task Force works to support people with HIV to re-imagine their futures. The Task Force seeks to address social, emotional, educational and vocational needs and to equip individuals to make positive steps to explore new possibilities, which lead to satisfying, meaningful and healthy lives.

- ❖ **AIDS Leadership Academy** – Launched in 2003, this leadership training program for persons with HIV disease provides instruction in advocacy, public policy making and prepares participants to serve on non-profit boards of directors, commissions, and planning bodies as well as apply for employment in service agencies. The program is co-sponsored by: Face to Face, Food for Thought, the Commission on AIDS, the Center for HIV Prevention and Care, and the Volunteer Center. Over the training period, each participant also works with a cohort to complete a project impacting people with AIDS with the assistance of a mentor.

- ❖ **Peer Coaches Program**– This program assists HIV+ clients in making major life decisions and changes with the help of volunteer Coaches trained by Face to Face. Coaches meet with their assigned client on a weekly or bi-weekly basis for three to six months to discuss potential opportunities, set meaningful goals, and devise a strategy to meet them. Peer Coaches encourage and support clients to make positive changes that will enable them to fully participate in their own life decisions in a productive and fulfilling way.

- ❖ **Support Groups for HIV+ Persons** -- The following agencies provide professional and peer-led support groups throughout the year:
 - The Center for HIV Prevention and Care
 - Face to Face: provided compassionate care to people living with HIV/AIDS and their loved ones, and prevention education to the entire community
 - Lomi Community Clinic: offers affordable counseling services to individual adults, adolescents and children, couples, families, and groups
 - Food for Thought (HIV and nutrition classes): provides comprehensive nutrition to people in Sonoma County living with, or affected by, HIV and AIDS.
 - Russian River Health Center
 - Sunburst Projects
 - Kaiser Permanente

- ❖ **HIV Specialty Care** – The Center for HIV Prevention & Care provides HIV specialty care (not general medical care) to County Jail inmates.
 - **La Vida:** Shanti's L.I.F.E. program is based on research that shows that cofactors (such as risky behavior, grief, or attitude) can affect one's physical health and thus works to develop a relationship between the mind and body for improved health.
 - **West County Health Clinic Methamphetamine Program** : The Health Clinic provided both individual and group relapse prevention counseling to MSMs in Sonoma County.

- **Next Step:** Next Step is a substance abuse support group that will focus on sharing ideas, addressing social behaviors that increase risk, and exploring options that can lead to making healthier choices.
- ❖ **Bridge Program** – The Bridge Program provides links to a variety of support services for HIV+ persons in the County Correctional system. A key focus is HIV+ persons who are not consistently in care.
- ❖ **DAAC** – DAAC provides substance abuse and other support services to HIV+ persons in the County Correctional system.

CRIMINAL JUSTICE SERVICES NOT SPECIFIC TO HIV PREVENTION, TESTING, OR TREATMENT

- ❖ **DAAC Drug Court Program** – Drug Court is a collaborative effort of the Sonoma County Health Department, Sonoma County Courts and DAAC. The program serves clients charged with non-violent misdemeanors or felonies related to drug abuse, and includes intensive counseling, drug testing, participation in self-help programs, daily monitoring and regular appearances before the Drug Court judge.
- ❖ **DAAC Juvenile Probation Program** – The Juvenile Probation Program is a collaborative effort of the Sonoma County Health Department, the Sonoma County Probation Department, Sonoma County Courts and DAAC. The program serves juveniles charged with non-violent misdemeanors or felonies related to drug abuse, and includes intensive counseling, drug testing, participation in self-help programs and regular case coordination with the referring probation officer.

4. OVERVIEW OF HIV PREVENTION PLANNING

A NEW ERA OF HIV PREVENTION PLANNING IN THE UNITED STATES

CDC's HIV Prevention Community Planning Guidance

The CDC's updated community planning guidance, disseminated in July 2003, outlines three major goals for HIV community planning with eight implementation objectives. The three goals advanced in the CDC's community planning guidance are:

- ❖ Community planning supports broad-based community participation in HIV prevention planning.
- ❖ Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.
- ❖ Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

While the guidance directs local jurisdictions to be aligned with national HIV prevention goals, it stresses that the local epidemic and needs of the jurisdiction must be a priority for each local planning group. Two major components from the CDC's HIV prevention strategic plan are highlighted⁵¹: (1) targeting populations for which HIV prevention activities will have the greatest impact; and, (2) reducing HIV transmission in populations with highest incidence.

CDC's Advancing HIV Prevention: New Strategies for a Changing Epidemic

The CDC's *Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic*⁵² represents a significant refocus of HIV prevention priorities for the CDC. Through *AHP*, CDC is putting more emphasis on counseling, testing, and referral for persons who are unaware of their HIV infection; partner notification, including partner counseling and referral services; and prevention services for persons living with HIV to help prevent further transmission once they are diagnosed with HIV. In addition, since perinatal HIV transmission can be prevented, CDC is strengthening efforts to promote routine, universal HIV screening as a part of prenatal care. CDC proposes accomplishing all of this through four strategies: (1) HIV screening as a routine part of medical care; (2) creating new models for diagnosing HIV infection, including the use of rapid testing; (3) improving and expanding prevention services for persons living with HIV/AIDS (PLWHA); and, (4) further decreasing perinatal HIV transmission. Because of its potential to substantially reduce HIV incidence, *AHP*

⁵¹ Centers for Disease Control and Prevention HIV Prevention Strategic Plan Through 2005. Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Atlanta, GA: January 2001.

⁵² *Advancing HIV Prevention: New Strategies for a Changing Epidemic – United States*, MMWR 2003; 52(15): 329-332.

suggests that HIV-infected persons should be the highest priority population for appropriate prevention services. CDC suggests that uninfected, high-risk populations, such as sex or needle-using partners of PLWHA, should be prioritized based on local epidemiology and community needs.

California Office of AIDS

In January 2006, the California Department of Public Health Office of AIDS HIV Education and Prevention Branch disseminated its revised Education and Prevention 2007-2010 Program Guidance to assist local health jurisdictions identify high-risk populations, develop comprehensive HIV prevention programs and strategies, and develop effective work plans.

The guidance identifies requirements for comprehensive HIV prevention programs, and specifies the following interventions as allowed:

- ❖ Targeted prevention activities for high-risk HIV-negative and HIV-positive persons (**TPA**);
- ❖ Individual level interventions (**ILI**);
- ❖ Group level interventions (**GLI**);
- ❖ Comprehensive Risk Counseling and Services (**CRCS**) for individuals with multiple health needs;
- ❖ Partner Counseling and Referral Services to inform people of their potential exposure to HIV (**PCRS**);
- ❖ Health Communication/Public Information programs for at-risk BRGs (**HCPI**), and
- ❖ Neighborhood Intervention **Geared toward High-risk Testing (NIGHT)**.

The California Office of AIDS revised *Education and Prevention 2007-2010 Program Guidance* served to assist our local Prevention Planning Group (PPG) in the identification of high-risk populations; the development of comprehensive HIV prevention programs and HIV prevention strategies; understanding interventions and how they relate to prevention strategies; and in developing effective work plans to implement selected interventions.

HISTORY OF HIV PREVENTION PLANNING IN SONOMA COUNTY

In December 1993, the National Centers for Disease Control and Prevention (CDC) issued guidance on HIV Prevention Community Planning to all of the states/territories that receive federal HIV prevention funding. The guidance outlines a process in which the local health department, representatives of the communities for whom the services are intended and epidemiologists and behavioral specialists share the responsibility in identifying high priority prevention needs. The information serves as the basis for HIV prevention allocation decisions consequently made by the local jurisdictions. Community planning was established as:

- ❖ A way to improve HIV prevention programs and prevent new infections by improving decisions about target populations, prevention strategies and resource allocation,

- ❖ A way to expand who is involved in making decisions to a diverse group of people and perspectives,
- ❖ A way to bring decisions “closer to home” from the national level to the state and local levels, and make them more relevant, and
- ❖ As a way to improve the information used to make decisions and make it both evidence-based and values-based.⁵³

Sonoma County’s first *Three-Year Prevention Plan* was completed in December 1995, coinciding with the provision of State Office of AIDS (SOA) HIV prevention funds directly to county health departments. Sonoma County’s Department of Health Services (DHS) is responsible for the development and implementation of the plan. The Sonoma County HIV Prevention Planning Group (PPG) is convened by the Department of Health Services and, utilizing SOA guidelines, acts as an ongoing planning and advisory body to the Department. The Sonoma County Commission on AIDS (COA) allocates Ryan White treatment and care funds and encompasses a broad scope in the context of the HIV/AIDS epidemic. In order to avoid redundancy and to strengthen the efforts of both bodies, the PPG also serves as the Commission's Prevention Subcommittee.

The Department of Health Services utilizes the HIV Prevention Plan in developing the County’s Request for Proposals (RFP) process, which in turn allocates funding for direct prevention services to community-based organizations, health care providers, population-specific agencies and divisions within the Health Department. The Prevention Planning Group and the Department regularly monitor and assess HIV/AIDS data, prevention programming, evaluation and community resources, as well as other aspects of HIV prevention. In 2001, the PPG issued a new *Sonoma County Multi-Year Plan for HIV Prevention*. The plan was updated again in 2003 and 2004.

SONOMA COUNTY HIV PREVENTION PLANNING: 2008 – 2011

In the summer of 2006, PPG embarked on a new two-year community planning process. The primary task of the PPG was to develop a comprehensive HIV prevention plan that includes prioritized target populations and a set of prevention activities/interventions for each target population. Target populations were prioritized and prevention activities chosen based on their ability to prevent as many new infections as possible. Key information needed to develop this plan was identified in an epidemiologic profile and the community services assessment. After reviewing this information, the PPG moved to the task of setting priorities for target populations and determining which interventions best meet the needs of the prioritized target populations.

Each of the steps of this planning process is detailed in the sections below

⁵³ Presentation “*HIV Prevention Community Planning: A National and State Perspective*,” Patricia Franks, Senior Research Association, Institute for Health Policy Studies, University of California San Francisco, February, 1998.

5. SONOMA COUNTY STRATEGIC DIRECTIONS

Using the county's epidemiology report as well as the community resource assessment, the planning group developed a series of directions to help produce the HIV prevention goals for Sonoma County. These directions provided a framework for the predominant issues surrounding HIV/AIDS in the county, and are detailed below in order to provide a more thorough explanation of the Prevention Planning Group's goal setting process.

Focus prevention more broadly

Health and disease are not equally distributed in society, and public health studies have documented a greater burden of morbidity and mortality among low-income communities across a wide range of health issues. Homelessness, incarceration, sex work, and a multitude of other issues that affect HIV risk have their roots in poverty. Though middle and upper income individuals are also at risk for HIV and experience many of the same cofactors as people living in poverty, including substance use and mental health issues, the elimination of poverty would go a long way toward stopping the HIV epidemic, both locally and nationally.

HIV prevention programs should have the capacity to address the needs of low-income individuals as the need arises. In essence, immediate survival needs must be addressed first in order for HIV prevention to be effective. This means linking individuals to services that can assist with housing, money, food, and clothing, as well as health care services and addressing the root causes of poverty through advocacy and policy change.

Discuss "integration" as a strategic direction

Integration is an overarching principle that will drive programming and ongoing strategic planning for Sonoma County. Looking at HIV prevention as a part of overall health promotion represents only a slight shift in philosophy but a huge adjustment in practice.

Integrating HIV and STD services, integrating HIV/STD testing into primary care; integrating HIV services and support into mainstream care settings, re-integrating persons with living with HIV into community life.

Addressing Cofactors

Recognizing that we will not be successful at reducing infection rates among a large segment of our at-risk communities until we are able to address the cofactors of mental health and substance abuse. To do so means a commitment to coordination, collaboration, support for and promotion of treatment services.

Prevention with Positives

HIV-positive individuals have been and continue to be a high priority in every BRG, in addition to high-risk HIV-negative individuals and those who do not know their

serostatus. In order to bring about a reduction in new infections, it is of primary importance that programs reach HIV-positive individuals. HIV prevention is not just for HIV-negative people. Further, interventions for HIV-positive people (both those who know their status and those high-risk individuals who are unaware that they are positive) should be designed to meet their specific needs.

Social Determinants of Health

Finally, it should be noted that although there are a number of cofactors presented here, many of them have their roots in one issue – poverty and income disparities. Health and disease are not equally distributed in society, and public health studies have documented a greater burden of morbidity and mortality among low-income communities across a wide range of health issues. Homelessness, incarceration, sex work, and a multitude of other issues that affect HIV risk have their roots in poverty. Though middle and upper income individuals are also at risk for HIV and experience many of the same cofactors as people living in poverty - including substance use and mental health issues - the elimination of poverty would go a long way toward stopping the HIV epidemic, both locally and nationally.

Sonoma County HIV prevention programs should have the capacity to address the needs of low-income individuals. Meeting the immediate survival needs means linking individuals to services that can assist with housing, money, food, and clothing, as well as health care services and addressing the root causes of poverty through advocacy and policy change.

In order to target populations for which HIV prevention activities will have the greatest impact and to reduce HIV transmission in populations with highest incidence, the PPG utilized CDC and Office of AIDS guidance to identify the following HIV prevention goals for Sonoma County:

HIV Prevention Goals for Sonoma County

- Improve awareness of HIV status through increased knowledge of risk and the promotion of routine testing;
- Improve and expand prevention services for persons living with HIV/AIDS (PLWHA) and their partners;
- Reduce barriers to early diagnosis of HIV infection among persons with co-occurring conditions of mental illness and alcohol and/or other drug addiction
- Eliminate racial and economic disparities in the delivery of HIV related prevention and support services; and,
- Ensure that those who test positive for HIV/AIDS are linked to primary care and HIV/AIDS treatment and prevention services as early as possible

6. PRIORITY SETTING

The priority setting process was guided by the State Office of AIDS and the Centers for Disease Control and Prevention (CDC) HIV Community Planning recommendations. This process, described by its components below, resulted in the identification of the three goals for the behavioral risk groups.

Description of Our Prioritization Model

The Prevention Planning Group and its subcommittee, the HIV Prevention Plan Working Group, undertook a 10-month process to develop the strategic priorities, completing the process in June 2007.

Steps in the Planning Process

An outline of key activities in the planning process is presented below:

A. Developing the epidemiological profile

This phase began in September 2006 and included review of the following data sets: information from HIV/AIDS confidential case reports, counseling and testing data, risk surveillance surveys, and other sources. Planning group members reviewed four years' of prior local data and statewide epidemiology.

B. Assessing prevention needs for behavioral risk groups

HPPWG (HIV Prevention Planning Working Group) developed a needs assessment that included the epidemiology-profile, risk surveys, focus group findings, and data on cofactors. This needs assessment identified the risk cofactors associated with each behavioral risk group. The assessment identified both existing services and an analysis of the influence of needs and capacity on the prioritization of intervention selection. Problem statements were developed based on the needs and gaps identified for each behavioral risk group.

C. Identifying priority populations

In this phase the planning team defined the behavioral risk groups (MSM, MSM/W, MSMP, WSR, IDU), reviewed demographic information (HIV status, ethnicity, gender, age, etc.), and identified behavioral and attitudinal cofactors for HIV risk. Working groups comprised of members of the HPPWG and additional experts in the field. The small groups identified interventions for each problem that the larger HPPWG had listed by behavioral risk group.

D. Developing specific prevention objectives for behavioral risk groups

The planning team reviewed effective behavioral interventions. These interventions were organized using the CDC's Advancing HIV Prevention goals. The CDC goals were compared to the needs of local behavioral risk groups. The team expanded

the CDC goals and developed three Sonoma County goals that included a more broad definition of each goal. These broadened local goals are listed below.

CDC Goal	Sonoma County Goal
Make HIV testing a routine part of medical care	Reduce barriers to early diagnosis of HIV with special emphasis on: barriers of high risk populations and benefits of knowing status
Implement new models for diagnosing HIV infections outside medical settings	Improve and expand prevention services for high-risk individuals including harm reduction interventions for high-risk HIV-negative individuals
Prevent new infections by working with persons diagnosed with HIV and their partners	Improve and expand prevention services for persons living with HIV/AIDS including all prevention with positive activities and increasing the number of individuals who are in care

D. Logic model development for each goal and each behavioral risk group

Small groups identified problem statements for each behavioral risk group; conceived intervention strategies for each problem statement; and, identified objectives. With the assistance of an evaluation consultant, the small groups also identified short-, intermediate-, and long-term outcomes for each intervention. The group combined interventions where behavioral risk groups were subsets of another risk group.

E. Developing evaluation metrics for interventions

Having identified desired outcomes, the small groups selected key outcome indicators based on goals and objectives, and developed evaluation measures for each outcome. This task was accomplished with an evaluation consultant to ensure that all interventions had outcomes that were measurable and were in compliance with the California Office of AIDS Guidance for 2007-2011.

F. Prioritization ranking process

Behavioral risk groups and interventions were ranked in the epidemiological subjective scoring system below.

- a. **Incidence** - the number of AIDS cases diagnosed in a population in a period of time
- b. **Prevalence data** - the number of persons currently living with HIV or AIDS as of 12/31/2006 according to the HIV/AIDS Reporting System
- c. **Key indicators of HIV-risk behaviors** - data that document HIV-risk behaviors are occurring within the target population.

The County Epidemiologist provided the group with the weightings of the factors based on the most recent data on HIV negative and HIV positive individuals. Subjective scoring was based on six factors. The factors were based on: local data, experience, program evaluation, local capacity, and specificity to the behavioral risk group. These six factors were:

- (1) The extent that local planners/providers/community members have considered the behavioral risk group and a specific intervention to be a priority and see it as an appropriate intervention to implement
- (2) Available indicators demonstrating that HIV risk behaviors are occurring within a population
- (3) Available indicators demonstrating that multiple high-risk behaviors such as a combination of using contaminated needles and having an HIV+ sex partner
- (4) Evidence of barriers to fulfilling the behavioral risk group's needs (cultural, linguistic, or community norms that prevent access to a population)
- (5) Outcome evidence that the intervention is effective; e.g., is it culturally appropriate, relevant, and acceptable to the target population and results in risk reduction
- (6) Intervention feasibility; i.e. is there community capacity to implement the intervention.

Planners scored interventions individually, recording each score to be submitted to the planning group for discussion. Once the planning group evaluated the effectiveness of each intervention and reviewed them, intervention strategies were accepted and recommended to the Prevention and Planning Division for further analysis and implementation.

7. STRATEGY DEVELOPMENT

In recent years, the CDC, researchers, behavioral scientists, and many others have conducted rigorous research to study and determine the effectiveness of a variety of HIV prevention interventions. Through extensive study, it has become increasingly clear that effective interventions are rooted in behavior change theory and have a strong evidence base.

Because the CDC and other experts have identified the following as best practices for HIV prevention intervention, Sonoma County’s Prevention Planning Group chose to develop their intervention strategies through the theoretical framework of one or more of the following concepts.

Behavioral Theories Underlying HIV Prevention Interventions

Numerous behavioral theories documented in the scientific literature help inform the design of specific HIV prevention interventions. Some behavioral theories are based upon individual behavior modification approaches to behavior change and other theories address social networks and support systems, attempting to change behavior through influencing peer networks and community norms. The following list provides a brief description of selected behavioral theories, which are commonly referenced in the literature and used as a base for HIV prevention interventions.

<p>Diffusion of Innovation Theory</p>	<p>Examples of HIV Prevention Interventions that may employ Diffusion of Innovation:</p>
<p>Diffusion of Innovation describes how new ideas or behaviors are introduced and become accepted by a community. People in the same community adopt new behaviors at different rates and respond to different methods of intervention. The primary components of this theory include:</p> <ol style="list-style-type: none"> 1. The target population perceives the innovation as new; 2. Channels of communication exist to disseminate the innovation; 3. There is sufficient time or process for the innovation to reach the target population; and 4. A social network exists that connects members of the target population. 	<ul style="list-style-type: none"> ❖ A program for Latino MSM/W workers, to keep in touch with families ❖ Increased support and opportunities to make it easier for HIV+ men to connect with a social network that supports taking care of oneself as well as helping to take care of others in the community. ❖ Supportive activities for HIV+ women, especially Latinas, to take care of themselves and others and understand HIV risk

Empowerment Theory	Examples of HIV Prevention Interventions that may employ Empowerment Theory:
Empowerment Theory explains how groups of people change through a process of coming together to share experiences, understanding social influences, and collectively developing solutions to problems	<ul style="list-style-type: none"> ❖ AIDS Leadership Academy ❖ Educating WSRs, especially Latinas, that partners may not know they are HIV+, and increase use of multiple harm reduction strategies ❖ Support for condoms for sex with secondary partners and safe sex from all STDs with HIV+ MSM/W and MSMP (Men who have Sex with Multiple Partners) especially Latinos ❖ Develop messages and build capacity with medical providers serving non-gay identified MSM/W and MSMP about risk reduction and safer sex from all STDs ❖ General promotion of condom use for sex with multiple/non-primary partners. Support for using condoms for sex with other partners outside primary relationship and safer sex from all STDs ❖ Program for Latino MSM/W workers, to keep in touch with families ❖ Increase support and opportunities to make it easier for HIV+ men to connect with a social network that supports taking care of oneself as well as helping to take care of others in the community. ❖ Supportive activities for HIV+ women, especially Latinas, to take care of themselves and others and understand HIV risk
Harm Reduction	Examples of HIV Prevention Interventions using Harm Reduction
Harm Reduction accepts that while harmful behaviors exist, the main goal is to reduce their negative effects. Harm Reduction examines behaviors and attitudes of the client to offer ways to decrease the negative consequences of the targeted behavior.	<ul style="list-style-type: none"> ❖ Needle exchange ❖ Increased condom availability among IDUs/SUs ❖ Non-occupational post-exposure prophylaxis with HIV- w/HIV+ partner ❖ Educate women that partners may not know they are HIV+, and increase use of multiple harm reduction strategies ❖ Integrate and maintain newly diagnosed HIV+ MSM in care upon diagnosis

	❖ Increase awareness of STD risk and promote use of safe/r sex practices among all IDUs and their partners
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Health Belief Model	Examples of HIV Prevention Interventions using the Health Belief Model:
<p>The Health Belief Model proposes that an individual’s actions are based on four key beliefs:</p> <ol style="list-style-type: none"> 1. People must believe they are personally susceptible to the disease to motivate behavior change (“perceived susceptibility”); 2. An individual must perceive the serious nature of the illness (“perceived severity”); 3. The person must believe that the behavior will have a benefit (“perceived efficacy”); and 4. The person must believe in his or her ability to overcome the barriers to the behavior. 	<ul style="list-style-type: none"> ❖ Outreach and support for benefits of routine testing for individuals who don’t receive regular medical care ❖ Outreach to promote testing to high-risk MSM: benefits of knowing status earlier outweigh negatives ❖ Outreach to high-risk SUs: benefits of knowing status earlier outweigh negatives, promote understanding of harm-reduction concept and strategies ❖ Outreach to high-risk IDUs: staff to promote benefits of knowing status ❖ Condom use with partners outside primary relationship for and when using substances

Popular Education	Examples of HIV Prevention Interventions using the Popular Education Model:
<p>Popular Education supports the belief that teachers and students both have strengths and should learn reciprocally from each other. Group discussions examine problems and develop solutions to personally empower people to change their environment, thereby influencing their subsequent actions.</p>	<ul style="list-style-type: none"> ❖ Many Group Level Interventions, including Reconnect, AIDS Leadership Academy, MantoMan/MantoMan+, Positive Women’s support group, etc.

Social Cognitive Theory	Examples of HIV Prevention Interventions using the Social Cognitive Theory:
<p>Social Cognitive Theory describes learning as a social process influenced by interactions with other people. In the Social Cognitive</p>	<ul style="list-style-type: none"> ❖ Educate women that partners may not know they are HIV+, increase use of multiple harm reduction strategies ❖ Support for condoms for sex with

<p>Theory, physical and social environments are influential in reinforcing and shaping the beliefs that determine behavior (reciprocal determinism). A change in any one of the theory's three components — behavior, physical, or social environments — will influence the remaining two. The concept of self-efficacy (i.e., the client's belief that he or she is capable of performing the new behavior in the proposed situation) is also an essential component of the theory.</p>	<p>secondary partners and safe sex from all STDs for HIV+ MSM/W and MSMP especially Latinos</p> <ul style="list-style-type: none"> ❖ Increase awareness of STD risk and promote use of safe/r sex practices among all IDUs and their partners
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<p>Theory of Reasoned Action</p>	<p>Examples of HIV Prevention Interventions Using the Theory of Reasoned Action:</p>
<p>In the Theory of Reasoned Action, a person's intention is the main influence on his or her behavior. Intention is defined as the combination of personal attitudes toward the behavior as well as the perceived opinions of peers, both heavily influenced by social norms.</p>	<ul style="list-style-type: none"> ❖ Reconnect HIV+ individuals to their communities by providing access to fulfilling volunteer, educational and employment opportunities, which accommodate their needs and create inclusive communities ❖ Increased support and opportunities to make it easier for HIV+ men to connect with a social network that supports taking care of oneself as well as helping to take care of others in the community ❖ Integrate and maintain newly diagnosed HIV+ MSM in care upon diagnosis ❖ Supportive activities for HIV+ Women to take care of themselves and others and understand HIV risk

Stages of Change ⁵⁴	The five stages described by the model are:
<p>Nearly all behavior change interventions rely on the trans-theoretical model, often called the stages-of-change model, which describes the stages people go through when changing behaviors. The stages-of-change perspective is important because it recognizes that people are at different stages of readiness when it comes to using condoms or making other changes. Individuals at different stages may be receptive to different types of intervention messages. Clearly, a different strategy is necessary when one is dealing with someone who has no intention of changing his or her behavior than when one is dealing with someone who intends to change but has not been able to act upon that intention. Similarly, someone who is trying to change but has not been able to consistently perform the protective behavior requires a different message or strategy than someone who is consistently performing the behavior. The stages-of-change model suggests that rather than viewing behavior as an “all or nothing” phenomenon, it is important to view behavior change in terms of a sequence of steps and that interventions should be tailored to the stage that an individual is in.</p>	<ol style="list-style-type: none"> 1. Pre-contemplation: when the person has no intention to adopt (and may not even be thinking about adopting) the recommended protective behavior; 2. Contemplation: when the person has formed either an immediate or long-term intention to adopt the behavior but has not, as yet, begun to practice that behavior; 3. Preparation: when there is a firm intention to change in the immediate future, accompanied by some attempt to change the behavior; 4. Action: when the behavior is being consistently performed but for less than six months; and 5. Maintenance: the period beginning six months after behavior change has occurred and during which the person continues to work to prevent relapse.

Another resource that describes behavioral science theories and their application to health programs is Theory at a Glance, A Guide for Health Promotion Practice,

⁵⁴ Description of Transtheoretical model available at: <http://www.cdc.gov/hiv/projects/acdp/change.htm>.

National Institutes of Health (NIH), September 1997 (NIH publication number 97-3896).

Behavioral theory provides HIV program planners with a framework within which to develop the intervention, its activities, goals, and objectives. Behavioral theory can also help explain aspects of risk-taking behavior when working with a new target population. Thus, using behavioral theory to design HIV prevention interventions can improve the quality of programs, as well as save valuable time and resources. The behavioral theories discussed above represent a subset of possible theories, which HIV program developers can use to design interventions. The theories are not mutually exclusive and multiple theories can be used to guide effective programs.

8. SONOMA COUNTY HIV PLAN

A wide variety of intervention types that have been defined by the State Office of AIDS span the HIV continuum of prevention activities and include: Targeted Prevention (TP), Individual Level Interventions (ILIs), Group Level interventions (GLIs). In addition, the working group further defined interventions by: Community Level Interventions (CLIs), and Systems-Level Strategies (SLSs) based upon current knowledge of best practices. The following section illustrates each of these types of interventions and suggests performance indicators for each type.

Targeted Prevention (TP)

In accordance with CDC guidance and in an effort to focus specifically on behaviors which place an individual at risk for contracting or transmitting HIV, the PPG utilized a results-based planning approach to identify desired outcomes, indicators and performance measures. Through review of local and state epidemiological data, community panels, literature review, presentation of best practice information and provider expertise, the PPG recommended a prevention plan which prioritizes at-risk populations paired with a specific set of prevention strategies. The recommended strategies are further defined below and are based on recent studies which support these strategies as most effective in reaching individuals at high risk for contracting or transmitting HIV, and in promoting positive behavioral changes which support a decrease in the rate of new HIV infections.

BRG	Targeted Prevention (TP)
High-risk MSM	❖ Outreach to promote testing: benefits of knowing status earlier outweigh negatives
High-risk SUs	❖ Outreach to promote testing: benefits of knowing status earlier outweigh negatives, promote understanding of harm-reduction concept and strategies
High-risk IDUs	❖ Outreach to promote testing – staff to promote benefits of knowing status
SU MSM	❖ Provide safer sex information and messages that encourage the use of harm reduction strategies on internet sites where men seek partners
Young MSM	❖ Internet information: safer sex, tools and information to practice safer sex
IDUs	❖ Increase use of needle exchange and other safe drug use practices through SSEs
SUs	❖ Condom use with partners outside primary relationship for and when using

HIV+ MSM	❖ Bridge Program reaches HIV+ individuals who have been lost to care through outreach workers trained to focus primarily on people of color.
IDUs/SUs	❖ Increase harm reduction strategies including condom availability among IDUs/SUs
WSRs especially Latinas	❖ Educate women that partners may not know they are HIV+, and increase use of multiple harm reduction strategies
HIV+ MSM/W and MSMP especially Latinos	❖ Support for condoms for sex with secondary partners and safe sex from all STDs
Newly diagnosed HIV+ MSM	❖ Integrate and maintain these individuals in care upon diagnosis
HIV+ IDU	❖ Increase awareness of STD risk and promote use of safe/r sex practices among all IDUs and their partners.
SU MSM/W	❖ Provide ongoing training and build accountability among providers; Develop trainings for all (i.e. doctors, nurses, therapists, outreach, CM, test counselors

Program performance indicators associated with Targeted Prevention include:

- ❖ Percent of newly identified, confirmed HIV-positive test results among all tests reported by CDC-funded HIV counseling, testing, and referral sites.
- ❖ Percent of newly identified, confirmed HIV-positive test results returned to clients.
- ❖ Percent of facilities reporting a prevalence of new HIV-positive tests equal to or greater than the jurisdiction's target as specified in the first indicator immediately above.
- ❖ Percent of contacts with unknown or negative serostatus who receive an HIV test after PCRS notification.
- ❖ Percent of contacts with newly identified, confirmed HIV-positive test among contacts who are tested.
- ❖ Percent of all contacts with a known, confirmed HIV-positive test among all contacts.

Individual Level Interventions (ILIs)

Individual level interventions (ILIs) consist of health education and risk-reduction counseling provided to one individual at a time and either face-to-face or via the Internet. Individual level interventions (ILI) assist clients in making plans for individual behavior change, provide ongoing appraisals of the client's own behavior, and include skills-building activities. These interventions also facilitate linkages to services in both clinic and community-based settings (e.g., substance abuse

treatment settings, HIV counseling and testing services) and are intended to support behaviors and practices that prevent transmission of HIV.

BRG	Individual Level Interventions (ILIs)
SU MSM	❖ Appropriate referrals and attendance for in substance treatment
HIV- w/HIV+ partner	❖ Non-occupational post-exposure prophylaxis
HIV+ MSM	❖ PCRS, non-occupational post-exposure prophylaxis
WSRs especially Latinas	❖ Educate women that partners may not know they are HIV+, and increase use of multiple harm reduction strategies
HIV+ MSM/W and MSMP especially Latinos	❖ Support for condoms for sex with secondary partners and safe sex from all STDs
Newly diagnosed HIV+ MSM	❖ Integrate and maintain these individuals in care upon diagnosis
HIV+ IDU	❖ Increase awareness of STD risk and promote use of safe/r sex practices among all IDUs and their partners.

Program performance indicators associated with ILIs include:

- ❖ The mean number of outreach encounters required to get one person to access any of the following services: HIV counseling and testing services, sexually transmitted disease screening or testing services, an individual level intervention services, a group level intervention service, or prevention case management.
- ❖ Proportion of persons that completed the intended number of prevention case management sessions.
- ❖ Proportion of the intended number of the target population to be reached with prevention case management who were actually reached.
- ❖ Proportion of persons that completed the intended number of individual level intervention sessions.
- ❖ Proportion of the intended number of the target population to be reached with the individual level interventions that were actually reached.

An ILI is successful when it helps an individual to change behavior that puts one at risk for HIV infection or at risk for transmitting HIV. Thus, to measure success, ensuring and documenting that individuals complete the required number of sessions is an important component of ILIs.

This can be very challenging with some target populations, particularly those who may be more transient in nature or who wish to remain hidden. Another measure of success is the ability of an ILI to get a person to access other needed services, particularly HIV counseling and testing for those with unknown HIV serostatus and partner counseling and referral services (PCRS) for HIV positive individuals. In the strictest sense, both outreach and prevention case management could be considered ILIs.

Group-Level Interventions (GLIs)

As the name implies, group level interventions (GLIs) are health education risk-reduction counseling activities that shift the delivery of service from the individual to groups of varying size. GLIs may be peer or non-peer models, involving a wide range of skills-building, information, education, and support. In general, GLIs have multiple sessions and include a follow-up component. Like ILI, the purpose of GLI is to change to and sustain positive, health promoting behaviors that reduce the risk of infection or transmission of HIV. They also seek to link participants to other needed services (e.g., HIV counseling and testing, prevention case management).

BRG	Group Level Interventions (GLIs)
Latino MSM/W	❖ Program for workers, to keep in touch with families
HIV+ Men	❖ Increase support and opportunities to make it easier for HIV+ men to connect with a social network that supports taking care of oneself as well as helping to take care of others in the community.
HIV+ Women especially Latinas	❖ Supportive activities for HIV+ Women to take care of themselves and others and understand HIV risk

Program performance indicators associated with GLIs:

Like ILIs, GLIs are successful when they help small group participants create and sustain positive behavior change over time. Thus, tracking participation and attendance is a core element of the intervention. Whether groups are peer-led or professionally-led, CBOs (Community Based Organizations) need to develop rigorous tracking mechanisms to document participation. Follow-up is also a core element to be able to assess longer-term change. However, this can be particularly challenging to CBOs when trying to entice participants to come back for follow-up sessions.

Two program performance indicators guide the evaluation of GLIs. These are:

- ❖ Proportion of persons that completed the intended number of group level intervention sessions.
- ❖ Proportion of the intended number of the target population to be reached with the group level interventions that were actually reached.

Community-Level Interventions (CLIs)

Community-level interventions (CLIs) seek to reduce risk conditions and promote healthy behaviors in the broader community as a whole, rather than by intervening with individuals or small groups. CLIs attempt to alter social norms, policies, and the environment. CLIs include community mobilization efforts, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

BRG	Community-Level Interventions (CLIs)
High-risk Latino MSM/W	❖ Radio and/or television information about HIV as part of health services and wellbeing.
Individuals who don't receive regular medical care	❖ HC/PI radio information, outreach and support for benefits of routine testing
Non-gay identified MSM/W and MSMP	❖ Develop messages and build capacity with medical providers about risk reduction and safer sex from all STDs
MSM/W and MSMP including	❖ General promotion of condom use for sex with multiple/non-primary partners. Support for using condoms for sex with other partners outside primary relationship and safer sex from all STDs
Latino MSM/W and MSMP	❖ Culturally appropriate HIV education/information on harm reduction strategies widely available/accessible to Latinos throughout Sonoma County.
IDUs/SUs	❖ Increase harm reduction strategies including condom availability among IDUs/SUs
HIV+ individual	<ul style="list-style-type: none"> ❖ Appropriate referrals and follow through for mental health services ❖ Appropriate referrals and follow through for substance treatment services

Program performance indicators associated with CLIs:
 Measuring the success of CLIs offers unique challenges as large-scale impact or change may not be evident for years. Thus, although long-term outcome-oriented evaluation is needed to measure the success of CLI, in the immediate-term, process measures lend themselves to CLIs. CBOs may be able to utilize more outcome-oriented measures for specific CLIs, such as structural interventions that produce concrete outcomes.

Structural Level Strategies (SLs)

System-wide integration and collaboration strategies, a.k.a. Structural-Level Strategies (SLs), remove barriers and incorporate facilitators of an individual's HIV prevention behaviors. These barriers or facilitators include physical, social, cultural, organizational, community, economic, legal, or policy circumstances or actions that directly or indirectly affect an individual's ability to avoid exposure to HIV. Structural interventions seek to modify the larger scale social, environmental, and political structures that influence the delivery of HIV prevention services. Structural interventions may impact legislation, funding policy, technology, and health care

standards, among others, to improve the delivery and/or effectiveness of HIV prevention efforts.

BRG	Structural Level Strategies (SLSs)
High-risk MSM	<ul style="list-style-type: none"> ❖ Establish county protocol to offer HIV test to individuals who test positive for STD ❖ Outreach to promote testing: benefits of knowing status earlier outweigh negatives
High-risk IDUs	<ul style="list-style-type: none"> ❖ Protocol for appropriate referrals to care for HIV+, and to prevention services for HIV- ❖ Outreach to test – staff to promote benefits of knowing status
High-risk MSM/W	<ul style="list-style-type: none"> ❖ Build and adopt a standardized protocol for testing per CDC guidelines in context of routine care
High-risk SUs	<ul style="list-style-type: none"> ❖ Develop and promote use of an appropriate protocol among substance and MH treatment providers. ❖ Outreach to test: benefits of knowing status earlier outweigh negatives, promote understanding of harm-reduction concept and strategies
Low risk youth /adults	<ul style="list-style-type: none"> ❖ Low risk individuals will receive information at ATS to reduce risk and access testing during routine medical care ❖ Build and promote a collaborative approach including medical provider training and individual assistance (test results) when requested
SUs	<ul style="list-style-type: none"> ❖ Inform providers at key “points of entry” to service systems in order to increase the number of appropriate referrals to MH Tx/support services ❖ Appropriate referrals and follow through for substance treatment ❖ Condom use with partners outside primary relationship for and when using
SU and MH	<ul style="list-style-type: none"> ❖ Capacity building for providers
SU MSM and MSM/W	<ul style="list-style-type: none"> ❖ Increase awareness among MH providers to include HIV risk issues at intake ❖ Appropriate referrals and follow through for mental health services
SU MSM	<ul style="list-style-type: none"> ❖ Provide safer sex information and messages that encourage the use of harm reduction strategies on internet sites where men seek partners

SU MSM/W	<ul style="list-style-type: none"> ❖ Provide ongoing training and build accountability among providers; Develop trainings for all (i.e. doctors, nurses, therapists, outreach, CM, test counselors ❖ Provide ongoing training and build accountability among providers; Develop trainings for all (i.e. doctors, nurses, therapists, outreach, CM, test counselors
IDUs/SUs	<ul style="list-style-type: none"> ❖ Increase harm reduction strategies inc condom availability among IDUs/SUs
IDUs incl. MSM	<ul style="list-style-type: none"> ❖ Appropriate referrals and follow through for mental health services
IDUs	<ul style="list-style-type: none"> ❖ Increase use of needle exchange and other safe drug use practices through SSEs
HIV+ IDU	<ul style="list-style-type: none"> ❖ Increase awareness of STD risk and promote use of safe/r sex practices among all IDUs and their partners.
HIV+ individual	<ul style="list-style-type: none"> ❖ Appropriate referrals and follow through for mental health services ❖ Appropriate referrals and follow through for substance treatment services
HIV+ MSM/W and MSMP especially Latinos	<ul style="list-style-type: none"> ❖ Support for condoms for sex with secondary partners and safe sex from all STDs
HIV+ MSM	<ul style="list-style-type: none"> ❖ Promote awareness of non-occupational post-exposure prophylaxis among target and providers, encourage appropriate referral and provide non-occupational post-exposure prophylaxis at HIV Center for Prevention and Care ❖ Bridge Program reaches HIV+ individuals who have been lost to care through outreach workers trained to focus primarily on people of color.
HIV+ Latino	<ul style="list-style-type: none"> ❖ HIV Clinic and Kaiser will work collaboratively to provide Information about health services, testing, and immigration status to Latinos
Newly diagnosed HIV+ MSM	<ul style="list-style-type: none"> ❖ Integrate and maintain these individuals in care upon diagnosis
HIV+ SU MSM/W	<ul style="list-style-type: none"> ❖ Build capacity in SU agencies to address sex risk among MSM/W, standard approach to HIV issues ❖ Appropriate referrals and participation in primary care services and/or substance treatment programs
Young MSM	<ul style="list-style-type: none"> ❖ Internet information: safer sex, tools and information to practice safer sex

<p>Latino MSM/W and MSMP</p>	<ul style="list-style-type: none"> ❖ Build provider (inc. medical provider) capacity to deliver culturally appropriate harm reduction information and education to Latino clients.
<p>WSRs especially Latinas</p>	<ul style="list-style-type: none"> ❖ Improve providers' capacities/competencies to provide culturally appropriate education re: HIV and increased condom use ❖ Educate women that partners may not know they are HIV+, and increase use of multiple harm reduction strategies
<p>Individuals who test for HIV</p>	<ul style="list-style-type: none"> ❖ Protocol for appropriate referrals to care for HIV+, and to prevention services for HIV-

9. GLOSSARY OF ACRONYMS USED IN THIS DOCUMENT

AIDS- Acquired Immune Deficiency Syndrome
BRG- Behavior Risk Group
CBO- Community Based Organization
CDC- Center for Disease Control
CIR- Cumulative Incidence Rate
COA- Commission on AIDS
CRCS- Comprehensive Risk and Counseling Services
DAAC- Drug Abuse Alternative Center
DHS- Department of Health Services
EIP- Early Intervention Program
GLI-Group Level Intervention
HAART- Highly Active Antiretroviral Therapy
HCPI-Health Communication/Public Information
HCV- Hepatitis C Virus
HET- Heterosexual Contact
HIV- Human Immunodeficiency Virus
HPPWG- HIV Prevention Planning Working Group
HRSA- Health Resources and Service Administration
IDU- Intravenous Drug User
ILI- Individual Level Intervention
MSM- Men who have Sex with Men
MSM/W- Men who have Sex with Men and Women
MSMP- Men who have Sex with Multiple Partners
NIGHT- Neighborhood Interventions Geared to High risk Testing
PCRS- Partner Counseling and Referral Service
PLWHA- Person Living With HIV/AIDS
PPG- Prevention Planning Group
RFP-Request For Proposals
RNS- Risk Not Specified
SHARP- Sonoma County Hepatitis/HIV/AIDS Risk Reduction Program
SLS- Structural Level Strategies
SOA- State Office of AIDS
SU- Substance User
TPA- Targeted Prevention Activity
WSR- Women at Sexual Risk

10. ADDITIONAL HIV EPIDEMIOLOGY AND PRIMARY DATA SOURCES

-- HIV/AIDS case surveillance is a core public health activity. The Sonoma County Department of Health Services, Public Health Division is responsible for tracking and monitoring trends related to HIV counseling and testing data, and HIV/AIDS incidence and prevalence. Non-AIDS HIV surveillance was mandated by California regulation starting in July 2002. These activities are supported by a grant from the California Office of AIDS. The following is a list of current HIV epidemiological studies being conducted by the Sonoma County Department of Health Services. They include:

HIV/AIDS

- ❖ **Epidemiology of HIV/AIDS in Sonoma County – Annual Report**
<http://www.sonoma-county.org/health/ph/hiv/data.htm>
- ❖ **Status of the Epidemic – HIV and AIDS in Sonoma County Quarterly Report**

STDs

- ❖ **Sexually Transmitted Disease in Sonoma County – Annual Report**
- ❖ **Sexually Transmitted Disease in Sonoma County – Quarterly Report**

Other HIV-Related Reports/Primary Data Sources

- ❖ **HIV and AIDS in the Latino Population of Sonoma County**, August 2005 – The content was updated in 2006 and is now incorporated into the Annual Report.
- ❖ **An Estimate Of Persons Who Know They Are HIV Positive, But Are Not In Care** – An annual assessment conducted as part of the CARE Act Part A planning process.
- ❖ **Chapter 5 – Sonoma County Health Profile – Communicable Diseases**
http://www.sonoma-county.org/health/ph/data_reports/hp/index05.htm
- ❖ **HARS** – The Centers for Disease Control and Prevention HIV/AIDS Reporting System (HARS) collects information about U.S. AIDS and HIV case reports.
- ❖ **CAREWare** – This database collects client demographic and utilization data from all CARE Act-funded programs.
- ❖ **HIV-Positive Behavioral Risk Survey** – A one-time study conducted by the County Department of Health Services, Prevention and Planning Division.
- ❖ **HIV6** – A database maintained by the State Office of AIDS on HIV testing and counseling activities.
- ❖ **SISnet data** – Anonymous responses to survey questions posted on the Stay Informed Sonoma.net website.
- ❖ **ELI data** – Evaluating Local Interventions (ELI) is a web-based information system used by prevention providers to collect and access information to prevent HIV infection.
- ❖ **Sonoma County Methamphetamine Profile** – A report to the Board of Supervisors produced in 2006. http://www.sonoma-county.org/health/aods/pdf/meth_report_final.pdf
- ❖ **Commission on AIDS Consumer Survey** – An anonymous client survey conducted on odd-numbered years by the Commission on AIDS.

- ❖ **HIV Housing and Transportation Needs Survey** – A one-time assessment of needs of HIV+ persons being conducted by the Commission on AIDS and the Public Health AIDS Section in 2006-07.

HIV Prevention – Community Assessment, Evaluation and Planning

- **HIV Prevention Planning Group** – The HIV Prevention Planning Group (PPG) was formed in 1995. Key activities include the development and design of HIV prevention strategies, as well as the gathering of input from constituencies throughout the community. It serves both as an advisory body to the Sonoma County Department of Health Services and as the Prevention Committee of the Sonoma County Commission on AIDS.
- **Social Marketing Behavior Change Campaign** – The HIV prevention social marketing campaign encourages members of the community to be aware their HIV status as well as behaviors that may put them at risk for HIV infection as a way of preventing future HIV infections.
- **Strategic Design Team** – The Social Marketing Strategic Design Team (SDT) is comprised of community partners and members of the campaign target audience, and serves an advisory capacity for the program.

AIDS Education Training, Capacity Building, and Technical Assistance

- ❖ **AIDS Education and Training Center** – The North Coast Area AIDS Education and Training Center (NCAAETC) was established in 1989 under the auspices of the Sonoma County Academic Foundation for Excellence in Medicine (SCAFEM). The goal is to improve the access and quality of care for HIV infected individuals providing AIDS education and training to physicians, nurses, dentists, mental health counselors and other allied health professionals of the HIV care team. The program works in conjunction with the Pacific AIDS Education and Training Center and the University of California at San Francisco.
- ❖ **DHS HIV Test Counselor Training** – The State Office of AIDS provides a required, one-week training for all HIV Test counselors.
- ❖ **Prevention and Planning Division Education and Skills Development** – The Program conducts training and education on HIV prevention for the general public, professionals and community volunteers.
- ❖ **HIV Collaborative Prevention Trainings** – The Department of Health Services Prevention and Planning Division offers capacity building and technical assistance to direct service agencies that serve high-risk individuals.