

PALM BEACH COUNTY, FLORIDA
EMA

COMPREHENSIVE
NEEDS ASSESSMENT
2003 - 2006



Palm Beach County
HIV CARE Council

A Program of The Treasure Coast Health Council, Inc.



**PALM BEACH COUNTY HIV CARE COUNCIL
2003-2006
THREE YEAR COMPREHENSIVE NEEDS ASSESSMENT**



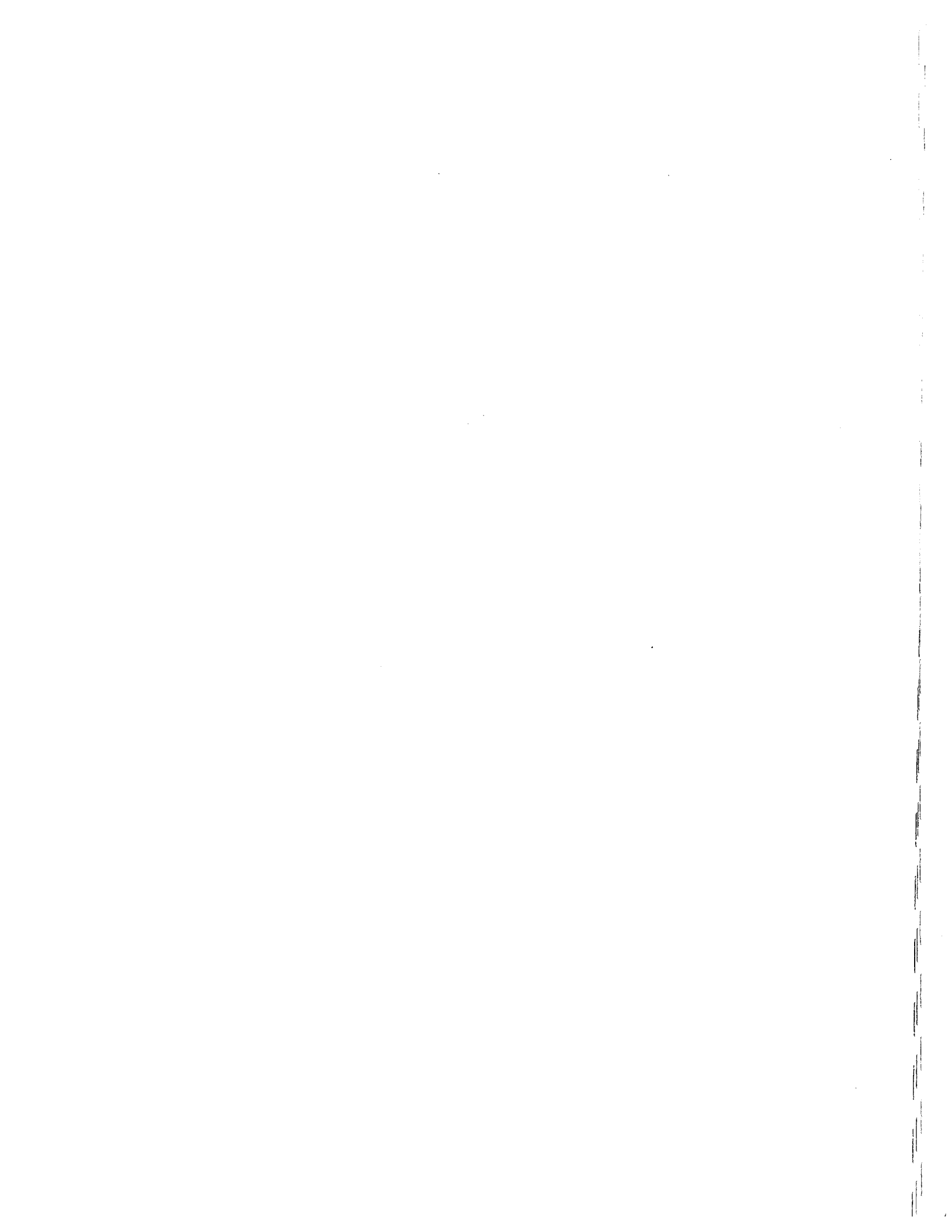
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Many thanks to all of the consumers and service providers whose input, commitment and inspiration contributed to the success of this project.



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Introduction

On August 18, 1990, Congress enacted Public Law 101-381; the *Ryan White Comprehensive AIDS Resources Emergency (C.A.R.E.) Act*. This legislation was reauthorized on May 20, 1996 as Public Law 104-146: *The Ryan White C.A.R.E. Act Amendments of 1996*. The C.A.R.E. Act represents the largest dollar investment by the Federal Government for the provision of services for People Living With HIV/AIDS.

The C.A.R.E. Act is intended to help communities and states increase the availability of primary health care and support services to reduce utilization of more expensive inpatient care, increase access to care for underserved populations and improve the quality of life of those affected by the epidemic.

The Health Resources and Services Administration (HRSA) has the primary responsibility for the implementation of the C.A.R.E. Act. Its Bureau of Health Resources Development (BHRD) manages Titles I through IV and *Part F*.

The following outlines the purposes of *Titles I through IV and Part F*:

- Title I** Directs emergency funding to Eligible Metropolitan Areas (EMAs) hardest hit by the HIV/AIDS epidemic.
- Title II** Provides formula funding to each state to improve the quality, availability and organization of health and support services for people and families living with HIV/AIDS. Additionally, there is a set-aside for AIDS Drug Assistance Program (ADAP).
- Title III** Supports outpatient early intervention to reduce risk of transmission and delay onset of symptoms and opportunistic infections.
- Title IV** Supports demonstration projects to organize and coordinate a broad range of services for children, youth, women and families with HIV/AIDS and provides access to clinical research.
- Part F** Supports Special Projects of National Significance (SPNs), the AIDS Education Training Center (AETC) and the Dental Reimbursement Program.



History of Funding for HIV/AIDS

Palm Beach County began receiving Title II funds in 1991. In 1994, because of growth in the number of AIDS cases, our area became eligible for Title I funding. Title I funds created a local HIV Health Services Planning Council.

The Palm Beach County HIV CARE Council acts as both the Title I HIV/AIDS Services Planning Council and Title II AIDS Consortium to provide a broad compendium of services which form the continuum of Care for county residents affected by HIV spectrum disease. The CARE Council produced the Palm Beach County Fiscal Year (FY) 2000-2003 HIV Care Needs Assessment.

The Council's purpose is to conduct a needs assessment, develop a care plan, establish medical and human service priorities, direct allocations and evaluate the effectiveness of those services. The Palm Beach County Board of County Commissioners is the grantee for the Title I funds and evaluates the effectiveness of those services which are distributed through the Palm Beach County Department of Community Services.

Housing Opportunities for People With AIDS (HOPWA) monies began in 1991. These funds have assisted by providing housing services for people with HIV/AIDS. HOPWA funds are administered by the City of West Palm Beach Housing and Community Development Department.

Palm Beach County began receiving Title IV planning funding in August of 1998 and program dollars in August of 1999. These dollars are managed by the Palm Beach County Health Department and provide services for women and families living with the disease and Pediatric Programs.

Two additional funding streams exist in Palm Beach County; General Revenue AIDS Network and General Revenue Patient Care. These State of Florida sources predate any funds from the Ryan White C.A.R.E. Act (commencing 1986 and 1989, respectively). They are both administered by the Palm Beach County Health Department through the Bureau of HIV/AIDS in Tallahassee and are funded with General Revenue dollars.

Currently, Palm Beach County does not receive Title's III and IV support. Therefore, early intervention services to prevent transmission, delay onset of symptoms and opportunistic infections is marginal and represents a significant disparity between need and access.

Finally, *Part F* exists by the designation of an AETC provider; (University of South Florida (USF), Department of Community Health, Tampa, Florida). This resource exists, although implementation has not begun in Palm Beach County.



Summary: Needs Assessment

A. Background

Between the months of December 2002 and June 2003, the Palm Beach County HIV CARE Council, for the Palm Beach County Eligible Metropolitan Area (EMA) conducted a Comprehensive Needs Assessment of HIV/AIDS Care Services in Palm Beach County, Florida. Quantitative epidemiological data, including past and current infection and case trends, were collected and analyzed by the Palm Beach County Department of Health Epidemiology Program in conjunction with the Palm Beach County HIV CARE Council and used in this comprehensive process.

The 2003 Needs Assessment was a research and planning activity that sought to:

- Identify the extent and types of existing and potential care service needs among persons living with HIV/AIDS in Palm Beach County;
- Examine the current relevant service delivery system in the county;
- Identify service utilization, priorities, gaps and access barriers;
- Create a baseline of client and provider information; and
- Determine the extent of unmet needs or underutilized resources in order to plan appropriate care services.

The main purpose of the 2003 Needs Assessment process was to provide informative data to guide decisions related to the CARE Council's prioritization of care services for the Ryan White C.A.R.E. Act's Title I, Title II, HOPWA, Patient Care and Network funding allocation processes (See Appendix A for a list of Planning Council-created Ryan White Service Categories). Additional goals of the Needs Assessment process were to:

- Assess the current Continuum of Care to strengthen the system and produce a collaboration between diverse cultures, communities and service systems;
- Provide legislatively mandated information to the federal Health Resources Services Administration (HRSA) related to service needs and system response; and
- Provide planning information for agencies, organizations and health care providers.

Efforts were made to collect data from a broad range of persons living with HIV/AIDS, from individuals who were HIV positive but not yet symptomatic to persons with end-stage illness. Underserved populations were given attention especially: men who have sex with men, women, injection drug users and Hispanics.

This HIV/AIDS Needs Assessment provides a "slice of life" or snapshot of community and culture services, priorities, gaps and access barriers as identified by consumers and providers in 2003. Needs assessments must be ongoing to represent the changing nature of the spectrum of care, treatment advances, funding availability and epidemic trends.



B. Methods

- (1) Planning Council meetings were held before data collection began to determine the structure of the project and accomplish:
 - The 2003 Comprehensive Needs Assessment document was reviewed and revised to create the 2003 Comprehensive Needs Assessment protocol. It was then approved by the Palm Beach County HIV CARE Council Needs Assessment sub-committee;
 - The Needs Assessment Sub-Committee reviewed the submitted documents including revised measurements to the CARE Council Planning Committee and;
 - Data collection teams were sought and trained to implement the gathering of information utilizing the Needs Assessment measurement package.
- (2) After the above planning stage occurred, data collectors gathered 400 face- to-face consumer surveys.
- (3) Provider surveys were completed at the April 2003 Provider Meeting held by the Title I Grantee. Thirty provider surveys were administered and 17 were handed into the Planner for analysis.
- (4) Annual Administrative Reports were used to harvest provider-related client demographic data and descriptions of the current services continuum related to HIV/AIDS.

C. General Findings from the 2003 Needs Assessment

- (1) The 2003 Comprehensive Needs Assessment Consumer Surveys were analyzed and revealed that overall, the consumers have indicated that they "need and use" the majority of medical services that were displayed in the survey instrument, representing utilization of services. As in 2000, the exceptions existed in auxiliary services, such as, acupuncture, alternative medicine, peer support, telephone referrals, continuation of private insurance, group counseling, housing, groceries, and payment of utilities. The three main barriers identified by consumers were lack of information about services, inability to afford the service, and that the service was unsatisfactory.
- (2) The 2003 Comprehensive Needs Assessment Provider Surveys were analyzed and revealed that overall, case management and medical services were being provided and utilized. However, the providers revealed that translation services, transportation, home health assistance and vocational rehabilitation needs are currently not being met; representing gaps in the service deliver system.



- (3) The Consumer and Provider Surveys were analyzed for associations and revealed that both were similar in recognition of most medical services being met, including ADAP. Additionally, they were also in agreement regarding gaps in services. Most notably, relating to dental care, housing, and payment of food, rent and utilities.



Description of the EMA and Map

Palm Beach County covers approximately 2,200 square miles and has a population of 1,147,184. Based on 2000 census data, the county's racial composition is 71.1 percent white, 12.9 percent Black, and less than 4 percent other. Approximately 23 percent of the population is over 65 years of age and 18.4 percent is 19 or younger. A mid-1998 Florida Department of Health Service report indicates there are approximately 65,000 seasonal farm workers in the county comprised primarily of Caribbean, Central American and Mexican workers.

Blacks are disproportionately affected by HIV/AIDS in Palm Beach County. Of those living with AID in the EMA, 65 percent are African Americans, 26 percent are white and eight percent are Hispanic. The historical patterns established by the epidemic in the EMA continue and increase with respect to those who become infected and the mode of exposure. AIDS diagnoses over the past two years (01/01/00 - 12/31/01) indicate 714 (69.79%) new AIDS cases were Blacks, 230 (22.48%) were Whites, and one (7.62%) was Hispanic.

Women are increasingly at risk for HIV infection as reflected by the epidemiological data. Women account for 34 percent of the live AIDS cases, 36 percent of the recent AIDS cases and 46 percent of live HIV cases. This trend exceeds the national where 18 percent of the cumulative AIDS cases are female.

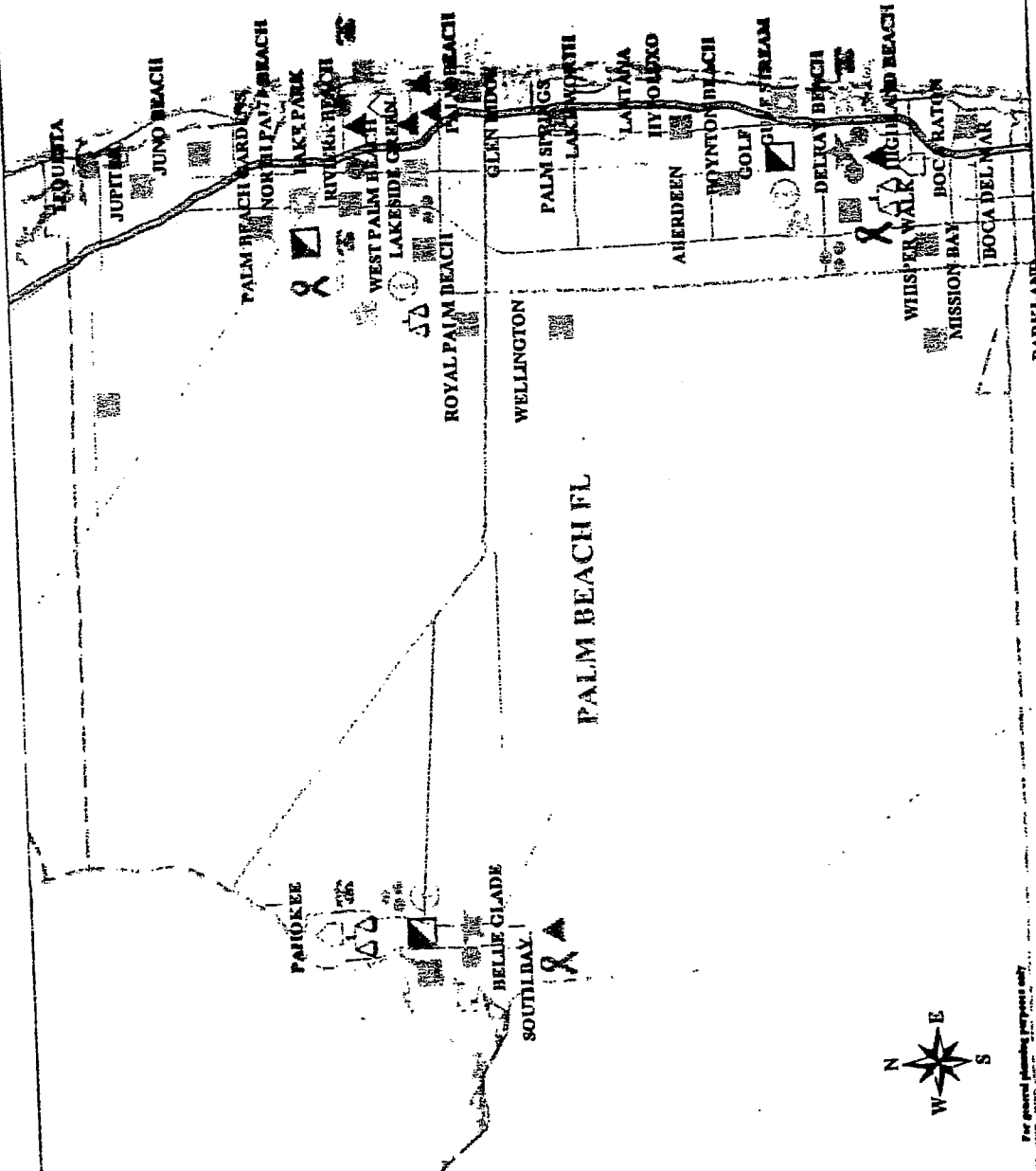
The geographic distribution of AIDS in Palm Beach County varies widely. Cumulative AIDS reports through 1999 indicate that the majority of AIDS cases are in the coastal, urban section of the county. The western rural portion had 1,361 reports of AIDS; the southern part of the EMA had 2,450 cases and the central; and northern parts had the lowest number of AIDS cases with 61 and 295 respectively. This geographic distribution is consistent with present case reporting with numbers in the southern section of the EMA increasing faster than other sections. This is attributed to the growing immigrant and minority populations in the areas of Lake Worth, Boynton Beach and Delray Beach.

Services for the HIV/AIDS population vary and are primarily provided by community-based organizations located in population centers throughout the service area (see map on the following page.) The Palm Beach County system of care is a partnership between local, state and federal funding sources, planning authorities, medical and social support agencies, plus people who are living with HIV/AIDS. The partnership is known as the Coordinated Services Network and provides care for persons and families living with HIV-Spectrum Disease. Title I funds are used to support services that enhance access to primary care and maintain quality of life.

Palm Beach County, Florida "Ryan White Title I Services"

- Primary Medical Care
- ★ Dental Care
- Drug Reimbursement Program
- ▲ Case Management
- Housing Services
- ⊕ Food Services
- ⊗ Substance Abuse Treatment
- ⊞ Transportation Assistance
- ⊟ Mental Health Therapy
- ⊠ Legal
- ⊡ Home Health Care
- ⊢ Complementary Therapies
- ⊣ Counseling (Other)
- ⊤ Buddy/Companion Services
- ⊥ Direct Emergency Assistance

Palm Beach County
Department of Community Services
810 Datura Street
West Palm Beach, Florida 33401
(561) 355-4700
filename: chria822.map



For general planning purposes only.



Epidemiological Profile of HIV/AIDS in Palm Beach County, Florida

HIV/AIDS Epidemiology: Table I illustrates AIDS incidence (01/01/00-to-12/31/01), AIDS Prevalence as of 12/31/01, and estimated HIV prevalence based on reported HIV cases as of 12/1/01, using the surveillance data collected and reported to the State of Florida Department of Health: HIV/AIDS Surveillance (2001) (HARS), and the Centers for Disease Control (CDC) generated data. Modeled HIV prevalence estimates have been increased by one and two tenths (1.2) percent by CDC recommendations.

Estimated HIV Prevalence is presented in two ways in this document. First, The Florida Department of Health: Bureau of HIV/AIDS' methodology is described followed secondly by the guidance provided within the Title I FY 2003 Grant Application guide; pages 93-94: HIV/AIDS Epidemiological Data for the EMA. Table I includes HIV Prevalence estimates utilizing both methods. Another column is added to accommodate the additional information.

The State of Florida Department of Health: HIV/AIDS Bureau, HIV/AIDS Surveillance has revised HIV prevalence estimates for Florida, based on recent findings announced by the Centers For Disease Control and Prevention (CDC) (2003) and a growing awareness of the magnitude and scope of the epidemic in the state.

New HIV prevalence estimates developed for Florida are higher than the estimates distributed by the department five years ago. The new estimates are predicated upon those recently distributed by CDC (i.e., 850,000-900,000 persons are living with HIV infection in the United States, Fleming, et al, HIV Prevalence in the United States, 2000 from the oral abstract, session 5, Ninth Conference on Retro-viruses and Opportunistic Infections, Seattle, February 24-28, 2002).

There are an estimated 900,000 American individuals currently living with HIV. It is believed that Florida comprises at least 11 percent of all persons living with AIDS, morbidity, in the United States. The State of Florida Department of Health estimates that approximately 95,000 Floridians, or roughly 10-11% of the National total, are currently living with HIV infection. A plausible range around this point-estimate would be approximately 88,000 to 102,000. Previously, the Department estimated that Florida's HIV prevalence was 82,500 (plausible range of 65,000 to 100,000). Currently, Palm Beach County contains 9.1% (n= 8,644) of the States' 95,000 estimated HIV prevalence total. It is important to bear in mind that Palm Beach County comprises only 7.1% of the state's 2000 Census total. ***This method of calculation indicates that one in every 131 persons living in Palm Beach County is infected with the HIV virus. This yields a population prevalence rate of approximately 0.76%.***

The Bureau of HIV/AIDS has developed new statewide HIV prevalence point estimates characterized by sex, age at diagnosis, current age, and mode of exposure. The estimated numbers of HIV-infected persons in each demographic subgroup are based on the proportion of reported cases of those living with HIV/AIDS in each subgroup, according to the HIV/AIDS Reporting System (HARS) as of 12/31/01. This information is included in the narrative description of Palm Beach County EMA and supported by Tables. Those with no identifiable risk (NIR) have been redistributed



into exposure categories according to how a large sample of persons living with HIV/AIDS initially reported as NIR has been historically reclassified.

All HIV Prevalence estimates by demographic characteristics are to be considered approximations. Partnership or area-specific HIV prevalence point estimates, may be regarded to be more provisional in nature than the statewide estimates. Estimates based on smaller numbers of reported living with HIV/AIDS cases will have broader plausible ranges associated with them. In addition, completeness and timeliness of HIV/AIDS reporting varies by area; to the extent that reportable cases are missed, the share of the state's total HIV prevalence in a given area may be underestimated.

Out-of-state residents who receive in-state HIV-related services may not be captured by the HIV/AIDS Reporting System (HARS), though they could contribute to the community's burden of HIV prevalence. Inter- area movement and migration out of state by HIV-infected persons could also be factors whose precise impact on local HIV prevalence and services may be difficult to assess.

The provisional area-specific HIV prevalence estimates have been developed with an understanding that local community planners may feel there is a sound basis for developing their own estimates. They may not agree with the estimates presented here.

All available HIV/AIDS surveillance indicators based on reportable data point to certain racial/ethnic disparities. Statewide, Non-Hispanic Blacks who represent only 14% of Florida's population in the 2000 Census, account for the majority of recently reported HIV cases, AIDS cases, and HIV/AIDS deaths. Approximately 50% of the Statewide estimated HIV prevalence is similarly thought to be among Blacks.

Little is known about those who are HIV infected but unaware of their serostatus or those who have been diagnosed but not reported. CDC however, has estimated that in the past years the undiagnosed group has diminished from one-third of all HIV- infected persons to one-quarter of all those infected (Fleming et al., 2002).

In Florida, since HIV infection reporting was implemented in mid-1997, we are rapidly learning more about the epidemic as an annual average of about 5,000 newly diagnosed HIV cases and 5,000 newly identified AIDS cases have been reported in HARS. An estimate of statewide HIV incidence would be about 4,000 new infections per year (assuming that Florida claims 10% of CDC'S estimate of a currently stable national incidence of 40,000 per year), while an annual average of 2,000 deaths have occurred since 1997 among Florida patients reported with AIDS. The current annual growth in statewide reported HIV/AIDS (about 10,000 per year), thus appears to be outpacing the estimated



annual growth in HIV prevalence (equal to approximately 4,000 [(annual HIV incidence) less 2,000 (annual AIDS deaths)]). This allows increasingly valid generalizations about the demographics of Florida's epidemic from the known data in HARS to the total population of HIV-infected persons.

A general limitation is that the smaller the demographic or geographic subgroup under consideration, the greater the uncertainty about the point-estimates. Statistical procedures are not currently available to establish plausible ranges around each estimate. For HIV/AIDS planning purposes, there have been tangible benefits to referring to statewide and local HIV prevalence in terms of point estimates rather than ranges, as long we maintain conceptually, the caveats about the underlying assumptions and the uncertainties.

The State of Florida Department Of Health: Bureau of HIV/AIDS Surveillance (2001), provided an HIV prevalence estimate for Palm Beach County that suggests a mid-point estimate of 3,900 and a range of between 2,400 and 5,400. For HIV and AIDS currently, CDC (2001), maintained that Palm Beach County had an estimated plausible range of between 5,500 and 10,300 live cases of HIV/AIDS and a mid-point estimate of 7,900 persons presumed to be living with HIV/AIDS. When the State of Florida's modeled HIV prevalence estimate of 3,900 was added to CDC'S AIDS prevalence of 3,400 for Palm Beach County, the minimum number of persons with HIV (including those unaware), is 7,300 or close to the CDC-generated mid-point estimate of 7,900 persons presumed to be living with HIV/AIDS. According to 2001 CDC calculations, the mid-point estimate for HIV/AIDS estimated prevalence includes 3,745 live AIDS cases and 1,707 live HIV cases. The balance of 2,448 is computed by adding the thirty percent unknown (n= 2,370) and twelve percent unreported (n= 948) for a total of 3,318, as used by the CDC referencing the formulas of Karon and Rosenberg (JAMA, 1996).

As of 2002, **one in 131** people is presumed to be infected with HIV-spectrum disease in Palm Beach County. Whereas, one in 168 people is presumed to be infected with HIV in the State of Florida. Demographically that indicates that one in 286 Whites, one in 50 Blacks and one in 127 Hispanics are thought to be infected with HIV/AIDS in Florida. Karon and Rosenberg (1996), suggest that one in 333 Americans is living with HIV/AIDS. Utilizing the 2000 Census count of 1,131,985 for Palm Beach County, the State of Florida: Bureau of HIV/AIDS Surveillance estimates that Palm Beach County has an HIV/AIDS estimated prevalence rate of 766 persons presumed to be living with HIV/AIDS per 100,000. Comparatively, the Florida HIV/AIDS estimated prevalence rate of persons presumed to be living with HIV/AIDS is 548 per 100,000. The United States HIV/AIDS estimated prevalence rate is 287 per 100,000.

The following is a presentation of HIV prevalence data and narrative utilizing the methods appearing in Appendix 4: HIV AIDS Epidemiology Data for the EMA, pages 93- 95 of the Title I FY 2003 Grant



Application Guidance. It is acknowledged that the estimated prevalence estimates that will be presented below are a departure from those presented in the previous portion of this document. **Both methodologies are discussed and the two computations included in Table I to provide the most comprehensive view of the HIV-spectrum disease in Palm Beach County EMA.**

The United States Centers for Disease Control and Prevention has developed models for estimating diagnosed HIV prevalence in states that had not implemented name-based HIV reporting by 1995. HIV and AIDS data reported to CDC through March 2002 were statistically adjusted for delays in reporting and for unreported risk. These estimates are based on national adjustments and therefore state health departments may choose to modify them or substitute other data that may be available locally. Palm Beach County consulted with local HIV/AIDS surveillance program staff to assure data are released in accordance with state and local data release policies. It is important to note the following relevant considerations.

These data represent estimates and do not represent actual case counts of persons with HIV/AIDS. The sum total of estimates for each category may not match the EMA totals because of rounding. Additionally, in the Palm Beach County EMA, the estimated HIV prevalence calculation derived from using the model provided by CDC vis a vis HRSA, is 1461. The total number of HIV cases reported exceeds the CDC-modeled estimate at 2018. This number includes 56 deaths with a mortality rate of 3%. Even if the EMA subtracts 56 cases from 2018 to equal 1962, we are 500 cases above the estimated HIV prevalence calculation provided by CDC/HRSA. Of course, the total number of HIV reported cases for Palm Beach County equaling 1962 does not consider 'unreported' usually computed at 12% as suggested by Karon and Rosenberg (1996) or the 30% usually added to account for 'unknowns' or 'unawares'. If we compute 12% of 1962 to equal 235 and 30% of 1962 to equal 589 and add these two figures to 1962 ($n = 2786$) we estimate that least 2786 individuals are infected with HIV in the EMA. That is more than a thousand additional individuals we can add to the CDC/HRSA calculation. This was derived by using the crudest of methods presented in summary of the work produced by Karon and Rosenberg using the 1996-CDC model.

Small numbers should be interpreted with caution. As with any statistically adjusted data, the inherent uncertainty of these estimates is greater for small numbers than for larger ones. Adjustments for unreported risk (i.e., risk redistribution) are based on historical patterns of risk ascertainment and reclassification. For both AIDS and HIV data the redistribution is not based on the individual EMA'S reclassification patterns, but rather on the patterns observed in the geographic area. Research has shown that the risk redistribution for the extremely low incidence categories no longer produces valid estimates. For this reason, the CDC has grouped cases attributed to hemophilia/coagulation disorder and receipt of blood transfusion, blood components, or tissue into



estimates of "other" exposure categories for adult/adolescent and pediatric cases.

Diagnosed HIV (not AIDS) prevalence represents estimates of the number of persons with HIV who had not progressed to AIDS and who was living at the end of June 2001. These estimates do not represent all persons living with HIV infection (i.e., estimates do not include persons living with HIV who have not been tested or who have been tested in an anonymous setting only).

HIV prevalence data were only provided for EMA'S within the 25 states that had name-based HIV reporting systems in place prior to 1995. These states do not include Florida. The Palm Beach County EMA is not included in this descriptor group. Further, CDC does not provide HRSA/HAB with modeled estimates of diagnosed HIV(not AIDS) prevalence for areas that have implemented HIV reporting since 1995 or that have not yet implemented HIV reporting. This EMA falls into this category. We will now present locally available HIV data and alter the estimate by the adjustment factor provided by CDC for 2002. This is based on the change in AIDS prevalence from June 2000 to June 2001.

The adjustment factor was calculated by dividing AIDS prevalence as of June 2001 (provided with this guidance) by AIDS prevalence as of June 2000 (provided in July of 2001). This adjustment factor was then multiplied by the diagnosed HIV (not AIDS) prevalence estimate at the end of June 2000 to obtain an estimate of diagnosed HIV prevalence at the end of June 2001.

Specifically, diagnosed HIV (not AIDS) prevalence as of June 2000 equaled 1218 (information provided September 2001). AIDS prevalence as of June 2000 equaled 3143. AIDS prevalence as of June 2001 equaled 3803. The adjustment factor equals 1.2. Diagnosed HIV (not AIDS) prevalence as of June 2001 = $1218 \times 1.2 = 1461.6$.

| | |
|---------------------------|------|
| HIV prevalence June 2000 | 1218 |
| AIDS prevalence June 2000 | 3143 |
| AIDS prevalence June 2001 | 3803 |

$$3803/3143 = 1.2099$$

Diagnosed HIV (not AIDS) prevalence as of 2001 = $1218 \times 1.2 = 1461$

It is evident that there is a disparity between the estimated HIV prevalence estimate calculated by the State of Florida at 8644 (discussed earlier in this section) and the HIV prevalence estimate calculated with the provided adjustment factor of about 1.2 to equal 1461, calculated by the CDC. To accommodate the discrepancy, the Palm Beach County EMA included both prevalence estimates in Table I yet, refers to the CDC model HIV Estimated Prevalence calculation in the narrative portion of this document.

TABLE 1: AIDS INCIDENCE, AIDS PREVALENCE AND HIV (NOT AIDS) PREVALENCE (CONT'D)

| Demographic Group/ Exposure Category | AIDS INCIDENCE: 01/01/00 TO 12/31/01 | | AIDS PREVALENCE AS OF 12/31/01 | | HIV (NOT AIDS) PREVALENCE AS OF 12/31/01 | | HIV (NOT AIDS) PREVALENCE AS OF 12/31/01 (FLORIDA MODEL) | |
|--|---|------------|-----------------------------------|------------|--|------------|---|------------|
| | # | % of Total | # | % of Total | # | % of Total | # | % of Total |
| Adult/Adolescent AIDS Exposure Category | | | | | | | | |
| Men who have sex with men | 154 | 0.197 | 963 | 0.259 | 231.3 | 16.0 | 1383.04 | 16.00 |
| Injection Drug users | 62 | 0.079 | 396 | 0.106 | 86.7 | 6.1 | 527.28 | 6.10 |
| Men who have sex with men and inject drugs | 7 | 0.0089 | 82 | 0.022 | 22.0 | 1.5 | 129.66 | 1.5 |
| Heterosexuals | 351 | 0.45 | 1569 | 0.422 | 693.8 | 48.0 | 4149.12 | 48.0 |
| Other/hemophilia/blood transfusion | 5 | 0.0064 | 20 | 0.005 | 7.0 | 0.005 | 43.22 | 0.005 |
| Risk not reported | 201 | 0.257 | 687 | 0.184 | 404.0 | 28.0 | 2420.32 | 28.0 |
| Total | 780 | 100 | 3717 | 100 | 1445 | 100 | 8644 | 100 |
| Pediatric AIDS Exposure Categories | | | | | | | | |
| Mother with/at risk for HIV infection | 2 | 100 | 84 | 0.976 | 5 | 0.83 | 5 | 0.83 |
| Other/hemophilia/blood transfusion | 0 | 0 | 1 | 0.011 | 0 | 0 | 0 | 0 |
| Risk not reported or identified | 0 | 0 | 1 | 0.011 | 1 | 0.16 | 1 | 0.16 |
| Total | 2 | 100 | 86 | 100 | 6 | 100 | 6 | 100 |

Complete: Does your State have HIV reporting? (Check one.) YES NO



Trends and Changes in the Epidemic: The first paragraph in this section of the application does not use the data dates suggested in Table I, AIDS incidence; AIDS prevalence; and HIV prevalence. Instead, more recent and therefore more accurate surveillance report data are presented as of 6/28/02.

As of June 2002, 4127 individuals (including pediatric cases) were presumed to be living in the Palm Beach County EMA with an AIDS diagnosis. An additional 1962 individuals (including pediatric cases) were presumed to be living with HIV in the County. Eighty-five percent (85%) of those living with AIDS/HIV in the EMA were identified in the coastal regions of the county, which includes the cities of West Palm Beach, Lake Worth, Riviera Beach, Boynton Beach and Delray Beach. The remaining fifteen percent (15%), of those individuals living with HIV spectrum disease were residents residing in the Western rural portion of the County. This area encompasses Belle Glade, Pahokee, South Bay and Canal Point. It is important to note that the Western section of the EMA has between 30,000 (year round residents) to 80,000 (seasonal residents), making the number of HIV/AIDS cases in the rural communities (n=748), disproportionately high.

A unique aspect of the HIV/AIDS epidemic in the EMA is that it has historically and continues to be largely centered in the Black (not Hispanic) population. Further, there continues to be a strong increase in the heterosexual risk category. The cumulative number of AIDS cases as of 6/28/02 in the Palm Beach County EMA among men who have sex with men was 2433 (29%). Whereas, the cumulative number of HIV cases (a more recent and therefore more representative picture of the virus in the county) among men who have sex with men in Palm Beach County, is 317 (16%) as of June 28, 2002. The cumulative number of AIDS cases as of 6/28/02 for heterosexuals in Palm Beach County was 2910 (35%), while the cumulative number of HIV cases among heterosexuals was 907 (45%).

In general, new trends in the HIV/AIDS epidemic, in Palm Beach County revolve around women, people of color, recent entrants, and heterosexuals comprising a larger proportion of the epidemic and white men who have sex with men and injection drug users composing a less significant proportion of the population. Women comprise 34% of the presumed living cases of AIDS through 12/31/2001 (AIDS Prevalence), 36% of the recent AIDS cases during the past two years (AIDS Incidence), and 46% of the HIV cases as of 12/31/01 (HIV cumulative incidence that corresponds to HIV prevalence). Injection drug users account for 11% of the cumulative presumed live cases of AIDS as of 12/31/01, 8% of recent AIDS reports for the past two years and 6% of HIV cases through 12/31/01. Blacks (collapsing African Americans with Haitians, and Jamaicans and a variety of Caribbean and West Indian populations) continue to compose an increasingly large proportion of the epidemic. Blacks account for 65% of the living AIDS cases in the EMA, 70% of the AIDS cases diagnosed in the past two years and 70% of the live HIV cases through 12/31/01. Hispanics/Latinos



have seen very little fluctuation regarding numeric counts, thus, remaining stable. This population has a significant undocumented (illegal immigrant) population and remains part of the unserved segment of the EMA. The number of documented entrants according to the recent 2000 Census is small. Yet, the United States Census, 2000, indicates that Hispanics contribute to 12.9% of the total Palm Beach County population. The Palm Beach 2000 Census is 1,131,184. Therefore, according to this calculation there are 146,000 Hispanics living in the County. As of 12/31/01, Hispanics accounted for 307 or eight percent (8%) of AIDS prevalence, 78 or eight percent (8%) of recent AIDS cases (AIDS Incidence), and 117 or eight percent (8%) of HIV prevalence. Anecdotal information and the results of the local Rapid Assessment and Response Evaluation (RARE), reveal that members of this marginalized and special group are afraid to go to the Health Department because they lack the necessary papers and are afraid of arrest, detainment, and deportation. Another barrier for HIV/AIDS testing and treatment among the Hispanics/Latinos is the stigmatization of this virus within their culture. Reports of familial and social rejection characterize the epidemic among this group. The Hispanics/Latinos account for eight percent (8%) of the live AIDS cases, eight percent (8%) of the AIDS reports during the past two years and eight percent (8%) of the living HIV cases diagnosed since mid-1997. These figures demonstrate little change. Additionally, these low percentages when compared to projected and real Census 2000 data, appear to create underestimates of the virus in this population locally, and are not commensurate with national data. This is discussed in the section entitled Demographics of the Epidemic.

AIDS incidence in Palm Beach County from January 1, 2001, to December 31st, 2001, AIDS prevalence as of December 31st, 2001 and HIV prevalence as of December 31st, 2001: For the race/ethnicity category, there is a strong association between AIDS and HIV incidence and prevalence. AIDS prevalence rates for whites is 26percent, incidence is 22percent, and HIV prevalence is 22 percent; for Blacks; AIDS prevalence is 65 percent, incidence is 70 percent, and HIV prevalence is 70 percent; for Hispanics; AIDS prevalence and incidence are both at eight percent (8%) and HIV prevalence is also at eight percent (8%.) A noticeable disparity exists however, in AIDS incidence and prevalence rates and HIV prevalence rates for males and females. Males have AIDS incidence and prevalence of 64 percent and 66 percent, respectively, yet, an HIV prevalence rate of 53 percent. Females have AIDS incidence and prevalence rates of 36 percent and 34 percent, respectively, yet, an HIV prevalence rate of 46 percent, indicating that females now comprise nearly half of all HIV cases in Palm Beach County. This is congruent with the findings below that discuss the continuation of heterosexual infection in the EMA.

Another illustration of the change among risk group follows. AIDS incidence rates are lower than AIDS prevalence rates for the categories of men who have sex with men (MSM) (20% vs. 26%), injection drug users (8% vs. 11%), and injection drug users who have sex with men (1% vs. 2%). HIV prevalence relating to the preceding categories are lower than both AIDS incidence and AIDS



prevalence with the exception of men who have sex with men and are injection drug users and heterosexuals. Each category exhibited an increase of one percent (1%.) The exposure category labeled heterosexual (sexual transmission), has far surpassed both the categories of men who have sex with men and injection drug use. On a positive note, only eight pediatric cases of HIV have been identified in total in Palm Beach County since mid-1997. This indicates that HIV-positive women in Palm Beach County are following through on treatment protocols that reduce the vertical transmission of the HIV spectrum disease.

Demographics of the Epidemic: Of those living with AIDS in the EMA, 26 percent are white, 65 percent are black, and eight percent are Hispanic. The historical patterns established by the epidemic in the EMA continue and increase, with respect to those who become infected and the mode of exposure. For example, only 22 percent of the new cases of AIDS diagnosed in the past two years (01/01/00 to 12/31/01) were among Whites, yet, 70 percent of the new AIDS diagnoses were among Blacks. Of those living with HIV, 22 percent are White, 70 percent are Black and eight percent are Hispanic. The epidemic in Palm Beach County has always provided a form of foreshadowing for the national epidemic, except for the Hispanic populace, where the EMA under reports. The national epidemic indicates that approximately 43 percent of persons living with AIDS are white, 37 percent are black, 18 percent are Hispanic, and less than one percent (1%) each for Asian and Native American.

Palm Beach County had experienced a shift in majority of diagnoses from white men who have sex with men to people of color who engage primarily in heterosexual sex as far back as five years ago. This trend continues to increase as reflected by the percentages displayed above. In the EMA, approximately 13 percent are Black, 12 percent Hispanic, and 75 percent White. These population estimates accentuate the disparate proportion of Blacks infected with AIDS compared to the total number that Blacks contribute to the total Palm Beach County population. Such a disproportionate impact of AIDS/HIV on the Black community is consistent with national trends. Palm Beach County, however, realized this unpleasant distinction previous to the United State's recognition of this disparity. Hispanic's comprise eight percent (8%) of the new AIDS cases (e.g., past two years), yet, constitute 12 percent of the EMA'S population. Although, those who work on the front lines suspect and report high numbers of infected but, untested and therefore, untreated Hispanics, it is believed that Hispanics are infected at a far greater rate than current numbers reveal. However, when one considers the 30 percent that CDC allows for above the AIDS prevalence rates to account for the unknown category, it could be assumed that lack of Hispanic reporting would be compensated for in this manner.

Specifically, it is important to note that Hispanics are approximately 12.4 percent of Palm Beach County's population, but just 3.7 percent of the County's voters. In Lake Worth, a site of the Palm



Beach County RARE project, Hispanics comprise 29.7 percent of the population and 7.9 percent of the voters. The problem is lack of representation and documentation. The Hispanics continue to be hidden due to fear of reprisal, apprehension and imprisonment or worse, a return to regimes that practice ethnic genocide or political oppression (e.g., The Guatemalan military and paramilitary practicing ethnic cleansing on Mayan Indians populating mountain villages).

Considering HIV transmission, MSM in the EMA, account for 26 percent of the living AIDS cases, 20 percent of the AIDS cases diagnosed over the past two years (01/01/00 to 12/31/01), and 16 percent of the living HIV cases. These numbers reflect an incline by percentage change, over the previous year's calculations in the categories of AIDS diagnosed over the past two years (18% for the years 7/01/98 through 6/30/00 vs. 20% for the years 01/01/00 through 12/31/01), and live HIV cases (14 % as of 6/30/00 vs. 16% as of 12/31/01). Injection drug users (IDU), account for 11 percent of the Live AIDS cases, eight percent (8%) of the AIDS cases diagnosed over the past two years and six percent (6%) of the estimated number of people presumed to be living with HIV as of 12/31/01. The category created by the intersect between IDU's and MSM's continues to comprise two percent (2%) of the live cases of AIDS, one percent (1%) of the AIDS cases diagnosed in the past two years, and two percent (2%) of the estimated number of HIV prevalence as of 12/31/01. While men who have sex with men, injection drug users and men who have sex with men and inject drugs continue to be groups affected by HIV-spectrum disease, there is a decreasing proportion of these three categories as reflected by local AIDS prevalence, AIDS incidence and HIV prevalence. The negligible and decreasing presentation of the epidemic in the injection drug use category is inconsistent with National trends, where approximately thirty percent of cases are attributed to IDU. This EMA is well below the National average. The recent Palm Beach County RARE project revealed that there is a robust and clearly defined local intersect between substance abuse, including injection drug use, crack, alcohol and across legal and illegal substances and drug classes and HIV, thereby confounding epidemiological data.

Women are increasingly at risk for HIV infection as reflected by the epidemiological data. Women account for 34 percent of the live AIDS cases, 36 percent of recent AIDS cases and 46 percent of live HIV cases. This trend exceeds the national epidemic where 18 percent of cumulative AIDS cases are females.

Consistent with data nationwide is that the overwhelming majority of living AIDS cases (96%) in the EMA is in adults over the age of 19. As of 12/31/01, the EMA had 136 living AIDS cases in children under the age of 19 years and 12 AIDS cases reported during the two-year period ending 12/31/01. There are however, 70 youth under 19 years of age living with HIV infection in the EMA as of 12/31/01. This age group accounted for four percent (4%) of all living HIV cases in the EMA. The higher number of youth living with HIV versus AIDS probably reflects the national trend associating



unsafe sexual practices among gay youth and adolescents in general. This burgeoning special population continues to require close attention.

Even though 80 percent of the EMA's total living AIDS cases and 79 percent of the new HIV cases are in the coastal region, with the remainder in the remote Western and rural communities, there are further distinctions that can be better portrayed by the HIV data (July 31st through September 2000) arranged by zip code. As summarized in the table and chart that follow, a total of 1,439 cases of HIV were diagnosed in Palm Beach County between July 31, 1997 and September 2000. Ten zip codes accounted for 1,054 (71.35%) of all cases in Palm Beach County.

Figure 1

| HIV DATA July 31, 1997 to September 2000 By Zip Code (1997 - 2000) | | |
|---|------------------------|-------------------------|
| Zip Code | Number of Cases | Percent of Total |
| 33444 | 179 | 12.12 |
| 33401 | 156 | 10.56 |
| 33404 | 148 | 10.02 |
| 33407 | 146 | 9.88 |
| 33430 | 142 | 9.61 |
| 33460 | 102 | 6.91 |
| 33435 | 92 | 6.23 |
| 33476 | 33 | 2.23 |
| 33425 | 30 | 2.03 |
| 33445 | 26 | 1.70 |
| Total Top 10 Zip Codes | 1,054 | 71.35 |
| ALL Palm Beach County Zip Codes | 1,439 | 100 |



These data portray an evolving epidemic. AIDS has historically affected the white gay and bisexual males but, no longer. While this community is still severely impacted, some trends that have developed nationally have either appeared in the EMA years ago, or are now appearing such as:

1. People of Color, predominantly Blacks, comprise an increasingly large and disproportionate portion of the HIV and AIDS cases. In the two years ending 12/31/01, Blacks accounted for 70 percent of the reported AIDS cases in the EMA yet, comprise 12.9 percent of the 2000 Census population count.
2. Women of Color, are becoming infected at increasing rates, particularly Black females, through heterosexual exposure, sexual contact with bisexual males and/or IDU's and their own injection drug use.
3. Even though the coastal or urban areas in this EMA continue disproportionately affected, the Western or rural areas of the county deserve special attention due to the upside ratios relating to the Western County population and HIV/AIDS infection rates.
4. Recent Entrants have long been considered a hidden and marginalized population in Palm Beach County. HIV-related prevention and treatment become especially problematic with this population because of their fears of arrest and deportation.
5. Substance abusers, other than IDU's, are anecdotally considered as participating in HIV high-risk behaviors due to the disinhibiting effects across all substance classes and categories. Substance abusers who are AOD'S (Alcohol and Other Drug) abusers versus IDU's (Injection Drug Users), continue to elude the attention of our current system of care in Palm Beach County.

The Epidemic's Impact on Cost and Complexity of Service Delivery: Trends and changes discussed earlier have an impact on the cost and complexity of service delivery in the EMA. The EMA faces major challenges in implementing a system that reaches all affected populations across the community. The Palm Beach EMA encompasses 37 municipalities, covers more than 2,200 square miles (the largest county West of the Mississippi), and centers on three distinct metropolitan coastal areas and one rural and remote western community. Although the coastal urban areas have a strong network of HIV/AIDS service providers, both connected and independent from the coast, many of these organizations have not traditionally targeted outreach activities to Blacks, Women, Mayan Indians, Hispanics, Caribbean Islanders, Youth, and Children. Education and outreach efforts need to target those who know and those who are unaware of the HIV status and are not in care.

Residents of the whole county to varying degrees, travel to three HIV/AIDS service centers distributed geographically, throughout the County. These HIV/AIDS centers are located in the Southern portion of our county in Delray Beach, in the Western portion of the county in Belle Glade, and in the Northern portion of the county in Riviera Beach. Transportation therefore, is an important issue, particularly for people who are homebound and have no cars. Public transportation



in Palm Beach County is limited and out of reach for many of the most vulnerable individuals. HIV/AIDS service centers are comprised of Department of Health medical clinics and satellites of case management agencies. There have been discussions and preliminary planning meetings to discuss and explore constructing a forth service center for the central area of the County, perhaps in Lantana but these discussions are exploratory in nature and are only in the preliminary and visionary stages.

As noted previously, the HIV epidemic is expanding to include more women, Blacks, Hispanics and youth, as well as individuals with complex life issues such as poverty, co-morbidities such as Hepatitis-C and Tuberculosis and various forms of sexually transmitted diseases (STD's), substance abuse including alcohol, homelessness, mental illness, criminal involvement, lack of education and issues relating to language, literacy and cultural barriers. Intense outreach, support and advocacy efforts are required to assure that Blacks, women, youth and children in all areas of the county gain and maintain access to the Coordinated System of CARE. Women of childbearing age have specific needs relating to childcare, pregnancy, pregnancy testing, counseling, gynecological services and prevention services. Transportation and childcare are important in encouraging women to access care and to be easily available. Females may also require legal services to plan for guardianship of children and permanency planning. Youth require specially targeted HIV/AIDS services because they do not respond to mainstream efforts. The EMA is encouraging more youth yet, is just beginning to penetrate this vulnerable special needs population.

While recent epidemiological reports indicate the increase of incidence and prevalence of HIV/AIDS in the African American community, there is a noticeable lack of increase among Hispanics even though the general population in Palm Beach County is now 12.9 percent Hispanic. The Hispanics in the EMA are comprised of many sub-populations that include: Peruvians, El Salvadorans, Cubans, Guatemalans, Puerto Ricans, Mexicans, and other South and Central American cultures. Hispanics are dispersed throughout the county but reside primarily in the farming regions and urban areas. Employment for Hispanics is often seasonal and part-time. Unstable employment and transient lifestyle make it difficult to connect to with much-needed medical and social services. Add to the aforementioned the issue of documentation or "the lack of papers", and barriers to care become insurmountable. As mentioned earlier, the fear of reprisal occurring locally by arrest, detainment and deportation, prevents Hispanics who are at high risk for HIV/AIDS from accessing health care. As a result, Hispanics often ignore their health and symptoms of HIV/AIDS until they are forced to seek treatment at emergency rooms. By this time the progression of their disease is end-stage. This debacle is avoidable. Culturally sensitive and appropriate prevention and interventions are currently being crafted to address this issue. Additionally, the issues of language and literacy prevent many Hispanics from receiving effective HIV/AIDS care.



There is a lack of trust in established health systems by Blacks in Palm Beach County as expressed in the 2001 RARE project. This finding was also supported by the 2002 Black Heterosexual Males and Black Heterosexual Females HIV/AIDS study conducted in Palm Beach County. The lack of trust in the Public Health system was seen as contributing to the discontinuity between prevention and Clinical Care services. It is necessary to recall that Blacks comprise the overwhelming majority of recent HIV (as of 12/31/01) prevalence estimates with 70 percent; and recent AIDS cases in the EMA at 70 percent (1/01/00 to 12/31/01). There is a shortage of minority-based service providers who provide culturally relevant services to our diverse Black communities (e.g., Haitian, Jamaican, West Indian, and other Caribbean groups), while addressing local, state, and federal requirements and including all genders and risk groups. Increased resources are needed to improve the capacity of community-based organizations to deliver appropriately diverse services to access/build the capacity of organizations within minority communities to serve people living with HIV/AIDS (PLWH/A).

The data from the Three Year Comprehensive Needs Assessment, the Palm Beach County RARE Project, The Palm Beach County Black Heterosexual Males and Black Heterosexual Female Study and The MSM EVOLVE Study, all indicate the need for additional Substance Abuse and Use services plus outreach for communities that are engaged in the interaction of high risk sex, drug abuse/use and alcohol abuse/use. The current epidemiological information reveal that IDU'S only comprise six percent (6%) of the total number of recent HIV cases, 10 percent of the cumulative AIDS cases and eight percent (8%) of recently reported AIDS cases. The State of Florida: Bureau of HIV/AIDS in 2000 conducted a study whereby four Florida counties were studied for the relationships between injection drug use and HIV/AIDS infection. The study included Palm Beach County and revealed that there are approximately 10,000 injection drug abusers residing in the in the county and that 2,500 IDU's are infected with HIV/AIDS. It is apparent that the EMA needs to enhance its testing, counseling, referrals and services to HIV/AIDS infected IDU'S. This is addressed in the Three Year Comprehensive Plan in the Second section: Where We Go from Here, and How We Are Going to Get There. It was evident when evaluating our current Coordinated System of CARE that the EMA does not have sufficient drug and alcohol prevention, coordinated referrals and treatment services, early intervention and follow-up/maintenance related to both substance abuse and HIV/AIDS. Substance abuse is a prominent co-morbid condition for people living with HIV-spectrum disease in Palm Beach County. Additionally, clients who are dually diagnosed with a mental illness and substance abuse place high demands on providers through out the system of care. For such individuals, intensive case management, in-patient treatment for stabilization and other support services and systems are mandatory to engage persons diagnosed across the three diagnoses of HIV/AIDS, substance abuse and mental health and keep them in care. Needs Assessments in addition to health care and social service providers and funding providers have identified the need for increased access to professionals with both substance abuse and mental health expertise



backgrounds to work with PLWH/A and to train staff on methods for working with multiply-diagnosed clients.

A final measure of complexity of the health care delivery system is in determining the average number of diagnoses per client and whether that number has increased over the past several years. It is hypothesized that there is an increase in the average number of diagnoses when considering the high rate of substance abusers with their accompanying diagnoses and that PLWH/A are living longer because of pharmaceutical protocols.

Co-Morbidity, Poverty, and Insurance Status: Table II presents specific data to describe co-morbidity, insurance and income factors for the EMA.

Tuberculosis: The Florida Department of Health's Florida Tuberculosis Annual Report, 2001, indicates that Florida had 1145 counted Tuberculosis cases in the year 2001. Texas had a total of 1643, New York a total of 1676 and California had the highest total counted cases with 3,332 in 2001. Palm Beach County had a plausible range of between 51 to 151 total estimated cases for the year 2001. The actual case count for Palm Beach County in 2001 was 79. Based on a total 2000 Census Population of 1,159,986, the rate per 100,000 Palm Beach County populations is 6.8. Palm Beach County has a cumulative total of reported cases from 1993 to 2001 of 907. The report concluded that the majority of TB cases reported in Florida occurred in members of minority populations. African Americans who account for approximately 13 percent of the State's total 2000 census population constitute 47 percent of the Tuberculosis cases in 2001. Hispanics, who comprise 12.5 percent of the State's total 2000 census, account for 21 percent of the TB cases in 2001. Whites who make up about 70 percent of the State's total 2000 Census population account for 25 percent of the 2001 TB cases. Asians who account for less than one percent of the State's 2000 Census account for about seven percent (7%) of the 2001 TB cases in Florida. Consistent with other states that have high TB morbidity, the largest number of cases occurred among males, 68 percent, and in people 25 to 44 years of age at 39 percent. Eight percent of the cases among males in this age group were non-white. Of the 1,145 TB cases reported in 2001, 23 percent had a positive HIV status. The TB/HIV case rates per 100,000 were 1.6 for the year span of 1993-2000. Seventy six (76) percent of the State's total HIV-infected Tuberculosis cases were Black non-Hispanic, 11 percent White non-Hispanic, 11 percent Hispanic and two percent Asian. Fifty nine percent of the HIV-infected tuberculosis cases in Florida were between 25-44 years of age, 36 percent were 45-64, three percent were 0-24, and two percent were 64 years or older. Seventy two percent of the HIV/TB co-infected cases were male, 34 percent were foreign born, 29 percent indicated that they used alcohol excessively, 24 percent revealed that they were IDU's, and 13 percent of the TB/HIV co-infected population stated that they were homeless. For states reporting HIV information in 1998, Florida ranked first in the percentage of total TB cases that were also co-infected with the



HIV virus. While co-morbidities are a consideration, they have not hindered the ability of the EMA to deliver HIV/AIDS care.

Syphilis and Gonorrhea: The epidemic of sexually transmitted diseases(STD's), in the EMA is of concern. In Palm Beach County, approximately 22 percent of the individuals living with HIV/AIDS have also reported a sexually transmitted disease. Providing medical care for these individuals can be challenging as STD's compromise an already weakened immune system, and creates additional opportunities for infection.

The Florida Department of Health, Division of Disease Control: Bureau of STD data files indicate that the annual rate per 100,000 for STD-infection has de-escalated over the past year. However, rates for infectious syphilis in the county per 100,000 have been unstable since 1999. In fact, in 1999, the rate of infectious syphilis per 100,000 Palm Beach residents was 3.53. In 2000, the rate was 4.75 yet, in 2001, the rate per 100,000 residents fell to 2.33. The annual rate per 100,000 for the State was 2.95 for 2001. There were a total of 27 new cases reported in Palm Beach County in 2001 and a total of 484 reported in the State of Florida in 2001. In 2001, Blacks compose 67 percent of the infectious syphilis cases in Palm Beach County; Hispanics comprise seven (7) percent and White non-Hispanic account for 25 percent of the infectious syphilis cases in the EMA. While STD data files indicate a rate of 2.33 per 100,000 for infectious syphilis in Palm Beach County in 2001, the STD data files demonstrate comparatively that gonorrhea has an overall Palm Beach County rate of 78.88 per 100,000 in 2001. The State of Florida has an overall Gonorrhea rate per 100,000 of 131.20 for 2001. Palm Beach County had an overall Gonorrhea rate of 90.29 in 1999, 87.28 in 2000, and 78.88 in 2001. It is evident that in Palm Beach County, the annual rates of Gonorrhea have declined over the past several years.

STD's disproportionately affect minorities in the EMA. In 2001, Blacks accounted for close to 75 percent of the reported Gonorrhea cases in 2001, Hispanics accounted for nearly four percent (4%) of Gonorrhea cases and Whites accounted for 17 percent of the reported Gonorrhea cases in the County. It is possible, if not likely, that risky behaviors continue to be practiced by those infected with HIV and thereby infecting previously HIV negative partners. There is a need for secondary prevention services in order to prevent these individuals from further transmitting HIV into the general population.

Intravenous Drug Users: The Florida Department of Health: Bureau of HIV/AIDS, reports that through July 2002, 80,509 adult/adolescent AIDS cases have been reported. Of that State total, 14 percent of males and 25 percent of females confirmed intravenous drug use. These are minimum estimates regarding IDU exposure as 17 percent of males and 27 percent of females were classified as "other or unknown" exposures. Some of these cases were undoubtedly IDU-related. In Palm



Beach County, the cumulative number of AIDS cases since 1980 was 8541 with 1254 identified as IDU's and 1350 with No Identified Risk (NIR). The estimated number of IDU's for the EMA is approximately 10,000, with an intersect of 2500 HIV co-infected individuals.

Data from prevalence surveys and case surveillance reports continue to demonstrate the heavy impact of the HIV/AIDS epidemic on racial and ethnic minority populations. There is no question that drug use plays a significant role in the spread of the epidemic. Florida Department of Health statistics of cumulative IDU data for Palm Beach County indicate that 55 percent of the IDU exposures were among Blacks (non-Hispanics); 32 percent were among Whites (non-Hispanics); and 13 percent were among the Hispanic population.

The Palm Beach County RARE project reported on four high-risk zip codes within the 10 highest reported HIV zip codes in Palm Beach County. The report revealed that by examining recent HIV data (since July 1999), provided by the Palm Beach County HIV/AIDS Epidemiology Unit, a prevalence rate of 742 per 100,000 could be estimated for the HIV/IDU co-infected population. The general risk/descriptors for IDU's are they are mostly male, often homeless, frequently exchange sex for drugs and/or money, engage in sex with males and females, are often in and out of prison and have mental illness as a co-morbidity causing "triple diagnoses".

The RARE Project's IDU Focus Group suggested that the low utilization of substance abuse treatment by HIV-infected individuals reported on the 2003 Comprehensive Needs Assessment Survey was a reflection of lack of access and barriers to residential substance abuse treatment in the EMA. Additionally, the self-disclosed substance-abusing respondents of the 2003 Comprehensive Needs Assessment Survey indicated that their withholding counterparts were not forthcoming because they did not perceive themselves as having a drug and/or alcohol problem; in other words, these individuals were operating under the delusion of denial. The low service utilization was augmented by the inability of the substance abuse providers to provide residential treatment on demand and the inability to address the severely compromised health of HIV clients. The group concluded that substance abuse continues to be an issue yet is hidden and therefore challenging to provide to 'phantom' patients.

Prevalence data and needs assessment data are indicating a troubling delta set created by the intersection of HIV/AIDS, high-risk sex and substance abuse. The data suggest that the underutilization of substance abuse treatment and HIV/AIDS clinical care may have more to do with an individual's willingness to acknowledge substance abuse and/or HIV than the availability and access to treatments. Those engaged in the mixing of high-risk sexual behaviors, substance abuse and HIV-co-infection are disproportionately People of Color and increasingly, female.



Alcohol and Other Drugs: The impact of non-injection drug use on care cost and complexity is subtler than the impact exhibited for IDU's. Drug use interferes with an individual's ability to adhere to his/her treatment regimen and keep appointments. It may also divert financial resources needed for food, shelter and other basic human requirements to the purchase of chemicals. Complicating issues revolving around drug use impacts health outcomes and adds to the cost of providing services for persons with HIV who have a substance abuse problem. SISAR, which is the Florida State reporting mechanism for ADM (Alcohol, Drug Abuse and Mental Health), uses data reporting variables of the following substances: Alcohol, methamphetamines, cocaine/crack, inhalants, benzodiazepines, barbiturates, narcotics, designer drugs (i.e., ecstasy), and 'other', but there is no specific data to link HIV/AIDS incidence or prevalence with these substances in this reporting system.

Homelessness: Living with HIV spectrum disease and being homeless is a complicated situation. Maintenance of physical and emotional health is frequently ignored when food, clothing and shelter are of primary concern. Medical appointments are difficult to meet and maintaining complicated HIV drug therapies is a major challenge. According to the 2003 Comprehensive Needs Assessment, 15 percent of the HIV-positive consumer respondents had been homeless within the previous 12 months. A recent needs assessment conducted by the Palm Beach Coalition for the Homeless indicated that there are 282 beds available for HIV-infected homeless persons in Palm Beach County. The report further offers that there is a currently 535 HIV-infected homeless persons residing in Palm Beach County.

Another issue confronting PLWH/A's who are homeless is the limited availability of affordable housing in the EMA. In many if not most cases, issues of housing must be addressed before health care and support services needs can be adequately addressed. Without stable housing, it is extremely difficult for HIV-infected individuals to maintain medical regimes and social services requirements.

Incarceration History: The information presented herein is from the Bureau of Justice Statistics Bullet, July 2001; NCJ). In 1999, 1.7 percent of Palm Beach County's local incarcerated population, 2.3 percent of Florida State inmates, and 0.9 percent of Federal inmates were known to be infected with HIV. If those known to be HIV positive an all U.S. prisons (N= 25,757), 6,642 were confirmed AIDS cases while 17,711 showed symptoms of HIV infection or were asymptomatic. Of those in jail, 3,081 had confirmed AIDS.

At the end of 1999, confirmed AIDS cases made up approximately 0.6 percent of all inmates in State and Federal prisons. Florida ranked third in the number of confirmed AIDS cases among the incarcerated populace. As of June 30th, 1999, Palm Beach County's total incarcerated population was 3,518, with 278 inmates determined to be HIV-infected. The rate of infection was 1 in 11. Palm



Beach County ranked first in the 50 largest jail jurisdictions in the number and percent of jail inmates who were HIV positive.

After release, inmates in Palm Beach County are referred by 'Bridge' connections established in jail, prior to release, to available treatment and medical care, but many offenders do not follow through with provided recommendations for a variety of reasons. Approximately two thirds of state prisoners serve their full sentences and are released without supervision. If an ex-offender is released with no community supervision conditions, there are no corrections officials to assist the individual with entering a system of care. Ex-offenders frequently have a high distrust of government that presents additional barriers to provision of HIV health and social care services.

Insurance: According to the 2000 Census Bureau's Annual Demographic Survey, March 2001 CPS Supplement, Florida had 17 percent of its population uninsured as opposed to 14 percent nationally and locally in Palm Beach County. This equates to approximately 158,365 individuals in Palm Beach county without any health insurance (including Medicaid), during 2001. The lack of health insurance, high deductibles, the price of prescription drugs and co-payments are barriers for accessing health care for many HIV/AIDS infected people. In Palm Beach County, there are several federal, state, and local programs to assist low-income people with the financial burdens of health care but, they do not come close to meeting the full need. Health care programs for the uninsured include: primary, preventive, specialty, AIDS treatment, prenatal, family-planning, pharmaceutical, labs, radiology, vision, dental, substance abuse, and mental health services. These are provided through the county health department and now through a network of Title II funded private doctors, and community-based HIV medical providers.

While individuals on fee for service Medicaid have good health coverage, in some instances they have fewer choices than those with private insurance, especially in rural areas where many providers do not accept Medicaid. Fortunately, the providers in the EMA who tend to have the largest patient loads and most experience with HIV/AIDS do currently accept Medicaid, however, this is a tenuous alliance and is threatening to change.

Statewide, the number of HMO's has collapsed leaving gaps in private insurance for much of the state's population. As the HMO crisis evolves, it is expected that more PLWH/A will have issues securing and maintaining private insurance.

The Florida Department of Health administers the AIDS Insurance Continuation Program (AICP) for those diagnosed with AIDS or is HIV-positive with symptoms and who, because of their illness, are unable to maintain their private health insurance coverage. The program makes direct payments of up to \$650 per month to each client's employer or insurance company for the continuation of



medical, dental, mental health and optical coverage. AICP will also pay any fees associated with conversion of a COBRA policy to an individual policy or policy upgrades. The program will also pay client co-payments and deductibles on an as needed basis.

Table 2: Co-Morbidity, Poverty, and Insurance Status

| EMA: | | | |
|---|--|------------|---|
| CO-MORBIDITIES, QUANTITATIVE DATA | | | |
| Co-morbidity | Prevalence within the general population within the EMA | | Data Source |
| Tuberculosis | Cumulative reported cases (2001) = 79 Rate/100,000 = 7.0 | | Florida Tuberculosis Annual Report, 2001 |
| Syphilis | Cumulative reported cases (2001) = 27 Rate/100,000 = 2.4 | | Florida Dept. of Health, Division of Disease Control: Bureau of STD Data Files, 2001 |
| Gonorrhea | Cumulative reported cases (2001) = 915 Rate/100,000 = 80.9 | | Florida Dept. of Health, Division of Disease Control: Bureau of STD Data Files, 2001 |
| Intravenous Drug Users | Between 7,500-9,000 prev. estimate IDU's n HIV = 2475 ¹ | | Bureau HIV/AIDS 2000 Four County Report |
| Other Substance Abuse (i.e. alcohol, Methamphetamine, cocaine, inhalants) Please specify. | Mid point for Florida = 870,000 PBC = 9% of state total (.9 X 870,000 = 78,300) PNC AOD's = 78,300 | | NIDA/SAMHSA state estimates (2000) regional breakouts, National Household Survey: Total all ages by all substances. |
| Homelessness | 5,000 in PBC on any given day | | Homeless Coalition of Palm Beach County, 2001 Survey |
| Other co-morbidities (optional) Incarceration | Total known to be HIV+ in PBC facilities – 274 or 10.6% of the jail population. PBC is #1 in the number of HIV reported cases in the 50 largest jail/prison populations nationally. | | Bureau of Justice Statistics Bulletin, <i>HIV in Prisons and Jails</i> , 1999 |
| INSURANCE AND POVERTY STATUS | | | |
| INSURANCE STATUS* | Number | Percentage | FL. Health Insurance Study, Agency for Health Care Administration, 2002 |
| | 92,000 uninsured under 65 years of age. | 13.6% | |
| POVERTY** | Number | Percentage | U.S. Census 2000 update 2002, PBC Quick Facts |
| | 130,086.16 | 11.5% | |

* Estimated percentage and number in EMA without insurance coverage, including without Medicaid

** Percentage and number of people in EMA below 300% of the Federal poverty level

¹ IDU's using midpoint between 75,000 and 9,000 of 8250. Multiplying by the national average of HIV infected via IDU of 30% (.30 X 8250 = 2475) Source: Minneapolis/St. Paul application 2001
Re: National Trends for IDU n HIV



The State of Florida also administers the AIDS Drug Assistance Program (ADAP). ADAP is intended to help HIV-positive people stay healthy by assisting with the purchase of HIV prescription medications. ADAP provides HIV drug treatments for people who do not have private health insurance, do not qualify for Medicaid or are waiting for Medicaid eligibility and cannot afford to purchase the medications themselves.

As the epidemic continues to disproportionately impact low-income individuals and persons with mental health/substance abuse problems, patients will bring a multitude of costly life issues to the primary care provider's office and rightly expect these complicated factors to be included in the provision of quality clinical care.

Poverty: According to the Census Bureau's Annual Demographic Survey, March 2001 CPS Supplement, Florida has 15.5 percent of the population living below 125 percent of Federal poverty guidelines. The number of people with HIV/AIDS living in poverty in Palm Beach County is higher than the general population. Estimates in 1999 by the County Health Department indicate that more than 26 percent of residents living with HIV/AIDS are living at or below 300 percent of the federal poverty level. These individuals are often marginalized and distrustful of governmental services systems and tend to be less educated or illiterate and less likely to follow treatment regimens than others who are not living in or below poverty. In order to be successful in achieving health outcomes, individuals living in poverty require intensive follow-up, adherence counseling and treatment education. This presupposes they place a personal value on their own health, which in many cases, they do not; or at best, their health needs are a low priority. Higher priority is placed on some type of financial stability, housing, food, care of children and other family members as well as other daily requirements and non-essentials. The stress these individuals place on the system is great and complex, as linkages between a variety of services along the continuum are needed in order to effectively meet their needs.

Assessment of Populations with Special Needs: Table III displays information relating to the Special Needs Groups

The EMA's populations with Special Needs have been identified as: (1) Youth 13-24 years of age; (2) Injection Drug Users; (3) Substance Users other than IDU's; (4) Men of Color Who Have Sex With Men; (5) White/Anglo Men Who Have Sex With Men; (6) Women of Child-Bearing Age(13+); and (7) Recent Entrants (i.e., Haitians and Mayan Indians). The CARE Council seeks to improve access to care for these Special Populations primarily through the culturally and ethnically appropriate case management and clinical care services delivered in the County through our Coordinated System of CARE. Outreach efforts target individuals who are not currently receiving primary medical care, especially those who know their HIV status and refuse care.



Youth: This group is primarily targeted through a collaboration with the Palm Beach County School District to reach youth attending school, after school, incarcerates and summer youth programs. Youth as all other residents represent a large variety of ethnic and cultural backgrounds. New data indicate that 50 percent of new infections are occurring in people under the age of 25, suggesting a need for continued prevention programming and increased access to services in this population. The Palm Beach County Health Department offers a Teen Clinic to better serve the needs of young adults with HIV/AIDS. Teens can enroll in primary care services through any of the eight enrollment sites in the EMA.

Injection Drug Users (IDU's): The CARE Council recognizes the need for increased substance abuse counseling services and has identified this as a top priority. One of the most challenging barriers to working with IDU's, is the lack of treatment on demand or residential substance abuse treatment available when the client is ready to seek chemical dependency treatment. Funding for residential substance abuse for PLWH/A is allocated in order to facilitate the receipt of such services for those in primary medical care. Support services such as housing, food assistance, and other basic services are also provided to clients through a comprehensive community-based case management system.

Substance Users Other Than IDU's: The intersection of substance abuse and risky sexual behaviors are prevalent in reported HIV/AIDS cases. In recognition of the association between HIV/AIDS and substance abuse, the legal system is requiring persons found guilty of driving under the influence of alcohol and other drugs, or of sex offenses to participate in HIV educational sessions. Case management agencies providing services to people with HIV/AIDS routinely refer to the substance abuse providers in the EMA when a client indicates a need for chemical dependency treatment. This is an area that is extensively explored during the initial intake of the case management process. The EMA is considering the implementation of Chemical Dependency Assessment at primary care appointments as a supplemental effort. The Department of Health physicians are now being trained in a one week experiential residential workshop at Hanley-Hazeldon Center in Palm Beach County. The physicians are being trained to diagnose, intervene and refer to substance abuse treatment when appropriate. Case Management agencies maintain a database to apprehend immediate chemical dependency treatment for motivated clients and give a reasonable array of treatment choices. Health Department clinics and outreach programs also provide direct referrals to clients encountered with substance abuse and mental health problems.

Men Who Have Sex With Men (Black and Anglo): Increased access to medical providers has been achieved by offering a wider variety of service locations in all areas of the EMA with three specific HIV/AIDS clinical care offices and a wide option of case management agencies. One such



case management agency solely serves gay/lesbian clientele. Treatment education/Outreach workers conduct outreach on the internet, on strolls, and in bars. The 2002 Palm Beach County Men Who Have Sex With Men Survey (Exhibit C, Section VI), indicate that an alarming percentage of men of all ages but primarily among young men, are practicing unprotected anal sex, regardless of HIV status awareness. Outreach workers that identify new clients can link them directly to the HIV/AIDS Coordinated System of CARE.

Women of Child-Bearing age (13+): Females comprise close to 50 percent of recent HIV cases in Palm Beach County. Black females constitute close to 70 percent of those cases. More than one-third of the health professionals providing primary outpatient medical care services in the Coordinated Services Network are women. Five of the primary medical care service sites in the EMA have female health care providers working in them. Health Department clinics schedule pediatric services at the same time as women's appointments to reduce the number of required trips for medical care. Women living with HIV spectrum disease can enroll in the network through any of the 11 enrollment sites throughout the EMA, each with female case managers who are familiar with women's needs as they relate to HIV/AIDS.

Recent Entrants: This includes Haitians, Mayan Indians, Caribbean Islanders and Central and South Americans. Four of the 11 enrollment centers for the Coordinated System of CARE are operated by minority community-based organizations dedicated to working with recent entrants (e.g., immigrants and refugees). Among primary medical care service providers, one is Haitian, one is African, several Hispanic and one Mayan Indian. Three service centers are located in Delray Beach in the Southern portion of the EMA. They serve a primarily Haitian population. Two service centers operate in the middle coastal region, in Lake Worth and serve an Hispanic/ Mayan Indian/ Mexican population. Three service centers are located in the western section of the county which serves the most diverse migrant population: Mayan, Mexican, Jamaican, West Indian, Caribbean Islander, Central and South American and Middle Eastern, and Haitian. The Northern part of the county is primarily African American and urban yet, there are emerging pockets of all above named populations. Through the school district, migrant and recent entrant youth are being targeted for prevention. Special attention is given to the cultural and language needs of these vulnerable populations. Outreach workers are trained to locate and work with these populations and build trust for medical care services. Education efforts work to erase the stigmatization associated with HIV in this community and override existing cultural/religious barriers such as Voodoo and Santaria rituals to 'cure' HIV disease.

Table 3: Assessment of Populations with Special Needs: Assessment of Populations with Special Needs

Data for special populations was derived by using 2000 census data for the EMA and extrapolating percentages based on historical data.

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| EMA: West Palm Beach |
| Population: Youth 13-24 years old |
| <u>Estimated</u> number of persons in this population in the EMA (all persons, regardless of HIV status): <u>110,000</u> |
| <u>Estimated</u> number of persons in this population in the EMA living with AIDS: <u>290</u> |
| <u>Estimated</u> number of persons in this population in the EMA with HIV infection (including AIDS): <u>400</u> |
| <u>Estimated</u> HIV prevalence rate in the EMA for this population: Neither numerator nor denominator is available to calculate rate. Florida Department of Health does not have adequate HIV reporting data to determine this prevalence |
| Briefly describe this population. Include the geographic distribution in the EMA, income level, any language barriers, and other characteristics. Youth are distributed throughout the county, speak primarily English and live in all ethnic and socio-economic categories. Among those currently diagnosed, most are Medicaid recipients and many abuse drugs. Too few have been diagnosed to form definitive characteristics of the group. The needs assessment states that approximately 96% of youth living with HIV/AIDS are due to vertical transmission. |
| What are the HIV infection and risk trends in this population? The primary risk among youth is risky sexual behavior (i.e. multiple partners, unprotected sex.) Affected youth who are children of infected parents tend to demonstrate risk-taking behaviors. Recreational alcohol and other drug use in this population also contributed to the likelihood of risky behavior. This population has high STD rates. Other risk factors include the refusal of social and educational institutions to educate teens about sexual behavior and condom use, young teens having few "positive" role models, gay teens experimenting with "bare backing" and Russian Roulette (engaging in unprotected sex with multiple partners, some of whom are HIV infected.) |
| Describe the HIV/AIDS service needs of individuals in this population who know their status and who <u>are</u> in primary medical care. Youth who are identified as HIV-infected receive a full compliment of medical care and support services, although services are not always tailored to youth. Many in this group are not tested for HIV, and due to their perceived immortality, many do not even consider that they could be infected. Needs assessment focus groups identified the following youth-related needs: increased, age-appropriate treatment, education and outreach; creation of teen support groups; mentors; changes in the foster care system to address the needs of HIV/AIDS youth; financial assistance for moving from foster care to independent living facilities; transportation; legal assistance and job skills training. |
| Describe the extent to which members of this population <u>are not</u> in a system of HIV/AIDS care. Provide quantitative estimates or discuss efforts by the Planning Council to gather and use quantitative data to identify and address the unmet HIV/AIDS service needs of members of this population who are not currently in the health-care system. CDC estimates that at least a quarter of all new infections occurs in this group. This is not showing up in the health care system. Very few positive youth have been identified. Epidemiological data compiled for Table 1 indicates that there were 15 new reports of AIDS in the 13-19 year old age group For those not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. The Planning Council is working to identify more HIV positive youth and link them with care as well as expand capacity on the CARE Council to include youth. The Care Council seeks to improve access to care for this population primarily through the culturally, ethnically and age-appropriate case management and information. Outreach efforts target individuals who are not currently receiving primary care, especially those who know their HIV status. |
| Describe the HIV/AIDS service needs of those individuals who know their status and <u>are not</u> in primary medical care. |

EMA: West Palm Beach

Population: Youth 13-24 years old

It is estimated that approximately 12% of the population is either in a private system of care or without any primary medical care. This population is greatly underrepresented in appropriate services and planning for HIV/AIDS services. They lack advocates that can articulate their needs and implement services. Primary medical care and pharmaceuticals are needed by youth who are not receiving medical care. Like their contemporaries who know their status and are in primary care a full range of age-appropriate services are needed including: increased, age-appropriate treatment, education and outreach; creation of teen support groups; mentors; changes in the foster care system to address the needs of HIV/AIDS youth; financial assistance for moving from foster care to independent living facilities; transportation; legal assistance and job skills training.

Discuss how members of this population were involved in the Need Assessment upon which the Planning Council based its service priority and funding allocation decisions?

Youth are not represented on the CARE Council. Members of this population participated in the Needs Assessment and priority setting process primarily through focus groups and interviews.

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| EMA: West Palm Beach |
| Population: Injecting Drug Users (IDUs) |
| <u>Estimated</u> number of persons in this population in the EMA (all persons, regardless of HIV status): <u>10,000</u> |
| <u>Estimated</u> number of persons in this population in the EMA living with AIDS: <u>1217</u> |
| <u>Estimated</u> number of persons in this population in the EMA with HIV infection (including AIDS): <u>3717</u> |
| <u>Estimated</u> HIV prevalence rate in the EMA for this population: Neither numerator nor denominator is available to calculate rate. Florida Department of Health does not have adequate HIV reporting data to determine this prevalence rate. |
| Briefly describe this population. Include the geographic distribution in the EMA, income level, any language barriers, and other characteristics. While the population is located throughout the EMA, concentrations are found along the coast in the communities of Riviera Beach, West Palm Beach and Delray Beach. Another concentration is located in the rural Glades area in the western portion of the EMA. The population is predominately African American, with a low to very low-income level and most are English speakers. Many have a prison or arrest history for drug use. Mental illness is frequently a co-morbidity creating a triple diagnosis. |
| What are the HIV infection and risk trends in this population? This is mostly a male population but the number of female IDUs is increasing. They frequently exchange sex with both male and female partners for drugs and/or money. The population is often homeless, is often in and out of prison and have mental illness as a co-morbidity. |
| Describe the HIV/AIDS service needs of individuals in this population who know their status and who <u>are</u> in primary medical care. It is challenging to enroll IDUs in care programs. Their motivation to follow treatment regimens is low. Ideally, entry into the service system should be through substance abuse treatment which links directly with appropriate medical care, medications, mental health counseling and long-term housing support in a recovery-oriented environment. However this type of program does not currently exist. The state funds a limited number of detox and residential treatment beds and the waiting list can range from weeks to months. The 2000 Needs Assessment Survey revealed that the population used the following services: primary medical care, laboratory tests, prevention, medical referrals, vitamins and health food, ADAP, insurance, case management, group support and food bank. |
| Describe the extent to which members of this population <u>are not</u> in a system of HIV/AIDS care. Provide quantitative estimates or discuss efforts by the Planning Council to gather and use quantitative data to identify and address the unmet HIV/AIDS service needs of members of this population who are not currently in the health-care system. Florida Department of Health statistics for the state indicate that approximately 25% of IDUs are HIV positive. Based on the AIDS prevalence indicated in Table 1 for IDUs, there is a significant number who are either in private health care systems or who are not receiving care. For those not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Unmet service needs for this population include substance abuse treatment, mental health counseling, vocational training and housing assistance in a sober environment. The lack of long-term follow-up care and long waiting lists create barriers to adequately serving this population. |
| Describe the HIV/AIDS service needs of those individuals who know their status and <u>are not</u> in primary medical care. For those not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Unmet service needs for this population include substance abuse treatment, mental health counseling, vocational training and housing assistance in a sober environment. The lack of long-term follow-up care and long waiting lists create barriers to adequately serving this population. The 2000 Needs Assessment Survey revealed that the population used the following services: primary medical care, laboratory tests, prevention, medical referrals, vitamins and health food, ADAP, insurance, case management, group support and food bank. |

Discuss how members of this population were involved in the Need Assessment upon which the Planning Council based its service priority and funding allocation decisions?

Members of this population participated in the Needs Assessment and priority setting process through the CARE Council, focus groups, interviews and public meetings. Members of this group were present at the full Planning Council meeting where final decisions were made.

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| EMA: West Palm Beach |
| Population: Other substance users* |
| <u>Estimated</u> number of persons in this population in the EMA (all persons, regardless of HIV status): <u>90,495</u> (Florida's current use rate for those aged 12 and older is estimated at between 7.5% and 8% of the total population- Florida Drug Control Strategy, 1999) |
| <u>Estimated</u> number of persons in this population in the EMA living with AIDS: Information not reported by the HARS system. |
| <u>Estimated</u> number of persons in this population in the EMA with HIV infection (including AIDS): Information not reported by the HARS system. |
| <u>Estimated</u> HIV prevalence rate in the EMA for this population: Information lacking to determine prevalence. |
| Briefly describe this population. Include the geographic distribution in the EMA, income level, any language barriers, and other characteristics. Local and state data do not separate IDUs and other substance abuser. HIV infection rates can be assumed to be lower in the general population of substance abusers as opposed to IDUs but their needs for services would be very similar. The population is located throughout the EMA with concentrations found along the coast in the communities of Riviera Beach, West Palm Beach and Delray Beach. Substance abusers are also located in the rural Glades area in the western portion of the EMA. The population is spread across all social, racial and ethnic populations. |
| What are the HIV infection and risk trends in this population? Florida's Department of Children and Families (DCF) reports that the rates of illicit drug abuse by Florida teens are significantly higher than the national rates for several types of drugs. Using 1995 Monitoring the Future (University of Michigan) national data, DCF compared Florida rates of current use for Alcohol, Tobacco, Marijuana, Cocaine and Inhalants by 8 th , 10 th and 12 th graders. Some of the more shocking differences are: 1) current marijuana use rates among 8 th graders: Florida is 54% higher than the national rate; 2) the cocaine use rate is almost 3 times higher for 10 th graders, and more than 3 times higher for 12 th graders. This is of concern because drug-related behavior that is developed as teens will often follow young people into adulthood. The resulting risk-taking behaviors lend themselves to unprotected sex with multiple partners. |
| Describe the HIV/AIDS service needs of individuals in this population who know their status and who are in primary medical care. It is challenging to enroll substance abusers in care programs. Their motivation to follow treatment regimens is low. Ideally, entry into the service system should be through substance abuse treatment which links directly with appropriate medical care, medications, mental health counseling and long-term housing support in a recovery-oriented environment. However this type of program does not currently exist. The state funds a limited number of detox and residential treatment beds and the waiting list can range from weeks to months. Additionally, the needs for youth and those for adults can vary greatly with youth reporting greater needs in support services such as age-appropriate treatment, education and outreach; creation of teen support groups; mentors; changes in the foster care system to address the needs of HIV/AIDS youth; financial assistance for moving from foster care to independent living facilities; transportation; legal assistance and job skills training. |
| Describe the extent to which members of this population are <u>not</u> in a system of HIV/AIDS care. Provide quantitative estimates or discuss efforts by the Planning Council to gather and use quantitative data to identify and address the unmet HIV/AIDS service needs of members of this population who are not currently in the health-care system. Florida Department of Health statistics for substance abusers do not estimate the number that may be HIV positive. As with IDUs and youth, it can be concluded that a significant number are either in private health care systems or do not receive care. For those not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Unmet service needs for this population include substance abuse treatment, mental health counseling, vocational training and housing assistance in a sober environment. The lack of long-term follow-up care and long waiting lists create barriers to adequately serving this population. Additionally, prevention and early intervention is needed that target youth. |

EMA: West Palm Beach

Population: Other substance users*

Describe the HIV/AIDS service needs of those individuals who know their status and are not in primary medical care. For those not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Unmet service needs for this population include substance abuse treatment, mental health counseling, vocational training and housing assistance in a sober environment. The lack of long-term follow-up care and long waiting lists create barriers to adequately serving this population.

Discuss how members of this population were involved in the Need Assessment upon which the Planning Council based its service priority and funding allocation decisions? Members of this population were not identified to participate in the Needs Assessment.

*The Florida Department of Health, HIV/AIDS Bureau does not track Other Substance Users. The Florida Department of Children and Families, Substance Abuse and Mental Health Division does not track IDUs separately from other users. Risks and needs are perceived to be similar to IDUs with an emphasis on prevention for youth.

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| EMA: West Palm Beach |
| Population: Men of color who have sex with men (Black & Hispanic) |
| <u>Estimated</u> number of persons in this population in the EMA (all persons, regardless of HIV status): <u>29,184</u> |
| <u>Estimated</u> number of persons in this population in the EMA living with AIDS: <u>1779</u> |
| <u>Estimated</u> number of persons in this population in the EMA with HIV infection (including AIDS): <u>2899</u> |
| <u>Estimated</u> HIV prevalence rate in the EMA for this population: Neither numerator nor denominator is available to calculate rate. Florida Department of Health does not have adequate HIV reporting data to determine this prevalence |
| Briefly describe this population. Include the geographic distribution in the EMA, income level, any language barriers, and other characteristics. The population resides throughout Palm beach County with concentrations in the coastal, urban communities of West Palm Beach, Riviera Beach, Delray Beach as well as the rural Glades area. The population includes both Blacks and Hispanics so the language is either English or Spanish with some Haitians speaking Creole. Incomes can vary widely, although many in this population live in poverty. Many of the men have a history of incarceration and do not readily admit to same-sex behavior. |
| What are the HIV infection and risk trends in this population? There is a high rate of substance abuse among this population that leads to high-risk behavior. Stigmatization based on race and sexual behavior often contributes to denial of same-sex behavior resulting in lack of preparation for low-risk encounters. Homelessness is a factor for some men in this population who will exchange sex for money. |
| Describe the HIV/AIDS service needs of individuals in this population who know their status and who <u>are</u> in primary medical care. Men who have sex with men were the earliest group affected by HIV/AIDS in the EMA and continue to bear a large burden of AIDS, HIV infection and risk of infection. As of 1999, 43% of the total exposure category of cumulative AIDS cases for the EMA was comprised of MSM. An increasing number of self-identified men of color who have sex with men are accessing care. This has been achieved by creating more service access sites throughout the EMA and through outreach targeting minority populations in general. Adherence to medication regimens remains an issue as does culturally sensitive support services. In general Black men enter treatment later in the disease spectrum than other populations so early intervention efforts must be increased targeting this population. The 2000 Needs Assessment Survey indicated the least amount of service gaps and service barriers among MSM. The survey reported high rates of needing and using dental care, primary medical care, laboratory tests, medical referrals, medical information, telephone referrals, case management, support groups, mental health counseling and legal services. |
| Describe the extent to which members of this population <u>are not</u> in a system of HIV/AIDS care. Provide quantitative estimates or discuss efforts by the Planning Council to gather and use quantitative data to identify and address the unmet HIV/AIDS service needs of members of this population who are not currently in the health-care system. The cumulative number of HIV cases among MSM (a more recent and therefore more representative picture of the virus in the county) is 14% as of 9/30/2000. A significant number are either in private care or are not receiving care. For those not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Unmet service needs for this population include cultural and linguistically appropriate substance abuse and mental health services are needed. Services must be sensitive to the lack of acceptance among Black and Hispanic cultures for men who have sex with men. Correctional facilities pose barriers to adequately educating inmates, identifying those who are HIV-infected, and providing access to care. Estimates of the population NOT in care have been inconsistent and the CARE Council is pursuing additional outreach to improve data for this population. The Care Council seeks to improve access to care for this population primarily through the culturally and ethnically appropriate case management and information. Outreach efforts target individuals who are not currently receiving primary care, especially those who know their HIV status. |
| Describe the HIV/AIDS service needs of those individuals who know their status and <u>are not</u> in primary medical care. For those who know their status and are not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Unmet service needs for this population include cultural and linguistically appropriate outreach, substance abuse and mental health services. Services must be sensitive to the lack of acceptance among Black and |

EMA: West Palm Beach

Population: Men of color who have sex with men (Black & Hispanic)

Hispanic cultures for men who have sex with men. Correctional facilities pose barriers to adequately educating inmates, identifying those who are HIV-infected, and providing access to care. Estimates of the population NOT in care have been inconsistent and the CARE Council is pursuing additional outreach to improve data for this population. The Care Council seeks to improve access to care for this population primarily through the culturally and ethnically appropriate case management and information. Outreach efforts target individuals who are not currently receiving primary care, especially those who know their HIV status.

Discuss how members of this population were involved in the Need Assessment upon which the Planning Council based its service priority and funding allocation decisions?

Members of this population participated in the Needs Assessment and priority setting process through the CARE Council, focus groups, interviews and public meetings. These men are significant participants in various data gathering efforts relating to HIV/AIDS services within the community. Data regarding this population was considered during priority and funding deliberations. Members of this group were present at the full Planning Council meeting where final decisions were made.

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| EMA: West Palm Beach |
| Population: White/Anglo men who have sex with men |
| <u>Estimated</u> number of persons in this population in the EMA (all persons, regardless of HIV status): <u>79,185</u> (7% of the total population) |
| <u>Estimated</u> number of persons in this population in the EMA living with AIDS: <u>788</u> |
| <u>Estimated</u> number of persons in this population in the EMA with HIV infection (including AIDS): <u>1,435</u> |
| <u>Estimated</u> HIV prevalence rate in the EMA for this population: Neither numerator nor denominator is available to calculate rate. Florida Department of Health does not have adequate HIV reporting data to determine this prevalence |
| Briefly describe this population. Include the geographic distribution in the EMA, income level, any language barriers, and other characteristics. This population is found throughout the EMA but the majority resides along the urban coastal area from Jupiter to Boca Raton. They speak generally English and have incomes that vary widely from poverty to affluence. The greatest at-risk sub-populations are young gay males, commercial sex workers and substance abusers. |
| What are the HIV infection and risk trends in this population? Interviews with this population that young gay men frequently practice unprotected sex. Many in this population spend significant amounts of time in nearby Ft. Lauderdale and Miami's South Beach where HIV-infection among the gay population is higher. Locally, HIV prevention messages are not as prevalent in the gay media as they were five to 10 years ago, indicating a decreased vigilance and lower perceived threat of HIV. |
| Describe the HIV/AIDS service needs of individuals in this population who know their status and who <u>are</u> in primary medical care. The population has a high rate of success in accessing medical care and antiviral medications. Adherence to treatment regimens in this population varies. Those who are not living in poverty tend to use complimentary therapies more than other populations. A segment of this population serves in an advocacy role to assist other in accessing quality care. |
| Describe the extent to which members of this population <u>are not</u> in a system of HIV/AIDS care. Provide quantitative estimates or discuss efforts by the Planning Council to gather and use quantitative data to identify and address the unmet HIV/AIDS service needs of members of this population who are not currently in the health-care system. As this group generally is well educated, employed and insured, the majority of this population who know their HIV status are probably in care. Some members of the population who don't have insurance or who fear using it (especially in self-insured companies) may fall through the cracks with incomes too high for programs like Medicaid and too low to pay for care out of pocket. Some men in this group also fear the stigma of being identified and shun both testing and care. For those not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Unmet service needs for this population include outreach, counseling and testing appropriate for this population. Young gay men do not typically gravitate to established programs which serve older clients. Lack of education and peer support are other barriers in care. Estimates of this population NOT in care been inconsistent. The CARE Council is pursuing additional outreach to improve data for those not in care. The Care Council seeks to improve access to care for this population primarily through the culturally and ethnically appropriate case management and information. Outreach efforts target individuals who are not currently receiving primary care, especially those who know their HIV status. |
| Describe the HIV/AIDS service needs of those individuals who know their status and <u>are not</u> in primary medical care. For those who know their status and are not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Unmet service needs for this population include: age-appropriate outreach, substance abuse and mental health services. Estimates of the population NOT in care have been inconsistent and the CARE Council is pursuing additional outreach to improve data for this population. The Care Council seeks to improve access to care for this population primarily through appropriate case management and information. Outreach efforts target individuals who are not currently receiving primary care, especially those who know their HIV status. |

Discuss how members of this population were involved in the Need Assessment upon which the Planning Council based its service priority and funding allocation decisions?

Members of this population participated in the Needs Assessment and priority setting process through the CARE Council, focus groups, interviews and public meetings. These men are significant participants in various data gathering efforts relating to HIV/AIDS services within the community. Data regarding this population was considered during priority and funding deliberations. Members of this group were present at the full Planning Council meeting where final decisions were made.

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| EMA: West Palm Beach |
| Population: Women of child bearing age (13 years old and older) |
| <u>Estimated</u> number of persons in this population in the EMA (all persons, regardless of HIV status): <u>402,445</u> |
| <u>Estimated</u> number of persons in this population in the EMA living with AIDS: <u>1160</u> |
| <u>Estimated</u> number of persons in this population in the EMA with HIV infection (including AIDS): <u>1950</u> |
| <u>Estimated</u> HIV prevalence rate in the EMA for this population: Neither numerator nor denominator is available to calculate rate. Florida Department of Health does not have adequate HIV reporting data to determine this prevalence |
| Briefly describe this population. Include the geographic distribution in the EMA, income level, any language barriers, and other characteristics. The overall population of women in the EMA is predominately white and middle class and composes 51.7% of the total. Of the EMAs adults living with HIV/AIDS, 36% are women. Women compose 32% of the cumulative number of AIDS cases and 47% of the HIV cases since 1997. Women with HIV/AIDS are mostly minorities in the EMA. The distribution of race/ethnicity is 16% White, 79% Black and 5% Hispanic. The current age group with the highest proportion of reported HIV/AIDS cases is 30-39. Women with HIV/AIDS live throughout the EMA and many are living in poverty and have no health insurance. The majority speaks English but some are not U.S. citizens. |
| What are the HIV infection and risk trends in this population? HIV and AIDS incidence continues to increase in this population especially among African American women. Male partners with a history of incarceration pose a significant risk for women, especially minorities who are over-represented in the prison/jail population. Heterosexual contact with an infected partner remains the highest transmission route. While drug use among this population is considered to be fairly minimal, reports indicate a growing number. |
| Describe the HIV/AIDS service needs of individuals in this population who know their status and who <u>are</u> in primary medical care. According to the 2000 Needs Assessment, women in the EMA are estimated to account for 32% of the cumulative number of AIDS cases and 47% of the HIV cases since 1997. Women, especially women of color are more likely to receive care than their male counterparts. Women who are receiving medical care are also receiving pharmaceuticals and non-medical support services. Women with children frequently enter the service system much later in the progression of the disease. Support services such as childcare and transportation are a factor in women maintaining their health regimens. |
| Describe the extent to which members of this population <u>are not</u> in a system of HIV/AIDS care. Provide quantitative estimates or discuss efforts by the Planning Council to gather and use quantitative data to identify and address the unmet HIV/AIDS service needs of members of this population who are not currently in the health-care system. Women are typically not assessed for HIV infection risk when presenting with symptoms of HIV disease. In fact, women are more likely than men to be reported initially without a risk for HIV because both women and their care providers may not recognize or report risk behaviors of the woman or her partners. Weak linkages between testing/counseling sites and the coordinated service system can delay medical care and treatment for newly diagnosed individuals. Estimates of this population NOT in care been inconsistent. The CARE Council is pursuing additional outreach to improve data for those not in care. The Care Council seeks to improve access to care for this population primarily through the culturally and ethnically appropriate case management and information. Outreach efforts target individuals who are not currently receiving primary care, especially those who know their HIV status. |

Describe the HIV/AIDS service needs of those individuals who know their status and are not in primary medical care. For those who know their status and are not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Outside the full spectrum of medical case, unmet service needs for this population include: gender-appropriate outreach, education, transportation, and child care services. Estimates of the population NOT in care have been inconsistent and the CARE Council is pursuing additional outreach to improve data for this population. The Care Council seeks to improve access to care for this population primarily through appropriate case management and information. Outreach efforts target individuals who are not currently receiving primary care, especially those who know their HIV status.

Discuss how members of this population were involved in the Need Assessment upon which the Planning Council based its service priority and funding allocation decisions?

Women participated in the Needs Assessment and priority setting process through the CARE Council, focus groups, interviews and public meetings. Women are significant participants in various data gathering efforts relating to HIV/AIDS services within the community. Data regarding this population was considered during priority and funding deliberations. Members of this group were present at the full Planning Council meeting where final decisions were made.

| |
|---|
| EMA: West Palm Beach |
| Population: Haitians (Recent Entrants) |
| <u>Estimated</u> number of persons in this population in the EMA (all persons, regardless of HIV status): <u>50,000</u> (documented and undocumented) |
| <u>Estimated</u> number of persons in this population in the EMA living with AIDS: <u>612</u> |
| <u>Estimated</u> number of persons in this population in the EMA with HIV infection (including AIDS): <u>845</u> |
| <u>Estimated</u> HIV prevalence rate in the EMA for this population: Neither numerator nor denominator is available to calculate rate. Florida Department of Health does not have adequate HIV reporting data to determine this prevalence |
| Briefly describe this population. Include the geographic distribution in the EMA, income level, any language barriers, and other characteristics. The Haitian population is mainly found in the southern portion of the county and in the western rural communities. There is a mix of employed and unemployed and insured and uninsured. As the R.A.R.E. study revealed, language is a primary consideration for this population with the majority composed of Creole-speaking Haitian immigrants and a small, French-speaking minority. There is often concern about residency status and fears that accessing care could result in problems with immigration. There is also high illiteracy in this population. |
| What are the HIV infection and risk trends in this population? The mixing of alcohol, drugs and unprotected sex is practiced among Haitians. Although Haitian participants initially reported that IDU does not occur in the population, the R.A.R.E. study found that the assimilation and integration occurring among African American and Haitian youth promotes the sharing of drug practices, thus creating a bond of IDU substance abuse between the two cultures. Another finding of the report with regard to Haitian prostitution was that sex in exchange for commodities (rather than cash) was not considered prostitution but rather a form of "family contribution." The study also observed the Haitian culture is patriarchal and polygamous in which men are socially, economically and sexually dominant. Haitian women reported that they had no right to ask their male partners about fidelity and most did not feel comfortable asking their partners to wear condoms. In addition, the Haitian women did not feel they had the right to refuse sexual requests from their partners. Health Care District data indicate that the rates of STD and HIV infection among Haitians is higher than in other populations. |
| Describe the HIV/AIDS service needs of individuals in this population who know their status and who <u>are</u> in primary medical care. Because much of the community is poor and without insurance the full range of the continuum is needed. Additionally, the R.A.R.E. study of the Haitian community found that language barriers impede access to services because there are few Creole-speaking social workers and even fewer Creole-speaking health care workers providing HIV-related services. The continuum offers case management services provided by a Haitian agency which is helping to bridge service gaps. |
| Describe the extent to which members of this population <u>are not</u> in a system of HIV/AIDS care. Provide quantitative estimates or discuss efforts by the Planning Council to gather and use quantitative data to identify and address the unmet HIV/AIDS service needs of members of this population who are not currently in the health-care system. The majority of community experts interviewed for the R.A.R.E. report demonstrated a lack of understanding about HIV/AIDS prevention, risk, diagnosis and treatment indicating that many do not seek care. Haitian beliefs and preferred methods of treatment did not conform to mainstream medical protocols. Culturally, the population holds deep-seated voodoo beliefs that label HIV/AIDS diagnosed individuals as "cursed" resulting in stigmatism, social isolation and ostracism. Therefore many do not seek assistance or they resort to voodoo healing. The CARE Council is gathering data and learning about the special needs of this population in order to assess and meet the unmet needs of Haitians. The Care Council seeks to improve access to care for this population primarily through the culturally and ethnically appropriate case management and information. A Haitian case management agency currently serves the majority of this population. Outreach efforts target individuals who are not currently receiving primary care, especially those who know their HIV status. |

Describe the HIV/AIDS service needs of those individuals who know their status and are not in primary medical care. For those who know their status and are not in care, the entire continuum including medical care and pharmaceuticals remain unmet needs. Outside the full spectrum of medical case, unmet service needs for this population include: culturally-appropriate outreach, education, legal, peer support, substance abuse treatment, and financial assistance for housing.. Estimates of the population NOT in care have been inconsistent and the CARE Council is pursuing additional outreach to improve data for this population. The Care Council seeks to improve access to care for this population primarily through appropriate case management and information. Outreach efforts target individuals who are not currently receiving primary care, especially those who know their HIV status.

Discuss how members of this population were involved in the Need Assessment upon which the Planning Council based its service priority and funding allocation decisions?

A Haitian Task Force provided information and data regarding the population for review. The task force compiled their report by meeting with service providers familiar with the community as well as members of the Haitian community, conducting focus groups and surveys. Task Force data and information was considered during priority and funding deliberations. Members of this group were present at the full Planning Council meeting where final decisions were made.



Methods

The needs assessment process utilized face-to-face interviews to solicit input. The centerpiece of the process was the creation and distribution of written surveys to persons living with HIV/AIDS (PLWH/As) and receiving HIV/AIDS services throughout Palm Beach County. Six teams totaling 15 professionals were trained in data collection techniques and administered them in their geographic area or to their designated special-group. Respondents were paid \$15.00 for their participation by filling out the survey questionnaire. The number of targeted individuals for each geographic area or special group were determined by recent epidemiological distributions of the HIV-spectrum disease. A sampling frame was designed to choose the appropriate number of surveys to administer to each special population. The Sampling frame designed was as follows for a total of 400 respondents:

| | |
|--|----------------|
| 1. Northern Urban Blacks/Whites, Male/Female – | 75 respondents |
| 2. Men Who Have Sex With Men, Black, White, Hispanic | 50 respondents |
| 3. Hispanic/Guatemalan Indians, Male/Female ---- | 50 respondents |
| 4. Haitians/ Blacks from Delray, Belle Glade, Male/Female- | 75 respondents |
| 5. Central Coastal Blacks/Whites, Males/Females | 75 respondents |
| 6. Western Blacks/Whites, Males/Females | 75 respondents |

N= 400 respondents

More specific demographic data related to survey respondents is display on pages 52 - 57.

A. Consumer Surveys

The 2003 Consumer Survey targeted 400 persons living with HIV/AIDS throughout Palm Beach County. The survey was based on ones developed for Three Year Comprehensive Needs Assessments by Boston, Baltimore and Seattle EMA's and the Palm Beach County CARE Council. (See Appendix 2 for a copy of the consumer survey instrument.) The Needs Assessment Sub-Committee of the Palm Beach County HIV CARE Council workgroup oversaw the development of the survey instrument. Staff from the CARE Council and indigenous teams comprised of community experts from six special geographic/special populations were responsible for distribution, administration and collection of the survey. Staff from the CARE Council encoded data and performed the analysis and interpreted the results.

The HIV CARE Council sought to collect information on a wide spectrum of persons living with HIV/AIDS in Palm Beach County, ranging from individuals who were HIV positive yet not symptomatic to persons with end-stage illness. The process emphasized traditionally under served populations, including people of color; White men having sex with men; men of Color having sex with men; injection drug users; women; Haitians; adolescents and Hispanics/Guatemalans. Surveyors were selected for their neighborhood appropriateness and their ability to speak either English, Spanish, a dialect of Guatemalan Mayan spoken by local Mayan Indians and Creole.



The survey questionnaire inquired about 48 types of HIV/AIDS related services offered in the Palm Beach County Continuum of Care. Consumers identified each service as either ones they needed and used, did not need, needed but could not get or, could get but did not use. Additionally, comments were solicited to provide a depth of understanding and identify barriers of care. Consumers were also asked to choose up to seven of the services that they would consider to be most important for them. The survey also collected basic demographic information including information specific to HIV/AIDS health status and current living situations.

In creating the survey instrument, the Palm Beach County HIV CARE Council made extensive efforts to safeguard the confidentiality of survey respondents. Survey instructions explicitly stated that consumers were not to include their names, addresses or phone numbers on completed survey instruments.

Data Collection Training

The trainees were paid \$25.00 to attend a two-and-one-half-hour training relating to this project (The Needs Assessment Training Protocol appears in the back as Appendix C). The participants received training on confidentiality and signed a State of Florida Confidentiality Statement. The survey instrument was read aloud and questions were solicited to clarify the data collection procedures. Fifteen individuals were selected to participate in the Needs Assessment Survey. These individuals were paid \$10.00 for each finished survey for a total of \$4000 paid to data collection team members. After each week for a total period of two months(January until March,2003), the data collectors delivered the completed surveys to the health planner for payment and data encoding.

Anecdotally, the data collectors spoke of wanting to more fully participate in the functions of the Palm Beach County HIV CARE Council as an unanticipated benefit of data collection involvement. Each data collector submitted names of area-appropriate agencies and meeting spots to the HIV CARE Council Health Planner. The Health Planner reviewed this submitted list with the six teams and together they determined a master-list of agencies, private doctors' offices and public meeting places to administer the survey questionnaires to HIV-positive individuals in Palm Beach County.

B. Provider Surveys

The Palm Beach County HIV CARE Council created and distributed "key informant" provider surveys at the 'Providers' monthly meeting held in April 2003. The agency representatives which attended this meeting were asked to complete a 20 minute survey questionnaire relating to HIV/AIDS services in Palm Beach County. The "key informant" provider questionnaires sought to gather information from administrators and case managers. The council's aim was to gather service priority and service gap data through written provider surveys from both tiers of agency employees. The council believed that provider service data would offer important comparisons to consumer-identified service priorities and gaps. (See Appendix C for a copy of the provider survey instrument.)



The survey collected data from agencies providing services to persons living with HIV/AIDS in Palm Beach County. This direction emerged from the Palm Beach County HIV CARE Council: Needs Assessment Sub-Committee. The provider survey distribution was accomplished by administering questionnaires to all attendees at the April 2003 Providers Meeting. Respondents were given verbal instructions and allowed sufficient time to complete the survey. There were a total of 10 participating agencies across four sites. More than one representative from participating agencies filled out the questionnaires accounting for the total provider survey number equaling 17.

The survey inquired about the types of services offered by the provider, identified trends or changes that they observed in their clientele and a brief categorical health indicator breakdown regarding the provider's HIV/AIDS clientele. Using the same list of 48 HIV/AIDS-related services that appeared on the consumer survey, providers were asked to identify up to seven services that they believed were most important for their client populations. The survey presented the same list again so that the providers could check off each service that they felt was needed by a substantial number of their clients, but that clients were having trouble accessing. The second list created a lack of access or gap identification by providers: 20 surveys were distributed across providers at the Providers' April meeting and the CARE Council received a total of 17 valid responses, for a return rate of 85.0 %.

D. Provider Annual Administrative Reports

In order to capture quantitative and descriptive information pertaining to providers, a review tabulation and analyses were completed to view service inventory, utilization and basic clientele demographics. The survey collected information from seventeen providers of services delivered to persons living with HIV/AIDS in Palm Beach County. These included primary medical care providers, case management agencies, mental health and substance abuse professionals and housing providers in Palm Beach County.

Forty-eight variables relating to client demographics, provider descriptors, service inventory, number of clients served, and funding comprised this component of the data collection.

The Health Planner from the Palm Beach County HIV CARE Council reviewed all of the annual administrative reports submitted. Tables of client and provider demographics, service inventory and consumer count lists, funding stream amounts were displayed to describe this EMA from an administrative service perspective. The purpose undergirding this effort was to determine gaps in availability and utilization.

General Findings from the Consumer and Provider Surveys

A. Distribution and Response

Consumer Surveys

The Palm Beach County HIV CARE Council delivered a total of 400 surveys to various sites



throughout Palm Beach County, including 16 agencies at a total 7 geographic sites. A variety of methods were made available for consumers to complete surveys bearing in mind differences and requests. For example, if the data collector saw that a respondent was unable to read the survey document, the data collector was trained to read the document to the respondent then, fill in appropriate responses. The Palm Beach County HIV CARE Council received a total of 400 valid consumer responses, for a return rate of 100 percent. This represents approximately ten percent of the of the estimated 3,500 persons living with HIV/AIDS and 'in care' in Palm Beach County. While external validity was attempted and achieved by face-value, true validity and therefore, generalizability were not achieved. The instrument was not standardized therefore, content, convergent, discriminant and criterion-related validity were not attempted therefore, not achieved. Acceptable reliability rates were obtained however, on the instrument utilizing calculations based on those participating in the study. This means that the survey scale was reliable and representative of those consumers who participated in the needs assessment only. Information contained within this study is not meant to be reflective of all HIV/AIDS consumers in Palm Beach County although survey demographics were similar to HIV/AIDS county demographics. Table 4 displays survey returns by type of survey administration/distribution source.

Table 4: Consumer Survey Returns by Distribution, Source ¹

| Distribution Site | # administered | # Returned | % of Total N=400* | % of Grande N=3,500** |
|------------------------|----------------|------------|-------------------|-----------------------|
| Data Collectors | | | | |
| North Coastal: Riviera | 100 | 100 | 25% | 2.8% |
| Central Coastal: WPB | 85 | 85 | 21.00% | 2.4% |
| West Boynton | 10 | 10 | 2.00% | 0.28% |
| Delray | 60 | 60 | 15.00% | 1.70% |
| Lake Worth | 30 | 30 | 7.50% | 0.85% |
| Western PB | 115 | 115 | 28.75% | 3.2% |

** The Grande N represents the total number of individuals who are P/HLWA'S 'In Care' in Palm Beach County.

* The % of total refers to the total number of consumer participants in the 2003 Needs Assessment

Provider Surveys

The Palm Beach County HIV CARE Council mailed a total of 40 provider surveys to the providers of case management in Palm Beach County. The agencies that deliver case management included primary medical care providers, housing and all social services. No Provider Surveys were returned by March 30, 2003. Another tactic was utilized whereby, administrators and front-line case workers both filled out the surveys and returned the surveys at the Providers' April meeting held at the Title I grantee's office. The CARE Council received a total of 17 out of 20 valid responses, for a return ratio of 85.5 %.

The surveys were coded by provider type to enable the Palm Beach County HIV CARE Council to track return rates. Table 5 shows a breakout of survey returns by provider type (N= 17).



Table 5: Provider Survey Returns by Provider Type (N=17)*

| Primary Service Provided | # Administered | # Returned | % of Total |
|--------------------------|----------------|------------|--------------|
| Medical | 3 | 3 | 3/17=0.176 |
| Case Management | 10 | 8 | 8/17=0.470 |
| Housing | 7 | 2 | 2/17=0.117** |

* Distributed at April 2003 Providers' Meeting

** The total of less than 100 % is accounted for by the incomplete response rate. Not all those who received surveys completed surveys.

B. Consumer Survey Demographics

In general, demographic responses on the consumer survey suggest a fairly representative sampling of persons living with HIV/AIDS in Palm Beach County (Table 6). Characteristic labels appear first followed by consumer survey respondents for 2003, second, consumer survey responses from 2000, and finishing with Palm Beach County PLWH/A's estimates for 2003 when available. Below, is the text which explains the accompanying table.

Sex: 54 % (n=216) of survey respondents were male; 43.5 % (n=174) were female; 1.6 (n=6) were transsexual; and 1.0 % (n=4) were other.¹

Race: 48 % (n=192) of survey respondents were African American; 0.03 % (n=1) were Native American; 0.03 % (n=1) were Asian; 18.0 % (n=72) were Haitian; 15.5 % (n=62) were White; 3 % (n=12) were Caribbean; 14.3 % (n=57) were Hispanic and 0.08 % (n=3) were other.¹

Zip: The most frequently responding zip codes were: 33460 (n=44, 1.0 %); 33430 (n=112, 28.0 %); 33407 (n=62, 15.5 %); 33404 (n=36, 9.0 %); 33462 (n=22, 5.5 %); 33444 (n=29, 7.3 %) and 33401 (n=33, 8.3 %).¹

Age: The minimum range of respondents ages were 16 and the maximum range was 72. The median age was 33. Nearly 80% of all respondents were less than 50 years old.¹

Annual Income: Nearly 70.0 % of all consumers indicated they had an average annual income of between 0-to-8,000 dollars. About 21.0 % reported they made between 8,001-16,000 yearly. Only 8.0 % of the consumers reported making more than 16,001 yearly.¹

¹ Not all percentages add to 100% because some survey participants did not respond to all questions.



Identity: 70.0 % of survey respondents indicated they were heterosexual; 21.00 % reported they were gay/lesbian, 6.3 % indicated they were bisexual and 2.8 % were non-responders.¹

Exposure Category: 22.0 % (n=88) of survey respondents reported being exposed to the virus by male to male sexual contact; 38.0 % (n=153) reported being infected by sex with males; 28.0 % (n=112) reported being infected by females; 2.8 % (n=11) reported being infected by sex with an IDU; and 3.8 % (n=15) reported exposure from sharing needles. Blood transfusions and the "other" category comprise almost 5.0 % of the survey responses accounting for 19 participants.

HIV Health Status: 35.0 % (n=141) of survey respondents reported being HIV positive asymptomatic; 32.0 % (n=129) were HIV positive symptomatic; 18.0 % (n=72) were AIDS diagnosed based on a low T-cell count; and 13.25 % (n=53) reported being AIDS-diagnosed based on an opportunistic infection.

Current HIV Medication Status: 49.75 % (n=199) of survey respondents reported taking anti-retroviral medications; 43.25 % (n=173) reported taking protease inhibitors, 12.3 % (n=49) take medication to treat opportunistic infections and 9.8 % (n=39) indicated that they take other drugs.¹

Other Demographic Variables: In general, 13.0 % of respondents had t-cell counts of less than 200; 22.3 % had viral loads below 200; 50.0 % of survey respondents reported not knowing either their current CD-4 counts nor viral loads; 45.5 % of participants tested positive since 1996; the majority of respondents (62.5 %) reported being infected by their partners; about two-thirds reported not being mentally ill; most participants (22.0 %) reported having two people living in their households or lived alone (33.8 %); and almost three-quarters reported having no children. Only 7.5 % had an HIV positive child. Most said they would apply for more benefits if their rent increased by \$50.00 and the majority indicated they would prefer to live in Coastal Palm Beach County if they required subsidized housing.

¹ Not all percentages add to 100% because some survey participants did not respond to all questions.



Table 6: Demographic Comparison of 2,003 Consumer Survey Respondents and Palm Beach County PLWH/As Estimates

| Characteristics | Consumer Survey Respondents (N=400) | | Palm Beach County Adult PLWH/A's Estimates (N=8,644) ² | |
|---|-------------------------------------|---------------------|---|--------------|
| | n | (%) | n | (%) |
| Sex | | | | |
| Male | 216 | (54 %) | 4,667 | (54 %) |
| Female | 174 | (43.5 %) | 3976 | (46 %) |
| Transgendered (Male to Female) | 3 | (0.08 %) | | ³ |
| Transgendered (Female to Male) | 3 | (0.08 %) | | |
| No Response/Other | 4 | (1.0 %) | | |
| Race | | | | |
| African American/Black (Not Hispanic) | 192 | (48 %) ¹ | 6,050 | (70 %) |
| American Indian/Native American | 1 | (0.3 %) | | |
| Haitian | 72 | (18 %) | | |
| Caucasian/White (Not Hispanic) | 62 | (15.5 %) | 1,901 | (22 %) |
| Caribbean Islander | 12 | (3 %) | | |
| Hispanic | 57 | (14.3 %) | 691 | (8 %) |
| Other | 3 | (0.8 %) | | |
| Zip Codes (top five) HIV Through '02 | Year 2003 Consumer Surveys | | Cumulative | |
| 1 | 33430 | (N=112) | 33444 | (N=245) |
| 2 | 33407 | (N=62) | 33404 | (N=235) |
| 3 | 33460 | (N=44) | 33407 | (N=229) |
| 4 | 33404 | (N=36) | 33401 | (N=202) |
| 5 | 33401 | (N=33) | 33430 | (N=146) |

¹ The discrepancy in totals reflects missing values on individual survey responses.. For example, not all survey participants indicated race, therefore the totals for race do not equal 100%.

² Palm Beach County DOH: HIV/AIDS Surveillance Bureau.

³ Palm Beach County DOH: HIV/AIDS Surveillance data do not include numeric breakouts on these variables therefore, comparisons are not available and not presented herein.



Table 6 (Cont.): Demographic Comparison of 2,003 Consumer Survey Respondents and Palm Beach County PLWH/As Estimates

| Characteristics | Consumer Survey Respondents (N=400) | | Palm Beach County Adult PLWH/A's Estimates (N=8,644) ² | |
|-----------------------|-------------------------------------|----------|---|--------------|
| | n | % | n | % |
| Age | | | | |
| < 13 | | | 25 | (0.03 %) |
| 16 - 21 | 6 | (1.5 %) | 128 | (0.4 %) |
| 22 - 30 | 46 | (11.5 %) | 6,050 | (70 %) |
| 31 - 40 | 124 | (31 %) | | |
| 41 - 50 | 132 | (33 %) | | |
| >50 | 72 | (18 %) | 2,161 | (25 %) |
| Income | | | | |
| 0 - \$8,000 | 276 | (69 %) | | ³ |
| \$8,000 - \$16,000 | 85 | (21 %) | | |
| \$16,001 - \$24,000 | 16 | (4 %) | | |
| \$24,001 - \$32,000 | 10 | (2.5 %) | | |
| \$32,001 - \$40,000 | 4 | (1 %) | | |
| >\$40,000 | 3 | (0.8 %) | | |
| Other | 6 | (1.5 %) | | |
| Identification | | | | |
| Straight/Heterosexual | 280 | (70 %) | | ³ |
| Gay/Lesbian | 84 | (21 %) | | |
| Bisexual | 25 | (6.3 %) | | |
| Other | 11 | (2.8%) | | |

¹ The discrepancy in totals reflects missing values on individual survey responses.. For example, not all survey participants indicated race, therefore the totals for race do not equal 100%.

² Palm Beach County DOH: HIV/AIDS Surveillance Bureau.

³ Palm Beach County DOH: HIV/AIDS Surveillance data do not include numeric breakouts on these variables therefore, comparisons are not available and not presented herein.



Table 6 (Cont.): Demographic Comparison of 2,003 Consumer Survey Respondents and Palm Beach County PLWH/As Estimates

| Characteristic | Consumer Survey Respondents (N=400) | | Palm Beach County Adult PLWH/A's Estimates (N=8,644) ² | |
|---|-------------------------------------|----------|---|--------------|
| | n | % | n | % |
| Exposure | | | | |
| Male to male sex | 88 | (22 %) | 1,383 | (16 %) |
| Sex with a man | 153 | (38 %) | 4,149 | (48 %) |
| Sex with a women | 112 | (28 %) | | |
| MSM/Sex with IDU | 11 | (2.8 %) | 129 | (1.5 %) |
| Sharing needles | 15 | (3.8 %) | 527 | (6.1 %) |
| Transfusion/Blood Products | 9 | (2.3 %) | 43 | (.005%) |
| Mother with HIV/AIDS | | | 5 | (0.83%) |
| Other | 12 | (5 %) | 2420 | (28 %) |
| Infected by Rape | 19 | (4.8 %) | | ³ |
| Infected by Partner | 250 | (62.5 %) | | |
| HIV/AIDS Status | | | | |
| HIV+, Without Symptoms | 141 | (35 %) | | ³ |
| HIV+, With Symptoms | 129 | (32 %) | | |
| AIDS Diagnosed (T-Cell) | 72 | (18 %) | | |
| AIDS Diagnosed (OI's) | 53 | (13 %) | | |
| First Positive = 52 % 1995 or before | | | | ³ |
| First Medical Treatment HIV = 35 % 1995 or before | | | | |
| First Other Services HIV = 25% 1995 or before | | | | |
| T-Cell / CD-4 Count | | | n | % |
| Don't Know | 213 | (53 %) | | ³ |
| <200 | 51 | (12.8 %) | | |
| 200 - 500 | 93 | (23 %) | | |
| >500 | 55 | (13.8 %) | | |

¹ The discrepancy in totals reflects missing values on individual survey responses.. For example, not all survey participants indicated race, therefore the totals for race do not equal 100%.

² Palm Beach County DOH: HIV/AIDS Surveillance Bureau.

³ Palm Beach County DOH: HIV/AIDS Surveillance data do not include numeric breakouts on these variables therefore, comparisons are not available and not presented herein.



Table 6 (Cont.): Demographic Comparison of 2,003 Consumer Survey Respondents and Palm Beach County PLWH/As Estimates

| Characteristics | Consumer Survey Respondents (N=400) | | Palm Beach County Adult PLWH/A's Estimates (N=8,644) ² | |
|----------------------------|-------------------------------------|----------|---|--------------|
| | n | % | n | % |
| Viral Load | | | | |
| Don't Know | 213 | (53 %) | | ³ |
| <200 | 89 | (22 %) | | |
| 200 - 1,000 | 27 | (6.8 %) | | |
| 1,001 - 10,000 | 34 | (8.5 %) | | |
| 10,001 - 100,000 | 27 | (6.8 %) | | |
| > 100,000 | 8 | (2 %) | | |
| Medications For HIV | | | | |
| Antiviral Medications | 199 | (49.75%) | | ³ |
| Protease Inhibitors | 173 | (43.25%) | | |
| Drugs to Prevent OI's | 49 | (12.3 %) | other drugs= n=39,9.8% | |
| Mental Illness | | | | |
| Yes | 67 | (16.8 %) | | ³ |
| No | 261 | (65.3 %) | don't know= n=70,17.5% | |
| 12 Month History | | | | |
| Jail/Prison | 37 | (9.3 %) | no response n=247 61.8 % | |
| Homelessness | 32 | (8 %) | | |
| Injecting Drugs (street) | 6 | (1.5 %) | | |
| Other Drug Abuse | 66 | (16.5 %) | | |
| Impairments | | | | |
| Blindness/Sight Impaired | 42 | (10.5 %) | | ³ |
| Deaf/Hearing Impaired | 7 | (1.8 %) | | |
| Wheelchair/Bed-Bound | 6 | (1.5 %) | | |
| Other | 343 | (85.9 %) | | |

¹ The discrepancy in totals reflects missing values on individual survey responses.. For example, not all survey participants indicated race, therefore the totals for race do not equal 100%.

²

³ Palm Beach County DOH: HIV/AIDS Surveillance Bureau.

³ Palm Beach County DOH: HIV/AIDS Surveillance data do not include numeric breakouts on these variables therefore, comparisons are not available and not presented herein.



Table 6 (Cont.): Demographic Comparison of 2,003 Consumer Survey Respondents and Palm Beach County PLWH/As Estimates

| Characteristics | Consumer Survey Respondents (N=400) | | Palm Beach County Adult PLWH/A's Estimates (N=8,644) ² | |
|---|-------------------------------------|----------|---|---|
| People in Household | $\bar{n} =$ | | | |
| Living Arrangements | n | % | n | % |
| Live Alone | 142 | (35.5 %) | | |
| With Spouse | 11 | (2.8 %) | | |
| With Spouse and Children | 35 | (8.8 %) | | |
| Friend(s)/Roommate(s) | 74 | (18.5 %) | | |
| Children, No Other Adults | 33 | (8.3 %) | | |
| Lover/Partner | 43 | (10.8 %) | | |
| Lover/Partner and Children | 2 | (12.5 %) | | |
| Parents/Family | 50 | (11%) | | |
| Other | 10 | (3.1 %) | | |
| Children under 18 | | | | |
| Yes | 109 | (27.3 %) | | |
| No | 282 | (70.5 %) | | |
| How Many Children HIV+ | 30 | (7.5 %) | | |
| What if Rent Increased \$50.00 | | | | |
| Move | 97 | (24.3 %) | | |
| Stop Taking Medicine | 7 | (1.8 %) | | |
| Borrow Money | 26 | (6.5 %) | | |
| Resort Criminal Behavior | 17 | (4.3 %) | | |
| Seek Additional Employment | 76 | (19 %) | | |
| Apply More Benefits | 112 | (28 %) | | |
| Other | 65 | (16.3 %) | | |
| Where Would You Live: Affordable Housing | | | | |
| Southern Palm Beach | 78 | (19.5 %) | | |
| Western Palm Beach | 92 | (23 %) | | |
| Central Palm Beach | 78 | (19.5 %) | | |
| Northern | 50 | (12.5 %) | | |
| None | 10 | (2.5 %) | | |
| All | 90 | (22.5%) | | |
| Other | 2 | (0.5%) | | |

¹ The discrepancy in totals reflects missing values on individual survey responses.. For example, not all survey participants indicated race, therefore the totals for race do not equal 100%.

² Palm Beach County DOH: HIV/AIDS Surveillance Bureau.

³ Palm Beach County DOH: HIV/AIDS Surveillance data do not include numeric breakouts on these variables therefore, comparisons are not available and not presented herein.



C. Provider Survey Demographics

The survey asked providers about some general descriptive characteristics of PLWH/A'S in Palm Beach County Florida.

Information was derived from provider agency- employees; executives or administrators and case managers. They were asked to characterize their agencies and their HIV/AIDS clientele by demographic indicators. (See Table 7). These characterizations were qualitative in nature and a content analysis was used to discern commonalities from comments. The accompanying text explains Table 7. The 17 provider key informants were asked to select seven services which they believed were most important for their clients and asked to use an identical list to select services which their clients need but, can't get. This comprises the quantitative component of the provider survey.

Array of Services Provided at Agency: Of the 17 Provider key informants responding to the survey, 35.3 % (n=6); indicated they provide case management; 11.8 % (n=2) provide housing;; 17.7 % (n= 3) provide medical services; 5.9 % (n=1) provide ADAP ; 17.6 % (n=3) provide legal services, and 11.8 % (n=2) provide substance abuse treatment.

HIV Health Status and Co-Morbids: The majority of participating providers indicated that their clients do adhere to medication protocol 58.8 % (N= 10); 29.4 % (n=5) report a HIV symptomatic health status, while 47% (n=8) reported a combination clientele health status range of HIV symptomatic to AIDS-diagnosed; 70.6 % (n= 12) report clientele have mental health-related issues; and 64.7 % (n= 11) observe substance abuse co-morbidities among their patients/clients.

Provider Surveys

Table 7: Characteristics of HIV/AIDS Consumers as Described by Providers

Array of Services Presented by Providers at the Providers Meeting

| Characteristics | n | Percent |
|---------------------------|----------|----------------|
| Case Management | 6 | 35.3% |
| Housing | 2 | 11.8% |
| ADAP | 1 | 5.9% |
| Legal/Permanency Planning | 3 | 17.6% |
| Substance Abuse Treatment | 2 | 11.8% |
| Outpatient Medical | 3 | 17.7% |



HIV Health Status and Co-Morbids

| Characteristics | N | Percent |
|----------------------------------|----|---------|
| Medication Non-Adherence | 4 | 23.5 % |
| Medication Adherence | 10 | 58.8 % |
| A diagnosed Mental Health Status | 12 | 70.6 % |
| AIDS and HIV Diagnosis | 8 | 47.1 % |
| HIV-symptomatic Consumers | 5 | 29.4 % |

¹ The duplicated numbers reflect duplicated votes from the providers. Additionally, totals that do not equal 100% are explained by other responses to specific questions.

D. Service Utilization Related to Consumers

Overall service utilization: The consumer survey inquired about 48 types of HIV/AIDS-related services offered in the Palm Beach County Continuum of Care. Consumers identified each service either as one they needed and used, did not need, needed but could not get or could get but won't use. Utilization rates were calculated based on services which consumers checked as "need and use." Cumulative responses are displayed in *Table 8*.

In order to make the data more useful in making planning and funding decisions, responses from the 48 services were collapsed into the Palm Beach County HIV CARE Council identified Ryan White service categories for reporting and clarification purposes. This was necessary because several Ryan White service categories include component services (e.g., the Ryan White category of "Counseling (emotional support)" includes one-on-one peer support, support groups and spiritual and religious counseling). (See *Appendix D* for the glossary which is a breakdown of the specific services associated with each Ryan White eligible service category.)

Consumers reported moderately high levels of utilization for medical services. 52.2 percent of respondents reported current use of outpatient medical care. There was a higher utilization of case management services 73.5 % yet, a low to moderate reporting of counseling/support services. There was a moderate to low utilization rate for housing, food services and utilities. There was a minimal utilization rate for alternative therapies, nursing, insurance, home health, transportation and employment-related services. Utilization increased with level of illness. This will be displayed and discussed on *page 60 - 63*.



Utilization

Table 8: Service Utilization from Consumer Surveys (N=400)

"Need and Use"

| Rank | Service | Responses | Percent |
|-------------|---|-----------|---------|
| 1 | Case Management | 294 | 73.5 % |
| 2 | Laboratory Tests | 288 | 72.0 % |
| 3 | Medical Referrals | 257 | 64.3 % |
| 4 | Medical Information <i>outreach HIV mtg Ed.</i> | 251 | 62.8 % |
| 5 | Dental | 246 | 61.5 % |
| 6 | HIV Prevention | 234 | 58.5 % |
| 7 | Benefits Information | 225 | 56.3 % |
| 7 | ADAP | 225 | 56.3 % |
| 8 <i>1A</i> | outpatient Medical Care | 211 | 52.8 % |
| 9 | Telephone referrals | 208 | 52.0 % |
| 10 | Help Filling out Govt. Forms | 207 | 51.8 % |
| 11 | Spiritual/Religious Counseling | 192 | 48.0 % |
| 12 | Groceries | 188 | 47.0 % |
| 13 | Getting Support Services | 187 | 46.8 % |
| 14 | Spiritual/Religious Services | 186 | 46.5 % |
| 15 | Transportation | 179 | 44.8 % |
| 15 | Food Bank | 179 | 44.8 % |
| 16 | Rent/Mortgage Payments <i>/Harassig</i> | 165 | 41.3 % |
| 17 | Support Groups <i>Counsel Other</i> | 149 | 37.3 % |
| 18 | Utility payments <i>Tr Emeg</i> | 146 | 36.5 % |
| 18 | Vitamins/Health Food <i>Advise/med</i> | 146 | 36.5 % |
| 19 | Help Finding Housing <i>housing Ref</i> | 142 | 35.5 % |



Table 8: (Cont.) Service Utilization from Consumer Surveys (N=400)

| Rank | Service | Responses | Percent |
|------|------------------------------|-----------|---------|
| 20 | Legal Assistance | 137 | 34.3 % |
| 21 | Peer Support <i>Advisory</i> | 119 | 29.8 % |
| 22 | Inpatient Hospital Care | 109 | 27.3 % |
| 23 | Mental Health Services | 108 | 27.0 % |
| 24 | Substance Abuse Services | 91 | 22.8 % |
| 25 | Help Paying for Insurance | 89 | 22.3 % |
| 26 | Peer Advocacy | 81 | 20.3 % |
| 27 | Hospital Discharge | 77 | 19.3 % |
| 28 | Help Finding a job | 72 | 18.0 % |
| 29 | Translation | 69 | 17.3 % |
| 30 | Clinical Trials | 64 | 16.0 % |
| 31 | Insurance Continuation | 57 | 14.3 % |
| 32 | Physical Therapy | 54 | 13.5 % |
| 33 | Massage Therapy | 52 | 13.0 % |
| 34 | Return to Work | 44 | 11.0 % |
| 35 | Acupuncture | 37 | 9.3 % |
| 36 | Adult Day Care/Respite | 36 | 9.0 % |
| 37 | Alternative Therapies | 35 | 8.8 % |
| 38 | Home Health Nurse Care | 31 | 7.8 % |
| 39 | Permanency Planning | 26 | 6.5 % |
| 40 | Home Delivered Meals | 25 | 6.3 % |
| 40 | Buddy/Companion | 25 | 6.3 % |
| 41 | Hospice | 23 | 5.8 % |
| 41 | Child Care | 23 | 5.8 % |
| 42 | Home Health Aid | 22 | 5.5 % |
| 43 | Nursing | 20 | 5.0 % |



Specific Data by Categories:

Medical and Related Services

Seventy-two percent (288 out of 400) of respondents reported needing and using laboratory testing; 52.8 % (211 out of 400) of the respondents reported needing and using primary medical care; 62.8 % (251 out of 400) need and use medical referrals; 61.5 % (246 out of 400) need and use dental services; 36.5 % (146 out of 400) need and use vitamins and health food; 56.3 % (225 out of 400) need and use ADAP; 58.5 % (234 out of 400) need and use HIV Prevention; 27.3 % (109 out of 400) need and use inpatient hospitalization; 22.3 % (89 out of 400) need and use help paying for insurance; 16 % (64 out of 400) need and use clinical trials; 13 % (52 out of 400) need and use massage therapy; 5.8 % (23 out of 400) need and use hospice; 8.8 % (35 out of 400) need and use alternative medicine; 5.0 % (20 out of 400) indicated they need and use nursing; 13.5 % (54 out of 400) need and use physical therapy; and 9.3 % (37 out of 400) need and use acupuncture. Additionally, consumers were asked by yes/no questions if they received alternative therapy and if they did, did they consider this treatment to be their primary form of medical care. 7.5 % (30 out of 400) indicated that they did receive alternative medicine and 6.3 % (25 out of 400) reported that alternative medicine was their primary form of medical care. The data reported that the HIV positive symptomatic was the group that most frequently used alternative medicine (35% of those who reported using alternative medical practices were HIV positive symptomatic vs. 27% HIV asymptomatic).

In-home Services

Six percent (25 out of 400) of survey respondents indicated they need and use buddy/companion care; 7.8 % (31 out of 400) need and use home health care (nursing); 6.3 % (25 out of 400) need and use home delivered meals and 5.5 % (22 out of 400) indicate they need and use the services of a home health aid (assistance with bathing, blood pressure, etc.).

Information and Help Getting Services

62.8% (251 out of 400) respondents needed and used medical information about HIV/AIDS; 52% (208 out of 400) needed and used medical telephone referrals; 17.3% (69 out of 400) needed and used interpreter services; 73.5% (294 out of 400) needed and used case management services; and 20.3% (81 out of 400) reported needing and using peer advocacy.

Case Management Services

46.8% (187 out of 400) of survey respondents reported needing and using help getting support services; 14.3 % (57 out of 400) reported needing and used continuation of private insurance; 56.3% (225 out of 400) reported needing and using benefits information (e.g.; Medicaid, Medicare, etc.); and 51.8% (207 out of 400) reported needing and using help filling out government forms.

Counseling, Treatment and Support

Twenty-seven percent (108 out of 400) of survey respondents reported needing and using mental health services; 37.3 % (149 out of 400) needed and used support groups; 29.8 % (119 out of 400) needed and used one-to-one peer emotional support; 22.8 % (91 out of 400) needed and used



substance abuse services; forty-six percent (186 out of 400) needed and used spiritual/religious services and 48 % (192 out of 400) reported needing and using spiritual and/or religious counseling.

Housing and Financial Help

Thirty-five percent (142 out of 400) of survey respondents reported needing and using help finding affordable housing; 47 % (188 out of 400) needed and used help paying for groceries; 36.5 % (146 out of 400) needed and used help paying for utilities; and 41.3 % (165 out of 400) reported needing and using help paying for rent.

Additionally, respondents were asked to indicate by yes/no if they were receiving housing services and if they qualified for housing due to being HIV/AIDS-diagnosed. Twenty percent (82 out of 400) reported receiving housing services and 22.8 % (91 out of 400) indicated they were receiving housing services due to a diagnosis of HIV/AIDS. There was no significant difference between males and females receiving housing services (54 vs. 41; $p > .05$).

Support Services

Forty-four percent (179 out of 400) survey respondents reported receiving and using food bank services; 5.8 % (23 out of 400) reported needing and using child care; 44.8 % (179 out of 400) reported needing and using transportation; 9.0 % (36 out of 400) needed and used adult day care/respite; 34.3 % (137 out of 400) needed and used legal services; 11 % (44 out of 400) needed and used help returning to work; 18 % (72 out of 400) needed and used help finding a new job/learning job skills; and 6.5 % (26 out of 400) reported needing and using permanency planning.

E. Service Priorities

Consumer-identified priorities: The consumer survey included a one-page list of the 48 types of HIV/AIDS-related services offered in the Palm Beach County Continuum of Care. The survey asked consumers to identify up to seven services that they considered as most important to them. Responses were ranked by overall percentage of response. *Table 9* includes cumulative responses of service categories (highlighting services which consumers rated as one of their seven most important services). There are duplications in ranked responses due to consumers voting more than one service at the same rate of importance. (e.g., transportation and massage therapy both received 37 votes from the consumers, therefore, both service categories are ranked 20.)



Priorities

Table 9: Service Priorities from Consumer Surveys (N=400)

| Rank | Service | Total Votes | Percent |
|------|--------------------------------|-------------|---------|
| 1 | Case Management | 269 | 67.3 % |
| 2 | ADAP | 215 | 53.8 % |
| 3 | Rent/Mortgage | 192 | 48.0 % |
| 4 | Dental | 175 | 43.8 % |
| 5 | Food Pantry | 148 | 37.0 % |
| 5 | Laboratory Tests | 148 | 37.0 % |
| 6 | Utility | 142 | 35.5 % |
| 7 | Groceries | 140 | 35.0 % |
| 8 | HIV Prevention | 102 | 25.5 % |
| 9 | Help Finding Housing | 91 | 22.8 % |
| 10 | Out-patient Medical Care | 86 | 21.5 % |
| 11 | Emergency Assistance | 83 | 20.8 % |
| 12 | Health Insurance Continuation | 76 | 19.0 % |
| 13 | Counseling | 75 | 18.8 % |
| 14 | Legal | 72 | 18.0 % |
| 15 | Vitamins/Health Food | 68 | 17.0 % |
| 16 | Spiritual/Religious Counseling | 61 | 15.3 % |
| 17 | Transportation | 57 | 14.3 % |
| 18 | Filling out Government Form | 54 | 13.5 % |
| 19 | Home Delivered Meals | 43 | 10.8 % |
| 20 | Translation | 37 | 9.3 % |
| 20 | Massage | 37 | 9.3% |



Table 9: (Cont.) Service Priorities from Consumer Surveys (N=400)

| Rank | Service | Total Votes | Percent |
|------|---------------------------------------|-------------|---------|
| 21 | Medical Information | 34 | 8.5 % |
| 21 | Buddy/Companion | 34 | 8.5 % |
| 22 | Out-Patient Substance Abuse Treatment | 32 | 8.0 % |
| 23 | Alternative Therapies | 31 | 7.8 % |
| 24 | Mental Health | 30 | 7.5 % |
| 25 | Child Care | 29 | 7.3 % |
| 26 | One-to-One Emotional Support | 28 | 7.0 % |
| 29* | Vocational Rehabilitation | 21* | *5.3% |
| 27 | Clinical Trials | 23 | 5.8% |
| 28 | Telephone Referrals | 23 | 5.8 % |
| 29* | Acupuncture | 21* | *5.3 % |
| 30 | Health Aid | 19 | 4.8 % |
| 31 | Residential Substance Abuse Tx. | 18 | 4.5 % |
| 32 | Inpatient Hospitalization | 13 | 3.3 % |
| 33 | Home Health Nurse | 10 | 2.5 % |
| 33 | Hospice | 10 | 2.5 % |
| 34 | Adult Day Care/Respite | 8 | 2.0 % |
| 35 | Nurse Care Coordination | 7 | 1.8 % |
| 35 | Permanency Planning | 7 | 1.8 % |



The Seven Top Consumer Priorities:

Consumers ranked Case Management as their highest priority, followed by Drugs/Medicine (ADAP), rent/mortgage payments, Dental services, Food Services (Pantry), Laboratory Tests, Help Paying for utilities, Help paying for groceries, HIV prevention, Help finding affordable housing, and Outpatient Medical Care. The remaining services are displayed, by rank, in Table 9. There was not a clear demarcation between the top seven services and the services below. The percentage difference between the number seventh ranked service; Help paying for groceries (n= 140, 35 %) and the eighth ranked service; HIV prevention (n= 102, 25.5 %) was not significant (p> .05).

F. Level of Illness by Consumer Service Priorities

There was a percentage difference between level of illness (i.e., HIV positive asymptomatic; HIV positive symptomatic; AIDS-diagnosed based on low t-cell count or AIDS-diagnosed based on O.I.'s) and service priorities (i.e., rankings).

Level of illness did appear to have an impact on the ways in which consumers prioritized the services. This applies both to the rank order of the services, as well as the relative importance of the service based on the percentage of those who report it as a priority. The top 15 rankings of service priorities by level of illness are as follows.

Table 10: Top 15 Consumer Service Priorities by Level of Illness

| n | Rank | Service | Level of Illness by Percentage | | | |
|-----|------|-------------------------------|--------------------------------|---------|-------------|-----------|
| | | | HIV+asym | HIV+sym | AIDS t-cell | AIDS O.I. |
| 269 | 1 | Case Management | 23% | 25% | 13% | 6% |
| 215 | 2 | ADAP | 21% | 19% | 8% | 6% |
| 192 | 3 | Paying Rent/Mortgage | 16% | 14% | 9% | 8% |
| 175 | 4 | Dental | 16% | 18% | 7% | 3% |
| 148 | 5 | Food Services (Pantry) | 10% | 10% | 9% | 8% |
| 148 | 5 | Laboratory Tests | 14% | 18% | 5% | 1% |
| 142 | 6 | Paying Utilities | 12% | 9% | 6% | 8% |
| 140 | 7 | Paying Groceries | 8% | 11% | 8% | 8% |
| 102 | 8 | HIV Prevention | 10% | 9% | 2% | 5% |
| 91 | 9 | Help Finding Housing | 10% | 8% | 3% | 2% |
| 86 | 10 | Out-pt. Medical Care | 10% | 8% | 3% | 1% |
| 83 | 11 | Direct Emergency Assist. | 6% | 6% | 5% | 4% |
| 76 | 12 | Health Insurance Continuation | 6% | 5% | 3% | 5% |
| 75 | 13 | Counseling | 8% | 4% | 4% | 3% |
| 72 | 14 | Legal Services | 7% | 6% | 3% | 2% |
| 68 | 15 | Vitamins/Health Food | 6% | 7% | 3% | 1% |



HIV positive asymptomatic consumers and persons who indicated they had been diagnosed with AIDS based on an opportunistic infection displayed the largest prioritization differences.

Table 11: The Remaining Rankings of Service Priorities by Level Illness

| n | Rank | Service | Level of Illness by Percentage | | | |
|----|------|--------------------------------|--------------------------------|---------|-------------|-----------|
| | | | HIV+asym | HIV+sym | AIDS t-cell | AIDS O.I. |
| 61 | 16 | Spiritual/Religious Counseling | 7% | 5% | 2% | 0.8 % |
| 57 | 17 | Transportation | 7% | 5% | 3% | 0.5 % |
| 54 | 18 | Filling out Govt. Forms | 3% | 4% | 3% | 4% |
| 43 | 19 | Home Delivered Meals | 2% | 2% | 4% | 4% |
| 37 | 20 | Translation | 4% | 3% | 1% | 0.5 % |
| 37 | 20 | Massage | 3% | 3% | 3% | 1% |
| 34 | 21 | Medical Information | 4% | 3% | 1% | 0.8 % |
| 34 | 21 | Buddy/Companion | 3% | 3% | 2% | 0.8 % |
| 32 | 22 | O.P. Substance Abuse | 5% | 3% | 0.8 % | 0.3 % |
| 31 | 23 | Alternative Therapies | 2% | 4% | 1% | 0.8 % |



Table II: (Cont.) The Remaining Rankings of Service Priorities by Level Illness

| n | Rank | Service | Level of Illness by Percentage | | | |
|-----|------|---------------------------|--------------------------------|---------|-------------|-----------|
| | | | HIV+asym | HIV+sym | AIDS t-cell | AIDS O.I. |
| 30 | 24 | Mental Health | 4% | 1% | 2% | 1% |
| 29 | 25 | Child Care | 4% | 2% | 1% | 0.2 % |
| 28 | 26 | 1-to-1 Emotional Support | 3% | 2% | 0.8 % | 1% |
| 28 | 26 | Vocational Rehab. | 3% | 2% | 0.3 % | 0.5 % |
| 27 | 27 | Clinical Trials | 1% | 2% | 2% | 0.8 % |
| 23 | 28 | Telephone Referrals | 2% | 2% | 2% | 0.5 % |
| 21 | 29 | Acupuncture | 2% | 2% | 0.8 % | 0.8 % |
| 19 | 30 | Home Health Aid | 0.5 % | 0.5 % | 2% | 2% |
| 18 | 31 | Residential Substance Tx. | 3% | 0.8 % | 1% | ----- |
| 13 | 32 | Inpt. Hospitalization | 0.3 % | 2% | 0.5 % | 0.8 % |
| 10 | 33 | Home Health Nurse | 0.8 % | 0.3 % | 1% | 0.5 % |
| 10 | 33 | Hospice | 0.3 % | 1% | 0.5 % | 0.5 % |
| 8 | 34 | Respite Care | ----- | 1% | 0.3 % | 0.8 % |
| 7 | 35 | Nurse Care Coordination | 0.8 % | 0.3 % | 0.5 % | 0.3 % |
| 7 | 35 | Permanency Planning | 1% | 0.3 % | 0.3 % | 0.3 % |
| 27* | 26* | Physical Therapy* | 2% | 2% | 3% | 0.5 % |

HIV asymptomatic ranked ADAP, Paying for Rent/Mortgage, Paying for Utilities, HIV Prevention, Help Finding Affordable Housing, Out-Patient Medical Care, Health Insurance Continuation, Counseling, Transportation, Translation, Legal Services , Spiritual/Religious Counseling, Medical Information, Out-Patient Substance Abuse, Mental Health Services, Child Care, One-to-One Emotional Support, Vocational Rehabilitation, and Residential Substance Abuse Treatment as important.

HIV symptomatic reported their important priorities as case management, dental, Lab tests, Paying for groceries, Vitamins/Health Foods, Filling out Government forms, Alternative Therapies, In-Patient Hospitalization, Hospice, and Adult Day Care.



Those diagnosed with AIDS based on t-cell or CD-4 counts of below 200 have indicated that the services that are important to them are: Case management, Paying for Rent/Mortgage, Food Services (Pantry), Paying for Groceries, Direct Emergency Assistance, Home Delivered Meals, Massage, Buddy/Companion, Telephone referrals, Home Health Aid, and physical Therapy.

Persons with AIDS based on diagnoses of opportunistic infections prioritized Paying for Rent/Mortgage, Food Services (Pantry), Paying for Utilities and Paying for Groceries, Filling out Government Forms, and Home Delivered Meals.

Generally, HIV asymptomatic prioritized Drugs and Medical Care services, HIV Prevention and secondarily, Counseling and Case Management as most important. HIV symptomatic reported that Case Management, Counseling, Lab tests and Dental as most important. AIDS t-cell/ AIDS CD-4 <200 ranked Housing, Food Services, and Utilities as most important. AIDS-Diagnosed on the presence of an Opportunistic Infection ranked in-home ancillary services such as home delivered meals, Home Health Nurse, and Home Health Aid as being most important.

For the third tier of services priorities by level of illness, in-home ancillary services were more likely to be prioritized by those with the most severe level of illness (AIDS-diagnosed based on opportunistic infections). Consumers with the least severe level of illness prioritized medical and advocacy services. Again, the largest prioritization differences were displayed between the HIV positive asymptomatic and the AIDS-diagnosed based on O.I.'s.

G. Provider-Identified Service Priorities

The provider survey included the same one-page list of 48 types of HIV/AIDS-related services as was included in the consumer version. The survey asked each responding provider to identify up to seven services that they considered as most important for the clients they served. *Table 11* reports cumulative responses of provider priorities. (In order to insure that provider-identified priorities were not biased by over-sampling certain types of providers (i.e., medical providers and case managers), additional data runs were conducted controlling for provider type. Analysis revealed that provider type did not significantly skew identification of priorities or gaps. There are duplications of rankings due to providers voting the same for more than one service at the same rate.



Priorities: Providers

Table 12: Service Priorities from Provider Surveys (N= 17)

| Rank | Service | Total Votes | Percent |
|-------------|---------------------------------------|--------------------|----------------|
| 1 | Case Management | 15 | 88.2 % |
| 2 | Mental Health | 11 | 64.7 % |
| 2 | ADAP/Drugs/Medicine | 11 | 64.7 % |
| 3 | Help Finding Affordable Housing | 9 | 52.9 % |
| 4 | Out-Patient/Ambulatory Medical Care | 8 | 47.1 % |
| 5 | Food Services (Pantry) | 6 | 35.3 % |
| 6 | Counseling | 5 | 29.4 % |
| 6 | Residential Substance Abuse Treatment | 5 | 29.4 % |
| 6 | Transportation | 5 | 29.4 % |
| 7 | Out-Patient Substance Abuse Treatment | 4 | 23.5 % |
| 7 | HIV Prevention | 4 | 23.5 % |
| 7 | Health Insurance Continuation | 4 | 23.5 % |
| 7 | Help Paying For Rent/Mortgage | 4 | 23.5 % |
| 7 | Dental | 4 | 23.5 % |
| 8 | Nurse Care Coordination | 3 | 17.6 % |
| 8 | Legal Services | 3 | 17.6 % |
| 9 | Lab Tests | 2 | 11.8 % |
| 9 | Utilities | 2 | 11.8 % |
| 9 | Direct Emergency Assistance | 2 | 11.8 % |
| 9 | Spiritual/ Religious Counseling | 2 | 11.8 % |
| 9 | Permanency Planning | 2 | 11.8 % |
| 10 | Home Health Aid | 1 | 5.9 % |
| 10 | In-Patient Hospitalization | 1 | 5.9 % |
| 10 | Translation | 1 | 5.9 % |
| 10 | Child Care | 1 | 5.9 % |



Table 12: (Cont.) Service Priorities from Provider Surveys (N= 17)

| Rank | Service | Total Votes | Percent |
|------|------------------------------|-------------|---------|
| 10 | Medical Information | 1 | 5.9 % |
| 10 | Telephone Referrals | 1 | 5.9 % |
| 10 | Vitamins/Health Foods | 1 | 5.9 % |
| 11 | Acupuncture | 0 | 0% |
| 11 | Alternative Therapies | 0 | 0% |
| 11 | Buddy/ Companion | 0 | 0% |
| 11 | Clinical Trial Outreach | 0 | 0% |
| 11 | Adult Day Care/Respite | 0 | 0% |
| 11 | Help Filling out Govt. Forms | 0 | 0% |
| 11 | Help Paying for Groceries | 0 | 0% |
| 11 | Home Delivered Meals | 0 | 0% |
| 11 | Home Health Nurse | 0 | 0% |
| 11 | Hospice | 0 | 0% |
| 11 | Massage | 0 | 0% |
| 11 | 1-to-1 Emotional Support | 0 | 0% |
| 11 | Physical Therapy | 0 | 0% |
| 11 | Vocational Rehabilitation | 0 | 0% |

¹ These services received no priority votes from providers.

The Seven Top Provider-Ranked Services

Providers ranked case management as the highest priorities for their HIV/AIDS clients, followed by drugs/medicine/ADAP and Mental Health Services. The remaining services are displayed in Table 11 by rank order. There was not a clear demarcation between the top seven priority services and the services below. The percentage difference between the number seventh-ranked services and the eighth-ranked services were not statistically significant ($p > .05$). This indicates that providers assign these services a similar degree of importance. However, the percentage difference between the number one-ranked services (case management) and the number seventh-ranked services (Out-Patient Substance Abuse Treatment, HIV Prevention, Paying for Rent/Mortgage, Health Insurance Continuation, and Dental) is significant ($p < .05$), suggesting a distinct difference between the top ranked services and those ranked seven and below.



H. Comparison Between 2003 Consumer and Provider Service Priorities

Comparison between consumer and provider responses yields numerous differences in both priority rankings and percentages. In general, providers were more likely to prioritize clinical services, while consumers were more likely to prioritize ancillary services, particularly those that provide financial support. There are some duplications of ranking explained in footnotes below.

Table 13: Comparison of Consumer and Provider Priorities

| Service | Consumers | | Providers | |
|--------------------------|-----------|------------------|-----------|------------------|
| | Rank | % of Respondents | Rank | % of Respondents |
| Case Management | 1 | 67.3 % | 1 | 88.2 % |
| ADAP | 2 | 53.8 % | 2 | 64.7 % |
| Rent/Mortgage | 3 | 48.0 % | 7 | 23.5 % |
| Dental | 4 | 43.8 % | 7 | 23.5 % |
| Food Pantry | 5 | 37.0 % | 5 | 35.3 % |
| Laboratory Tests | 5 | 37.0 % | 9 | 11.8 % |
| Utilities | 6 | 35.5 % | 9 | 11.8 % |
| Groceries | 7 | 35.0 % | 0 | 0 |
| HIV Prevention | 8 | 25.5 % | 7 | 23.5 % |
| Help Finding Housing | 9 | 22.8 % | 9 | 53.9 % |
| Out-Patient Medical Care | 10 | 21.5 % | 8 | 47.1 % |

¹ Providers did not vote for this service at all.
² Rankings are duplicated based upon statistical ordering.



Table 13: (Cont.) Comparison of Consumer and Provider Priorities

| Service | Consumers | | Providers | |
|--------------------------------|-----------|------------------|-----------|------------------|
| | Rank | % of Respondents | Rank | % of Respondents |
| Direct Emergency Assistance | 11 | 20.8 % | 9 | 11.8 % |
| Health Insurance Continuation | 12 | 19.9 % | 7 | 23.5 % |
| Counseling | 13 | 18.8 % | 6 | 29.4 % |
| Legal Services | 14 | 18.0 % | 8 | 17.6 % |
| Vitamins/Health Foods | 15 | 17.0 % | 10 | 5.9 % |
| Spiritual/Religious Counseling | 16 | 15.3 % | 9 | 11.8 % |
| Transportation | 17 | 14.3 % | 6 | 29.4 % |
| Filling out Govt. Forms | 18 | 13.5 % | 11 | 0 |
| Home Delivered Meals | 19 | 10.8 % | 11 | 0 |
| Translation | 20 | 9.3 % | 10 | 5.9 % |
| Massage | 20 | 9.3 % | 11 | 0 |
| Medical Information | 21 | 8.5 % | 10 | 5.9 % |
| Buddy/Companion | 21 | 8.5 % | 11 | 0 |
| Out-Pt. Substance Abuse Tx. | 22 | 8.0 % | 7 | 23.5 % |
| Alternative Therapies | 23 | 7.8 % | 11 | 0 |
| Mental Health | 24 | 7.5 % | 2 | 64.7 % |
| Child Care | 25 | 7.3 % | 10 | 5.9 % |
| I-to-I Emotional Support | 26 | 7.0 % | 11 | 0 |
| Clinical Trials | 27 | 5.8 % | 11 | 0 |
| Telephone Referrals | 27 | 5.8 % | 10 | 5.9 % |
| Acupuncture | 28 | 5.3 % | 11 | 0 |
| Vocational Rehabilitation | 28 | 5.3 % | 11 | 0 |
| Home Health Aid | 29 | 4.8 % | 10 | 5.9 % |

¹ Providers did not vote for this service at all.

² Rankings are duplicated based upon statistical order



Table 13: (Cont.) Comparison of Consumer and Provider Priorities

| Service | Consumers | | Providers | |
|---------------------------------|-----------|------------------|-----------|------------------|
| | Rank | % of Respondents | Rank | % of Respondents |
| Residential Substance Abuse Tx. | 30 | 4.5 % | 6 | 29.4 % |
| In-Patient Hospitalization | 31 | 3.3 % | 10 | 5.9 % |
| Home Health Nurse | 32 | 2.5 % | 11 | 0 |
| Hospice | 32 | 2.5 % | 11 | 0 |
| Adult Day/Respite | 33 | 2.0 % | 11 | 0 |
| Nurse Care Coordination | 34 | 1.8 % | 8 | 17.6 % |
| Permanency Planning | 34 | 1.8 % | 9 | 11.8 % |

² Ranking are duplicated based upon statistical ordering.

There is not a percentage difference between consumers and providers regarding the top two priority services. In fact, they are interchangeable, suggesting that all respondents assign these services an identical degree of importance. However, the percentage and ranking differences between providers and consumers for the number three ranked service is noticeable. Consumers ranked help paying for Rent/Mortgage as priority number 3 (48.0 % of respondents indicating this opinion) while providers ranked paying for Rent/Mortgage in the seventh place with 23.5 % of the providers voting it as a service priority.

Providers ranked case management as the highest priority for clients (82.2%) and consumers ranked case management as number 1 (67.3%). ADAP was ranked number 2 for both providers and consumers.

There were differences between consumers and providers for the fourth ranked service priority; Dental Care (consumers rank 4, 43.8 %; providers rank 7, 23.5 %). Consumers and Providers ranked Food Services (pantry) as the fifth most important service priority (37.0 %) and (35.3 %), respectively.

Consumers ranked the following service categories with more importance than providers: Help Paying for Rent/ Mortgage; Dental Care, Lab Tests, Utilities, and Groceries.

Providers ranked the following categories as higher priorities than consumers: Out-Patient Ambulatory Medical Care, Direct Emergency Assistance, Health Insurance Continuation, Counseling, Legal Services, Vitamins/Health Food, Spiritual/Religious Counseling,



Transportation, Translation, Medical Information, Out-Patient Substance Abuse Treatment., Mental Health Services, Child Care, Telephone Referrals, Home Health Aid, Residential Substance Abuse Treatment, In-Patient Hospitalization, Nurse Care Coordination, and Permanency Planning.

Both Groups assign similar importance to these following service groups:
Case Management, ADAP/Medicine/Drugs, Foods Services (Pantry), HIV Prevention, and Help Finding Affordable Housing.

Providers assigned no Prioritization to the following service categories:
Filling out Government Forms, Home Delivered Meals, Massage Therapy, Buddy/Companion, Alternative Therapies, One-to-one Emotional Support, Clinical Trials, Acupuncture, Vocational Rehabilitation, Home Health Nurse, Hospice, and Adult Day Care/Respite.

The similarities and discrepancies are important to notice for funding decision-making.

I. Service Gaps

Consumer-Identified Service Gaps: As was previously stated, consumers identified each of the 48 services offered in the Palm Beach County Continuum of Care as ones that they needed and used, did not need, or needed but could not get. Each service that a consumer identified as “needed, but could not get” is considered a service gap. Cumulative categorical service gap responses appear below in *Table 14*.

Table 14: Service Gaps from Client Surveys (N=400)

| Rank | Service | Total Votes | Percent |
|------|-------------------------------|-------------|---------|
| 1 | Finding Affordable Housing | 135 | 33.8 % |
| 2 | Help Paying for Groceries | 110 | 27.5 % |
| 3 | Food Services (Pantry) | 107 | 27.0 % |
| 3 | Vitamins/Health Foods | 108 | 27.0 % |
| 4 | Help Paying for Rent/Mortgage | 107 | 26.8 % |
| 5 | Help Paying for Utilities | 105 | 26.3 % |
| 6 | Help Getting Insurance | 98 | 24.5 % |
| 7 | Insurance Maintenance | 95 | 23.8 % |
| 8 | Massage | 88 | 22.0 % |



Table 14: (Cont.) Service Gaps from Client Surveys (N=400)

| Rank | Service | Total Votes | Percent |
|------|----------------------------------|-------------|---------|
| 9 | Dental | 80 | 20.0 % |
| 10 | Benefits Information | 79 | 19.8 % |
| 11 | Help Finding a Job | 69 | 17.3 % |
| 12 | Alternative Therapies | 67 | 16.8 % |
| 13 | Buddy/Companion | 66 | 16.5 % |
| 13 | Clinical Trials | 66 | 16.5 % |
| 14 | Help Getting Support | 65 | 16.3 % |
| 15 | Peer Advocacy | 59 | 14.8 % |
| 15 | Help Preparing to Return to Work | 59 | 14.8 % |
| 16 | Telephone Referrals | 55 | 13.8 % |
| 16 | Acupuncture | 55 | 13.8 % |
| 17 | Home Delivered Meals | 54 | 13.5 % |
| 17 | Transportation | 54 | 13.5 % |
| 17 | Support Groups | 54 | 13.5 % |
| 18 | Physical Therapy | 51 | 12.8 % |
| 18 | I-to-I Emotional Support | 51 | 12.8 % |
| 18 | Help Filling out Govt. Forms | 51 | 12.8 % |
| 19 | Legal Services | 49 | 12.3 % |
| 20 | ADAP/Drugs/Medicine | 46 | 11.5 % |
| 21 | Hospice | 45 | 11.3 % |
| 22 | Medical Information | 44 | 11.0 % |
| 22 | Adult Day Care/Respite | 44 | 11.0 % |
| 23 | In-Patient Hospitalization | 43 | 10.8 % |
| 23 | Child Care | 43 | 10.8 % |
| 23 | Mental Health Services | 43 | 10.8 % |



Table 14: (Cont.) Service Gaps from Client Surveys (N=400)

| Rank | Service | Total Votes | Percent |
|------|---------------------------------------|-------------|---------|
| 24 | Case Management | 40 | 10.0 % |
| 25 | Hospital Discharge | 39 | 9.8 % |
| 26 | Home Health Care (Nurse) | 38 | 9.5 % |
| 26 | Out-Patient Medical Care (Ambulatory) | 38 | 9.5 % |
| 26 | Spiritual/Religious Counseling | 38 | 9.5 % |
| 27 | Permanency Planning | 37 | 9.3 % |
| 28 | Substance Abuse Services | 36 | 9.0 % |
| 29 | Medical Referrals | 35 | 8.8 % |
| 29 | Home Health Aid | 35 | 8.8 % |
| 30 | Nurse Care | 32 | 8.0 % |
| 31 | Lab Tests | 31 | 7.8 % |
| 32 | Spiritual/Religious Services | 30 | 7.5 % |
| 33 | Translation | 27 | 6.8 % |

As shown in *Table 14*, consumers identified several service gaps in the Palm Beach County Continuum of Care as being grossly deficient. Consumers consider lack of access (lack of access=gap) to Finding Affordable Housing as the number one service gap. A companion of this service category is payment of rent/mortgage. Almost one-quarter of survey respondents also consider there to be a lack of access in this category.

Other service categories that were ranked as gaps by one-quarter, or nearly one-quarter of survey respondents were: Help Paying for Utilities, Help Paying for Groceries, Food Services (Pantry), Vitamins/Health Foods, Help Getting Insurance, and Help Maintaining Insurance (Continuation).

Service categories that were ranked as gaps by one-fifth, or close to one-fifth, of survey respondents were: Massage Therapy, Dental Services, and Benefits Information.

Additional differences emerged in service gap identification based on level of illness (x) by service gap. Persons who reported being HIV positive asymptomatic were almost four times as likely as other consumers to identify gaps in service provision in almost all categories. This indicates a need for the CARE Council to enhance efforts to insure that agencies provide "needs based" attention to address service provision for HIV positive asymptomatic individuals as well as individuals presenting as HIV positive symptomatic, AIDS-diagnosed based on a low t-cell count and AIDS diagnosed based upon an opportunistic infection. It appears that consumers need to be severely ill to get some services.



Provider-Identified Service Gaps

The provider survey asked respondents to identify service gaps for the clients they serve using the same list of HIV/AIDS-related services from which priorities were identified. Each responding provider was asked to check any of the services which a substantial number of their clients needed, but had difficulty accessing. *Table 15* includes cumulative responses of provider-identified service gaps. (There are duplications in rank orderings due to providers voting the same for multiple services.)

Table 15: Service Gaps from Provider Surveys (N=17)

| Rank | Service | Total Votes | Percent |
|------|---------------------------------------|-------------|---------|
| 1 | Finding Affordable Housing | 10 | 58.8 % |
| 2 | Out-Patient Substance Abuse Treatment | 9 | 52.9 % |
| 3 | Health Insurance Continuation | 8 | 47.1 % |
| 4 | Help Paying for Rent | 7 | 41.2 % |
| 5 | Help Paying for Utilities | 6 | 35.3 % |
| 5 | Residential Substance Abuse Treatment | 6 | 35.3 % |
| 6 | Clinical Trials | 5 | 29.4 % |
| 7 | Counseling | 4 | 23.5 % |
| 7 | Alternative Therapies | 4 | 23.5 % |
| 7 | Child Care | 4 | 23.5 % |
| 7 | ADAP | 4 | 23.5 % |
| 7 | HIV Prevention | 4 | 23.5 % |
| 7 | Home Health Nurse | 4 | 23.5 % |
| 7 | I-to-I Emotional Support | 4 | 23.5 % |
| 8 | Buddy/Companion | 3 | 17.6 % |
| 8 | Paying for Groceries | 3 | 17.6 % |
| 8 | In-Patient Hospitalization | 3 | 17.6 % |
| 8 | Legal Services | 3 | 17.6 % |
| 8 | Mental Health | 3 | 17.6 % |

¹ Duplications in rank orderings



Table 15: (Cont.) Service Gaps from Provider Surveys (N= 17)

| Rank | Service | Total Votes | Percent |
|------|--------------------------------|-------------|---------|
| 8 | Nurse Care Coordination | 3 | 17.6 % |
| 8 | Transportation | 3 | 17.6 % |
| 8 | Vocational Rehab. | 3 | 17.6 % |
| 9 | Vitamins/Health Foods | 2 | 11.8 % |
| 9 | Permanency Planning | 2 | 11.8 % |
| 9 | Medical Information | 2 | 11.8 % |
| 9 | Massage Therapy | 2 | 11.8 % |
| 9 | Food Services (Pantry) | 2 | 11.8 % |
| 9 | Acupuncture | 2 | 11.8 % |
| 9 | Adult Day/Respite | 2 | 11.8 % |
| 10 | Case Management | 1 | 5.9 % |
| 10 | Dental | 1 | 5.9 % |
| 10 | Direct Emergency Assistance | 1 | 5.9 % |
| 10 | Help Filling out Govt. Forms | 1 | 5.9 % |
| 10 | Home Delivered Meals | 1 | 5.9 % |
| 10 | Hospice | 1 | 5.9 % |
| 10 | Lab Tests | 1 | 5.9 % |
| 10 | Physical Therapy | 1 | 5.9 % |
| 10 | Spiritual/Religious Counseling | 1 | 5.9 % |
| 10 | Telephone Referrals | 1 | 5.9 % |
| 11 | Health Aid | 0 | 0 |
| 11 | Out-Patient Hospitalization | 0 | 0 |

¹ Duplications in rank orderings.

² Providers did not report gaps for these services.

Higher percentages of providers identified gaps in services (e.g., transportation, etc.) than did consumers. This is probably due to the fact that providers were asked to consider a service as a gap if a substantial number of their clients had trouble accessing a service, while each consumer vote represents the response of one individual. As a result, the provider-identified service gaps are useful as a measure of provider opinions about the Continuum of Care, rather than determining the



possible magnitude of service gaps for the population of PLWH/A's in Palm Beach County.

Providers identified help Finding Affordable Housing as the number one gap for the clients they serve. Health Insurance Continuation and Out-Patient Substance Abuse Treatment were identified as gaps by half of responding providers.

Other services that providers ranked among the top service gaps for their consumer populations were: rent/mortgage payments, Utilities payments, and substance abuse treatment (residential).

Comparison Between Consumer and Service Provider Gap Rankings: Consumers and providers differed in the service gaps they identified in the Palm Beach County Continuum of Care. The key differences emerged in the percentage of consumers and providers identifying gaps in over half of the categories, with consumers being more likely than providers to identify service gaps.

It is difficult to determine if this disparity represents actual differences in consumer versus provider perceptions of service gaps, or a methodological limitation (since consumers were asked to identify personal gaps while providers were asked to identify service gaps across the entire population of clients with whom they worked). Aggregate provider response may, in fact, overstate gaps by inflating gaps for small numbers of consumers into system-wide problems. Conversely, it is possible that provider responses were more reflective of actual gaps for populations that the consumer survey may have under-sampled. For example, translation (Haitians and Hispanics); substance abuse services (drug addicts and alcoholics); transportation (people living in poverty without access to transportation).

The largest disparities in consumer and provider-identified service gaps emerged in the areas of Help Paying for Groceries (consumer rank 2, provider rank 8); Food Services (Pantry) (consumer rank 3, provider rank 9); Vitamins/Health Foods (consumer rank 3, provider rank 9); Massage Therapy (consumer rank 8, provider rank 9); Dental (consumer rank 9, provider rank 10); Out Patient Substance Abuse Treatment (consumer rank 28, provider rank 2); Residential Substance abuse treatment (consumer rank 28, provider rank 5; and ADAP (consumer rank 20, provider rank 7). Perhaps providers identify gaps for services they provide yet are not expected to provide (e.g., case managers report that they provide transportation for clients; a service not usually associated with their job description). It is important to consider that Providers had a maximum ranking of only 11 whereas, Consumers had a maximum ranking of 33. Because of this a Consumer ranking in the twenties is similar to a Provider ranking of about nine or ten. An example is contained in the relationship between Consumers and Providers relating to both medical out-patient (Consumers' Gap Rank =26, Providers' Gap Rank =11) and In-Patient Hospitalization (Consumers' Gap Rank=23, Providers' Gap Rank = 8).

Categories in which consumers and providers agreed that relatively few gaps existed included: Help Finding Affordable Housing, Help Paying for Rent/Mortgage, Help Paying for Utilities, and Health Insurance Continuation.



J. Comparison of Service Priorities and Service Gaps

Consumer-Identified Service Priorities as Compared to Service Gaps: Comparing service gaps with service priorities helps determine the magnitude of potential system inadequacies and supports strategic planning and resource allocation decisions. *Table 16* lists the top ten consumer-identified service priorities in comparison with the gap ranking and percentage for each service. Six of the top ten consumer priorities also ranked among the top ten gaps.

Table 16: Priorities as Compared to Service Gaps (N=400) (From Consumer Surveys)

| Service | Priority | | Gap | |
|--------------------------|----------|------------------|------|------------------|
| | Rank | % of Respondents | Rank | % of Respondents |
| Case Management | 1 | 67.3 % | 24 | 10.0 % |
| ADAP/Drugs | 2 | 53.8 % | 20 | 11.5% |
| Help Pay Rent/Mortgage | 3 | 48.0 % | 4 | 26.8 % |
| Dental | 4 | 43.8 % | 9 | 20.0 % |
| Food Services (Pantry) | 5 | 37.0 % | 3 | 27.0 % |
| Lab Tests | 5 | 37.0% | 31 | 7.8 % |
| Utility Payments | 6 | 35.5 % | 5 | 26.3 % |
| Help Pay Groceries | 7 | 35.0 % | 2 | 27.5 % |
| HIV Prevention | 8 | 25.5 % | -- | ---- |
| Help Finding Housing | 9 | 22.8 % | 1 | 33.8 % |
| Out-Patient Medical Care | 10 | 21.5% | 26 | 9.5% |

The services that consumers reported as having the highest priority-to-gap ratios were ADAP/Drugs (53.8 % of consumers rating the service as a priority and 11.5 % rating it as a gap); Laboratory Tests (37.0 % of consumers rating service as a priority and 7.8 % rating as a gap); dental (43.8 % of consumers rating as a priority and 20.0 % rating as a gap); housing assistance (22.8 % of consumers rating as a priority and 33.8 % rating as a gap); Out-Patient Medical Care (21.5 % rating as a priority and 9.5 % rating as a gap); and HIV Prevention (21.5 % rating as a priority and 0.0 % rating as a gap).

Another way to compare service priorities and gaps is to analyze consumer survey data using paired responses to see what percentage of consumers identified a service as both a priority and a gap.



This method illustrates the percentage of consumers who report difficulty in accessing services which they feel are most important for them.

To accurately compare paired priorities and gaps, services had to be interpreted into categories (e.g., health insurance continuation on consumer priorities equaled help getting/ maintaining private insurance on “levels on need” on consumer surveys). They were both collapsed into the category, “insurance”. The limitation is that the categories are sometimes not identical therefore, yielding a study limitation. However, the importance of the comparison outweighs the limitation. *Table 17* lists the top ten services which consumers listed as both priority and gap. (Only the top ten out of 48 services are included on the table, due to the low percentages and differences in the remaining 35 categories.)

Table 17: Services Identified as both Gaps and Priorities (N=400)

| Rank | Service |
|------|---------------------------------|
| 1 | Help Paying For Rent/ Mortgage |
| 2 | Dental |
| 3 | Food Services (Pantry) |
| 4 | Utility Payments |
| 5 | Help Paying for Groceries |
| 6 | Help Finding Affordable Housing |
| 7 | Health Insurance Continuation |
| 8 | Vitamins/Health Foods |
| 9 | Transportation |
| 10 | Massage |

As seen above, this ranking indicates that Help Paying for Rent/Mortgage is the number one paired response for priority and gap. Services related to the number one priority/gap are other services related to the provision of financial assistance (i.e., utilities, groceries, housing assistance, vitamins/health foods, insurance and transportation).

The only medically-related service that emerged as both priority and gap was dental care.



K. Access Barriers

The survey asked all consumers to identify services as “can get, won’t use” to represent access barriers (Table 18). Additionally, an adjacent comment space was made available to gather qualitative information to provide a depth of understanding about what consumers considered obstacles and why. There are duplications in rank orderings.

Table 18: Access Barriers from Consumer Surveys (N=400)

| Rank | Service | n | % | Barriers |
|------|--------------------------------|----|-------|---|
| 1 | Religious/Spiritual Services | 26 | 6.5 % | 1. Don't know where to go 2. No one to trust |
| 2 | Religious/Spiritual Counseling | 25 | 6.3 % | 1. Lack of information 2. Not What I Like |
| 3 | Alternative Therapies | 23 | 5.8 % | 1. Lack of information 2. Not available 3. Not what I liked |
| 4 | Support Groups | 21 | 5.3 % | 1. Uncomfortable |
| 5 | Massage Therapy | 20 | 5.0 % | 1. Don't know where to go 2. Can't afford 3. Not available |
| 6 | Peer Advocacy | 17 | 4.3 % | 1. Don't like them 2. Nosey |
| 7 | Acupuncture | 16 | 4.0 % | 1. Can't afford 2. Service unsatisfactory 3. Don't like |
| 8 | Physical Therapy | 15 | 3.8 % | 1. Hard to feel comfortable 2. Service not available |
| 9 | Substance Abuse Treatment | 13 | 3.3 % | 1. Lack of comfort 2. Not available 3. Can't Trust Anyone |
| 9 | Medical Information | 13 | 3.3 % | 1. Not relevant 2. Lack of information |
| 10 | ADAP/Drugs | 12 | 3.0 % | 1. Side Effects 2. Can't afford 3. Hard to qualify |
| 11 | Clinical Trials | 11 | 2.8 % | 1. Not available |
| 11 | HIV Prevention | 11 | 2.8 % | 1. Don't need now 2. Don't like the approaches |
| 11 | Nurse Care Coordination | 11 | 2.8 % | 1. No Comment |
| 12 | Help Finding a job | 10 | 2.5 % | 1. Don't feel good 2. No skills |
| 13 | Medical Referrals | 9 | 2.3 % | 1. Too much paperwork 2. Hard to Navigate the system |

¹ Duplications in rank orderings.



Table 18: (Cont.) Access Barriers from Consumer Surveys (N=400)

| Rank | Service | n | % | Barriers |
|------|--------------------------|---|-------|--|
| 13 | Home Delivered Meals | 9 | 2.3 % | 1. Not available 2. Don't Qualify 3. Don't like the food |
| 13 | Mental Health | 9 | 2.3 % | 1. No issue w/Mental Health 2. Not enough services 3. Not mentally ill |
| 14 | Dental | 8 | 2.0 % | 1. Fear 2. Bad previous experience 3. Don't like the quality of care |
| 14 | Vitamins/Health Foods | 8 | 2.0 % | 1. Not available, Don't Qualify 2. Quality of service is unsatisfactory |
| 14 | Hospice | 8 | 2.0 % | 1. Quality of service is unsatisfactory |
| 14 | Help Getting Support | 8 | 2.0 % | 1. Geography |
| 15 | Legal | 7 | 1.8 % | 1. Too much paperwork 2. Takes too long to get |
| 15 | 1-to-1 Emotional Support | 7 | 1.8 % | No comments |
| 15 | Telephone Referrals | 7 | 1.8 % | 1. Lack of information |
| 15 | Case Management | 7 | 1.8 % | 1. Can't afford 2. Eligibility 3. Don't like case manager |
| 16 | Hospital Discharge | 6 | 1.5 % | No comments |
| 16 | Buddy/Companion | 6 | 1.5 % | No comments |
| 16 | Home Health Aid | 6 | 1.5 % | No comments |
| 16 | Food Services (Pantry) | 6 | 1.5 % | No comments |
| 16 | Return to Work | 6 | 1.5 % | 1. Eligibility 2. Depressed, no hope 3. Don't feel good |
| 17 | Permanency Planning | 5 | 1.3 % | 1. Too much paperwork 2. I'll do it on my own |
| 17 | Pay Rent/Mortgage | 5 | 1.3% | No comments |
| 17 | Pay Utilities | 5 | 1.3% | No comments |

¹ Duplications in rank orderings.



Table 18: (Cont.) Access Barriers from Consumer Surveys (N=400)

| Rank | Service | n | % | Barriers |
|------|------------------------------|---|------|--|
| 17 | Benefits Information | 5 | 1.3% | 1. Not available 2. Don't like it 3. Too far from neighborhood |
| 17 | Maintaining Insurance | 5 | 1.3% | No comments |
| 18 | Out-Patient Medical Care | 4 | 1.0% | No comments |
| 18 | Translation | 4 | 1.0% | No comments |
| 18 | Help Filling out Govt. Forms | 4 | 1.0% | No comments |
| 19 | In-Patient Hospitalization | 3 | 0.8% | No comments |
| 19 | Laboratory Tests | 3 | 0.8% | Not available |
| 19 | Home Health Nurse | 3 | 0.8% | No comments |
| 19 | Adult Day Care/Respite | 3 | 0.8% | No comments |
| 19 | Pay Groceries | 3 | 0.8% | No comments |
| 20 | Transportation | 2 | 0.5% | No comments |
| 20 | Child Care | 2 | 0.5% | No comments |
| 21 | Help Finding Housing | 1 | 0.3% | No comments |

¹ Duplications in rank orderings.

Access Barriers by Specific Services: In most service categories, no pattern emerged regarding specific access barriers, with consumers reporting a mix of different barriers.

The services that consumers identified as having the greatest amounts of barriers were Religious/Spiritual Services, Religious/Spiritual Counseling, Alternative Therapies, Support Groups, Massage Therapy, Peer Advocacy and Acupuncture. Of the aforementioned barriers, the most prominent obstacle was lack of information.

The services that reported the fewest service barriers were: Outpatient medical care, Maintaining Insurance, Benefits Information, The Payment of Rent, Groceries and Utilities. Translation, Help Filling Out government Forms, In-Patient Hospitalization, Lab Tests, Home Health Nurse, Respite Care, Transportation, Child Care, and Help Finding Affordable Housing. The consumers did not generally assign a comment to these service categories.



L Annual Administrative Reports

This part of the Needs Assessment provides an organizational review of (1) provider characteristics; (2) office-based services; (3) case management services; (4) home health care services; (5) number of clients receiving services; (6) HIV/AIDS funding (in dollars); and (7) staffing. Table 19 displays provider characteristics. (See Appendices)

M. Estimates of Need

Overall Consumer Service Needs: In order to estimate how many consumers might be in need of the services in the Continuum of Care, data from the consumer survey were compared to current epidemiological data. Respondents to the consumer survey were considered "in need" if they identified a service either as "need and use" or "need, but can't get". If a respondent listed the same service as "need and use" and "need, but can't get," the service was counted only once. Table 20 shows the estimated consumer need in each service category.

Service need estimates were calculated as follows:

- (1) Use of local epidemiological data: asymptomatic and symptomatic HIV infection were not reportable in Palm Beach County until 1997. Seroprevalence estimates for the county were taken from the State of Florida Department of Health: HIV/AIDS Surveillance (2002) and Monthly AIDS Surveillance Report (Palm Beach County, HIV/AIDS, Epidemiology Unit, 2002). Based on these data, the Epidemiology Program estimates that 6,244-11,044 persons in Palm Beach County are believed to be infected with HIV (this includes AIDS), with 8,644 considered the midpoint value.
- (2) Breakdown of seroprevalence data into gender and race. Palm Beach County's HIV/AIDS Epidemiology Program maintains current surveillance data regarding cumulative HIV/AIDS case counts by these demographics. As of December 7, 1999, the number of persons presumed living with HIV/AIDS (seroprevalence rates) in the county was 8,644. This includes 4,125 live AIDS cases (8,813-4,688 deaths), and 2,220 live HIV positive cases (2,286-66 deaths). The combined numbers of 4,125 live AIDS cases and 2,220 live HIV cases = 6,345. The middle point estimate for Palm Beach County is 8,644. The remaining 2,299 cases represent the CDC (2002) figure of estimated unknown or unreported HIV/AIDS cases for our EMA. According to the above seroprevalence studies conducted in Palm Beach County, the Epidemiology Program estimates that approximately 54 % of the total number of persons living with HIV/AIDS are male and 46 % are female. These percentages were multiplied across the total seroprevalence estimates for the county to derive the following numbers:

Gender

Males living with HIV/AIDS:

Low estimate $6,244 \times .54 = 3,371$
Mid point $8,644 \times .54 = 4,668$
High estimate $11,044 \times .54 = 5,964$

Females living with HIV/AIDS:

Low estimate $6,244 \times .46 = 2,872$
Mid estimate $8,644 \times .46 = 3,976$
High estimate $11,044 \times .46 = 5,080$



Race

Blacks (including African Americans, Jamaicans, Haitians and all other groups that would be identified as Black) account for 70 % of the total HIV/AIDS cases in Palm Beach County. (This average has remained consistent from 1994-2002, while Hispanics account for 8 % and 22% for whites.)

Blacks with HIV/AIDS:

Low estimate $6,244 \times .70 = 4,371$
Mid estimate $8,644 \times .70 = 6,050$
High estimate $11,044 \times .70 = 7,731$

Hispanics with HIV/AIDS:

Low estimate $6,244 \times .08 = 499$
Mid estimate $8,644 \times .08 = 691$
High estimate $11,044 \times .08 = 883$

Whites with HIV/AIDS:

Low estimate $6,244 \times .22 = 1,373$
Mid estimate $8,644 \times .22 = 1,902$
High estimate $11,044 \times .22 = 2,429$

Calculation of Need by Service Category

- (3) Calculation of percentage of consumers in need by service category: The number of people in need of each of the various services was estimated by applying the percentage of people who stated they needed and used (received) each service listed in the Comprehensive Needs Survey to the above range of estimates. Table 20 displays the low, mid point and high estimates per service.

Table 20: Estimates of Overall Consumer Need by Service Category - Palm Beach County

| Service Category | Consumers in Need | | |
|---------------------------|---------------------------|------------------------|----------------------------|
| | Low Estimate ¹ | Mid Point ² | High Estimate ³ |
| Dental Care | 3,190 | 4,582 | 5,974 |
| Inpatient Hospitalization | 1,980 | 2,844 | 3,708 |
| Outpatient Medical | 3,245 | 4,661 | 5,974 |
| Laboratory Tests | 4,125 | 5,925 | 7,725 |
| Clinical Trials | 1,320 | 1,896 | 2,472 |
| HIV Prevention | 2,310 | 3,318 | 4,326 |
| Medical Referrals | 3,190 | 4,582 | 5,974 |
| Vitamins/Health Foods | 3,025 | 4,345 | 5,665 |

¹ Assuming 5,500 PLWH/As in Palm Beach County
² Assuming 7,900 PLWH/As in Palm Beach County
³ Assuming 10,300 PLWH/As in Palm Beach County



Table 20: (Cont.)
Estimates of Overall Consumer Need by Service Category - Palm Beach County

| Service Category | Consumers in Need | | |
|-----------------------------------|---------------------------|------------------------|----------------------------|
| | Low Estimate ¹ | Mid Point ² | High Estimate ³ |
| Drugs/ADAP | 2,915 | 4,187 | 5,459 |
| Insurance | 1,485 | 2,133 | 2,781 |
| Hospice | 605 | 869 | 1,133 |
| Nursing | 605 | 869 | 1,133 |
| Physical Therapy | 550 | 790 | 1,030 |
| Massage Therapy | 1,045 | 1,501 | 1,957 |
| Acupuncture | 385 | 553 | 721 |
| Alternative Therapy | 605 | 869 | 1,133 |
| Buddy/Companion | 770 | 1,106 | 1,442 |
| Home Health, Nurse | 605 | 869 | 1,133 |
| Home Health Aid | 330 | 474 | 618 |
| Home Delivered Meals | 495 | 711 | 927 |
| Medical Information | 3,245 | 4,661 | 6,077 |
| Telephone Referrals | 2,310 | 3,318 | 4,326 |
| Translation/Interpretation | 550 | 790 | 1,030 |
| Case Management | 3,740 | 5,372 | 7,004 |
| Peer Advocacy | 1,540 | 2,212 | 2,966 |
| Help Getting Support | 2,860 | 4,108 | 5,356 |
| Maintaining Private Insurance | 1,210 | 1,580 | 2,060 |
| Benefits Information | 2,530 | 3,634 | 4,738 |
| Help Filling out Government Forms | 2,035 | 2,923 | 3,811 |
| Mental Health | 1,925 | 2,765 | 3,605 |

¹. Assuming 5,500 PLWH/As in Palm Beach County
². Assuming 7,900 PLWH/As in Palm Beach County
³. Assuming 10,300 PLWH/As in Palm Beach County



Table 20: (Cont.)
Estimates of Overall Consumer Need by Service Category - Palm Beach County

| Service Category | Consumers in Need | | |
|---------------------------------|---------------------------|------------------------|----------------------------|
| | Low Estimate ¹ | Mid Point ² | High Estimate ³ |
| Help Paying Utilities | 1,320 | 1,896 | 2,472 |
| Help Paying Rent | 1,705 | 2,449 | 3,193 |
| Food Bank | 2,365 | 3,397 | 4,429 |
| Child Care | 275 | 395 | 515 |
| Transportation | 1,485 | 2,133 | 2,781 |
| Adult Day Care/Respite | 660 | 948 | 1,236 |
| Legal | 1,815 | 2,607 | 3,399 |
| Return to work | 605 | 869 | 1,133 |
| New Job | 495 | 711 | 927 |
| Permanency Planning | 440 | 632 | 824 |
| Support Groups | 1,705 | 2,449 | 3,193 |
| Emotional Support | 1,265 | 1,817 | 2,369 |
| Drug/Alcohol | 770 | 1,106 | 1,442 |
| Spiritual/Religious | 1,595 | 2,291 | 2,987 |
| Housing Services (help finding) | 1,155 | 1,659 | 2,163 |
| Help Paying Groceries | 1,540 | 2,212 | 2,884 |
| Spiritual/Religious Counseling | 2,997 | 4,149 | 5,301 |

¹. Assuming 5,500 PLWH/As in Palm Beach County

². Assuming 7,900 PLWH/As in Palm Beach County

³. Assuming 10,300 PLWH/As in Palm Beach County

Estimates of Unmet Need: Similar mathematical formulas were used to estimate how many Palm Beach County PLWH/As might currently be in need of a service, but not able to obtain it. In deriving these estimates, "unmet need" data were drawn from consumer survey respondents who identified a service as "need, but can't get". As with the estimates of overall need, figures were calculated by applying survey response percentages across the estimates of Palm Beach County population as suggested by the CDC (1999).



Table 21: Estimates of Unmet Consumer Needs - Palm Beach County

| Service Category | Consumers with Unmet Need | | |
|----------------------------|---------------------------|------------------------|----------------------------|
| | Low Estimate ¹ | Mid Point ² | High Estimate ³ |
| Dental Care | 1,045 | 1,501 | 1,957 |
| Inpatient Hospitalization | 495 | 711 | 927 |
| Outpatient Medical | 330 | 474 | 618 |
| Laboratory Testing | 110 | 158 | 206 |
| Clinical Trials | 660 | 948 | 1,236 |
| HIV Prevention | 275 | 395 | 515 |
| Medical Referrals | 385 | 553 | 721 |
| Vitamins/Health Foods | 1,155 | 1,659 | 2,163 |
| ADAP/Drugs/Medicine | 605 | 869 | 1,133 |
| Insurance | 1,210 | 1,738 | 2,266 |
| Hospice | 220 | 316 | 412 |
| Nursing | 330 | 521 | 618 |
| Physical Therapy | 1,155 | 1,659 | 2,163 |
| Massage Therapy | 1,595 | 2,291 | 2,987 |
| Acupuncture | 1,100 | 1,580 | 2,060 |
| Alternative Therapy | 1,155 | 1,659 | 2,163 |
| Buddy/Companion | 550 | 790 | 1,030 |
| Home Health, Nurse | 330 | 474 | 618 |
| Home Health Aid | 220 | 316 | 412 |
| Home Delivered Meals | 605 | 869 | 1,133 |
| Medical Information | 550 | 790 | 1,030 |
| Telephone Referrals | 880 | 1,264 | 1,648 |
| Translation/Interpretation | 220 | 316 | 412 |

¹ Assuming 5,500 PLWH/As in Palm Beach County

² Assuming 7,900 PLWH/As in Palm Beach County

³ Assuming 10,300 PLWH/As in Palm Beach County



Table 21: (Cont.) Estimates of Unmet Consumer Needs - Palm Beach County

| Service Category | Consumers in Need | | |
|-----------------------------------|---------------------------|------------------------|----------------------------|
| | Low Estimate ¹ | Mid Point ² | High Estimate ³ |
| Case Management | 495 | 711 | 927 |
| Peer Advocacy | 550 | 790 | 1,030 |
| Help Getting Support | 880 | 1,264 | 1,648 |
| Private Insurance | 1,650 | 2,370 | 3,090 |
| Benefits Information | 1,320 | 1,896 | 2,472 |
| Help Filling out Government Forms | 770 | 1,106 | 1,442 |
| Mental Health | 495 | 711 | 927 |
| Support Groups | 880 | 1,264 | 1,648 |
| Emotional Support/Peer | 935 | 1,343 | 1,751 |
| Drug/Alcohol | 330 | 474 | 618 |
| Spiritual/Religious | 550 | 790 | 1,030 |
| Housing Assistance (help finding) | 1,705 | 2,449 | 3,193 |
| Help Paying for Groceries | 1,925 | 2,765 | 3,605 |
| Help Paying for Utilities | 1,870 | 2,686 | 3,502 |
| Help Paying for Rent | 1,815 | 2,607 | 3,399 |
| Food Bank | 1,045 | 1,501 | 1,957 |
| Child Care | 330 | 474 | 618 |
| Transportation | 1,155 | 1,659 | 2,163 |
| Adult Day Care/Respite | 440 | 632 | 824 |
| Legal | 1,100 | 1,580 | 2,060 |
| Return to work | 1,110 | 1,580 | 2,060 |
| New Job | 1,375 | 1,975 | 2,575 |
| Permanency Planning | 495 | 711 | 927 |

¹. Assuming 5,500 PLWH/As in Palm Beach County

². Assuming 7,900 PLWH/As in Palm Beach County

³. Assuming 10,300 PLWH/As in Palm Beach County



Table 22: Needs Assessment Summary Statistics

| Service Category | Utilization | | Priority (Rankings) | | | | Gaps (Need, Can't Get) | | | | Barriers | | Need (by category) | | Recommendations |
|--|-----------------------|------|---------------------|------|----------|------|------------------------|------|----------|------|----------|-----|--------------------|------------|--|
| | Consumer (Need & Use) | | Consumer | | Provider | | Consumer | | Provider | | Rank | % | Need | Unmet Need | |
| | Rank | % | Rank | % | Rank | % | Rank | % | Rank | % | | | | | |
| | | | | | | | | | | | Rank | % | Rank | % | |
| Laboratory Tests | 2 | 72 | 5 | 37 | 9 | 11.8 | 31 | 7.8 | 10 | 5.9 | 19 | 0.8 | 5316 | 674 | Priority. Increase capacity times population estimates. |
| Case Management | 1 | 73.5 | 1 | 67.3 | 1 | 88.2 | 24 | 10 | 10 | 5.9 | 15 | 1.8 | 6453 | 864 | Priority. Increase capacity times population estimates. Planning project redefine "How Best to Meet Need." |
| Out-Patient Medical Care | 8 | 52.8 | 10 | 21.5 | 4 | 47.1 | 26 | 9.5 | 11 | 0 | 18 | 1.0 | 4564 | 821 | Priority. Increase capacity times population estimates. Consider including and enhancing secondary prevention. |
| Medical Information ¹ | 4 | 62.8 | 21 | 8.5 | 10 | 5.9 | 22 | 11 | 9 | 11.8 | 9 | 3.3 | 5428 | 950 | Priority. Part of Primary Medical Care. Provider directed; increase suggested. |
| Medical Referrals ¹ | 3 | 64.3 | | | 10 | 5.9 | 16 | 13.8 | 10 | 5.9 | 13 | 2.3 | 5558 | 760 | Priority. Part of Primary Medical Care. Provider directed; increase suggested. |
| Dental Care | 5 | 61.5 | 4 | 43.8 | 7 | 23.5 | 9 | 20 | 10 | 5.9 | 14 | 2.0 | 5316 | 1728 | Priority. Increase capacity. Planning project redefine "How Best to Meet Need." |
| Vitamins/Health Foods | 18 | 36.5 | 15 | 17 | 10 | 5.9 | 3 | 27 | 9 | 11.8 | 14 | 2.0 | 3155 | 2333 | Priority. Part of Complementary Therapies. Planning project redefine "How Best to Meet Need." |
| ADAP/Drugs/Medicine | 7 | 56.3 | 2 | 53.8 | 2 | 64.7 | 20 | 11.5 | 7 | 23.5 | 10 | 3.0 | 4866 | 994 | Priority. Increase capacity times population estimates. |
| Help getting support services ¹ | 13 | 46.8 | | | | | 14 | 16.3 | | | 14 | 2.0 | 4045 | 1408 | Priority. Part of Case Management. Provider directed; increase suggested. |

¹ This service appeared on either only priority or utilization section of survey. The missing values reflect this.



Table 22: (Cont.) Needs Assessment Summary Statistics

| Service Category | Utilization | | Priority (Rankings) | | | | Gaps (Need, Can't Get) | | | | Barriers | | Need (by person) | | Recommendations |
|--|-----------------------|------|---------------------|------|----------|------|------------------------|------|----------|------|----------|------|------------------|------|---|
| | Consumer (Need & Use) | | Consumer | | Provider | | Consumer | | Provider | | Rank | Need | Unmet Need | | |
| | Rank | % | Rank | % | Rank | % | Rank | % | Rank | % | | | | | |
| | | | | | | | | | | | Rank | % | Rank | % | |
| Help getting benefits | 7 | 56.3 | | | | | 10 | 19.8 | 10 | 5.9 | 17 | 1.3 | 4866 | 1711 | Priority. Part of Case Management. Provider directed; increase suggested. |
| Direct Emergency Assistance ¹ | | | 11 | 20.8 | 9 | 11.8 | | | 10 | 5.9 | | | | | Priority because dollars can be used for housing/food. Planning project redefine "How Best to Meet Need." |
| Food Bank/Pantry | 15 | 44.8 | 5 | 37 | 5 | 35.3 | 3 | 27 | 9 | 11.8 | 16 | 1.5 | 3872 | 2333 | Planning project redefine "How Best to Meet Need." Part of Food Services. |
| Telephone Referrals ¹ | 9 | 52 | 28 | 5.8 | 10 | 5.9 | 16 | 13.8 | 10 | 5.9 | 15 | 1.8 | 4494 | 1192 | Part of Client Advocacy or Case Management. Consider implementing "Hot Line." |
| HIV Prevention | 6 | 58.5 | 8 | 25.5 | 7 | 23.5 | | | 7 | 23.5 | 11 | 2.8 | 5056 | 691 | Will improve if Treatment/Education/Outreach is enhanced. Part of Client Advocacy. |
| Completing Government Forms | 10 | 51.8 | 18 | 13.5 | | | 18 | 12.8 | 10 | 5.9 | 18 | 1.0 | 4477 | 1106 | Part of Case Management. |
| Inpatient Hospitalization | 22 | 27.3 | 32 | 3.3 | 10 | 5.9 | 23 | 10.8 | 8 | 17.6 | 19 | 0.8 | 2359 | 933 | Not Ryan White funded. Seek linkages in community. |
| Mental Health | 23 | 27 | 24 | 7.5 | 2 | 64.7 | 23 | 10.8 | 8 | 17.6 | 13 | 2.3 | 2333 | 933 | Providers consider more important than consumers. Consider alternate treatments. |
| Legal Services | 20 | 34.3 | 14 | 18 | 8 | 17.6 | 19 | 12.3 | 8 | 17.6 | 15 | 1.8 | 2964 | 1063 | Part of Client Advocacy. Planning project redefine "How Best to Meet Need." |

¹. This service appeared on either only priority or utilization section of survey. The missing values reflect this.



Table 22: (Cont.) Needs Assessment Summary Statistics

| Service Category | Utilization | | Priority (Rankings) | | | | Gaps (Need, Can't Get) | | | | Barriers | | Need (by person) | | Recommendations |
|----------------------------|-----------------------|------|---------------------|------|----------|------|------------------------|------|----------|------|----------|------|------------------|------|---|
| | Consumer (Need & Use) | | Consumer | | Provider | | Consumer | | Provider | | Rank | Need | Unmet Need | | |
| | Rank | % | Rank | % | Rank | % | Rank | % | Rank | % | | | | | |
| Rent Payments | 16 | 41.3 | 3 | 48 | 7 | 23.5 | 4 | 26.8 | 4 | 41.2 | 17 | 1.3 | 3569 | 2316 | Considered high priority and gap. Planning project redefine "How Best to Meet Need." |
| Support Groups, Counseling | 17 | 37.3 | 13 | 18.8 | 6 | 29.4 | 17 | 13.5 | | | 4 | 5.3 | 3224 | 1166 | Part of Counseling (Other). Consider for Planning project. |
| Spiritual Counseling | 11 | 48 | 16 | 15.3 | 9 | 11.8 | 26 | 9.5 | 10 | 5.9 | 2 | 6.3 | 4149 | 821 | Part of Counseling (Other). Consider for Planning project. |
| Groceries | 12 | 47 | 7 | 35 | 11 | 0 | 2 | 27.5 | 8 | 17.6 | 19 | 0.8 | 4062 | 2377 | Considered high priority and gap. Part of Food Services. Planning project redefine "How Best to Meet Need." |
| Peer Advocacy | 26 | 20.3 | | | 11 | 0 | 15 | 14.8 | 7 | 23.5 | 6 | 4.3 | 2575 | 1279 | Part of Client Advocacy. Increase capacity times population estimates. |
| Insurance Payments | 25 | 22.3 | 12 | 19 | 7 | 23.5 | 7 | 23.8 | 3 | 47.1 | 17 | 1.3 | 1927 | 2117 | Is a mid-range gap and barrier. Consider for future planning. |
| Transportation | 15 | 44.8 | 17 | 14.3 | 6 | 29.4 | 17 | 13.5 | 8 | 17.6 | 20 | 0.5 | 3872 | 1166 | Planning project redefine "How Best to Meet Need." |
| Utilities | 18 | 36.5 | 6 | 35.5 | 9 | 11.8 | 5 | 26.3 | 5 | 35.3 | 17 | 1.3 | 3155 | 2273 | Not utilized, yet high priority and high gap. Part of Housing Planning Project. Redefine "How Best to Meet Need." |
| Clinical Trials | 30 | 16 | 27 | 5.8 | 11 | 0 | 13 | 16.5 | 6 | 29.4 | 11 | 2.8 | 1383 | 1426 | Part of Primary Outpatient Medical Care. Increase capacity time population estimates. |

! This service appeared on either only priority or utilization section of survey. The missing values reflect this.

* There is currently more unmet need than need.



Table 22: (Cont.) Needs Assessment Summary Statistics

| Service Category | Utilization | | Priority (Rankings) | | | | Gaps (Need, Can't Get) | | | | Barriers | | Need (by person) | | Recommendations |
|---|-----------------------|------|---------------------|------|----------|------|------------------------|------|----------|------|----------|------|------------------|------|---|
| | Consumer (Need & Use) | | Consumer | | Provider | | Consumer | | Provider | | Rank | Need | Unmet Need | | |
| | Rank | % | Rank | % | Rank | % | Rank | % | Rank | % | | | | | |
| One-to-one Emotional Support | 21 | 29.8 | 26 | 7 | 11 | 0 | 18 | 12.8 | 7 | 23.5 | 15 | 1.8 | 2575 | 1166 | Part of Counseling (Other). Increase capacity time population estimates. |
| Housing Assistance | 19 | 35.5 | 9 | 22.8 | 3 | 52.9 | 1 | 33.8 | 1 | 58.8 | 21 | 0.3 | 3068 | 2921 | Priority. Planning project redefine "How Best to Meet Need." |
| Maintaining Insurance ¹ | 31 | 14.3 | 12 | 19 | 7 | 23.5 | 6 | 24.5 | 3 | 47.1 | 17 | 1.3 | 1236 | 2057 | Mid-range priority. Consider for future planning. |
| Massage Therapy | 33 | 13 | 20 | 9.3 | 11 | 0 | 8 | 22 | 9 | 11.8 | 5 | 5.0 | 1123 | 1901 | Part of Complementary Therapies. Mid-range priority; high gap and barriers. |
| Substance Abuse Outpatient ¹ | 24 | 22.8 | 22 | 8 | 7 | 23.5 | 28 | 9 | 2 | 52.9 | 9 | 3.3 | 1970 | 777 | Providers consider higher priority than consumers. Consider alternate treatments. |
| Buddy/Companion | 40 | 6.3 | 21 | 8.5 | 11 | 0 | 13 | 16.5 | 8 | 17.6 | 16 | 1.5 | 544 | 1426 | High barrier; not a high priority. |
| Adult Day Care/Respite | 36 | 9.0 | 34 | 2 | 11 | 0 | 22 | 11 | 9 | 11.8 | 19 | 0.8 | 777 | 950 | High barrier; not a high priority. |
| Home Nursing | 38 | 7.8 | 33 | 2.5 | 11 | 0 | 26 | 9.5 | 7 | 23.5 | 19 | 0.8 | 674 | 821 | High barrier; not a high priority. |
| Hospice ¹ | 41 | 5.8 | 33 | 2.5 | 11 | 0 | 21 | 11.8 | 10 | 5.9 | 14 | 2.0 | 501 | 976 | Reconsider category entirely. |

¹ This service appeared on either only priority or utilization section of survey. The missing values reflect this.

* There is currently more unmet need than need.



Table 22: (Cont.) Needs Assessment Summary Statistics

| Service Category | Utilization | | Priority (Rankings) | | | | Gaps (Need, Can't Get) | | | | Barriers | | Need (by person) | | Recommendations |
|--------------------------------------|-----------------------|------|---------------------|------|----------|------|------------------------|------|----------|------|----------|------|------------------|------|---|
| | Consumer (Need & Use) | | Consumer | | Provider | | Consumer | | Provider | | Rank | Need | Unmet Need | | |
| | Rank | % | Rank | % | Rank | % | Rank | % | Rank | % | | | | | |
| | | | | | | | | | | | Rank | % | Rank | % | |
| Return to Work ¹ | 34 | 11 | 29 | 5.3 | 11 | 0 | 15 | 14.8 | 8 | 17.6 | 16 | 1.5 | 950 | 1279 | Not Ryan White funded. Issue for Case Management. Planning Project |
| Nurse Care Coordination ¹ | 43 | 5 | 35 | 1.8 | 8 | 17.6 | 25 | 9.8 | 8 | 17.6 | 11 | 2.8 | 432 | 691 | A high provider priority and gap. Clients unaware. Needs attention. Planning Project |
| Alternative Medicine | 37 | 8.8 | 23 | 7.8 | 11 | 0 | 12 | 16.8 | 7 | 23.5 | 3 | 5.8 | 760 | 1452 | Part of Complementary Therapies. Reconsider category. |
| Physical Therapy | 32 | 13.5 | 26 | 6.7 | 11 | 0 | 18 | 12.8 | | | 8 | 3.8 | 1166 | 1106 | Part of Specialty Outpatient Medical Care. Planning project redefine "How Best to Meet Need." |
| Translation/ Interpretation | 29 | 17.3 | 20 | 9.3 | 10 | 5.9 | 33 | 6.8 | 8 | 17.6 | 18 | 1.0 | 1495 | 1192 | High gap; not a high priority. Case Management issue. |
| Help Finding a Job | 28 | 18 | 29 | 5.3 | 11 | 0 | 11 | 17.3 | 8 | 17.6 | 12 | 2.5 | 1555 | 1495 | Not Ryan White funded. Issue for Case Management. Planning Project |
| Home Delivered Meals | 40 | 6.3 | 19 | 10.8 | 11 | 0 | 17 | 13.5 | 10 | 5.9 | 13 | 2.3 | 544 | 1166 | Reconsider category. |
| Permanency Planning | 39 | 6.5 | 35 | 1.8 | 9 | 11.8 | 27 | 9.3 | 9 | 11.8 | 17 | 1.3 | 561 | 803 | Reconsider category. Part of Client Advocacy legal. |
| Acupuncture | 35 | 9.3 | 29 | 5.3 | 11 | 0 | 16 | 13.8 | 9 | 11.8 | 7 | 4.0 | 803 | 1192 | Part of Complementary Therapies. Planning project redefine "How Best to Meet Need." |

1. This service appeared on either only priority or utilization section of survey. The missing values reflect this.

* There is currently more unmet need than need.

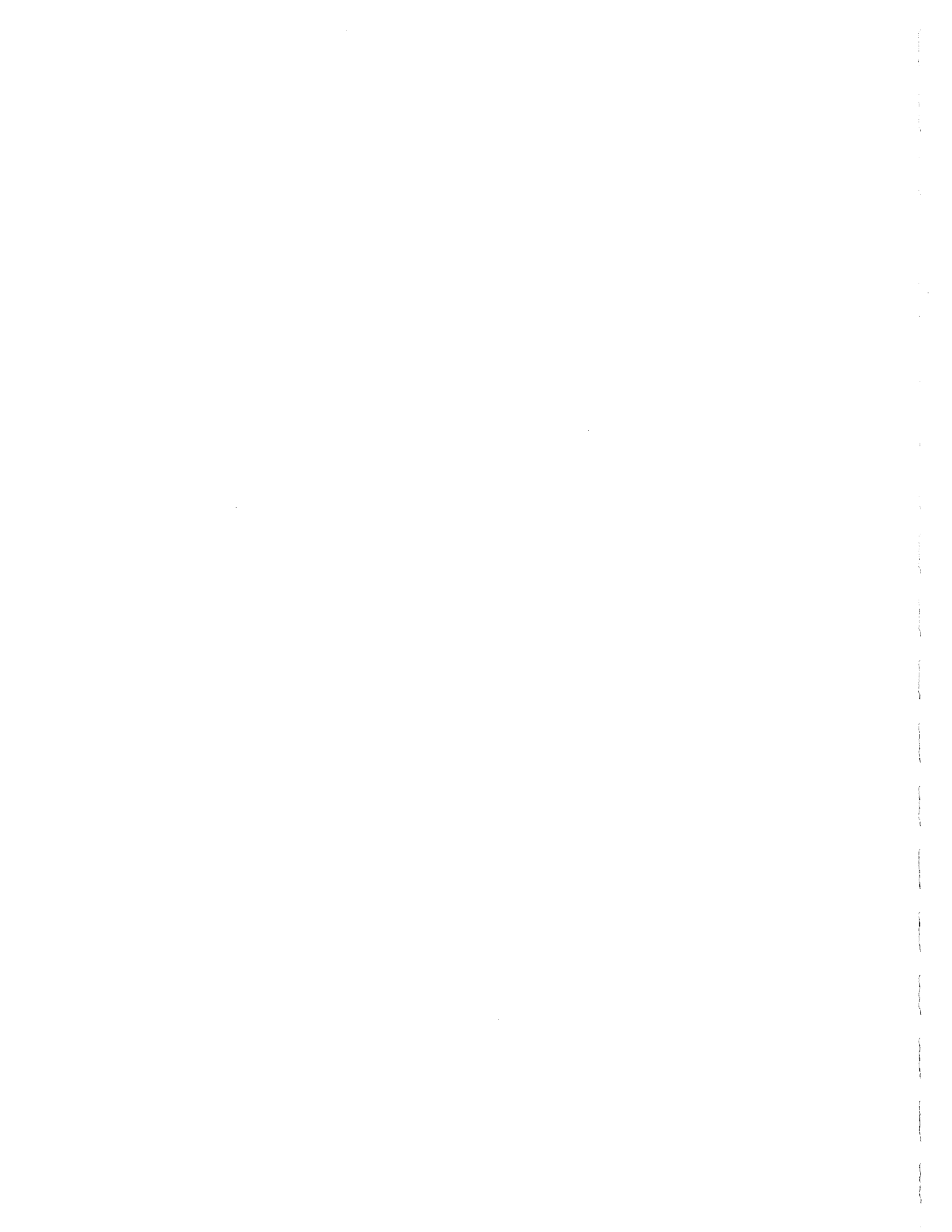


Table 22: (Cont.) Needs Assessment Summary Statistics

| Service Category | Utilization | | Priority (Rankings) | | | | Gaps (Need, Can't Get) | | | | Barriers | | Need (by person) | | Recommendations |
|--|-----------------------|------|---------------------|------|----------|------|------------------------|------|----------|------|----------|------|------------------|------------|---|
| | Consumer (Need & Use) | | Consumer | | Provider | | Consumer | | Provider | | Rank | Rank | Need | Unmet Need | |
| | Rank | % | Rank | % | Rank | % | Rank | % | Rank | % | | | | | |
| | | | | | | | | | | | Rank | % | Rank | % | |
| Home Health Aid | 42 | 5.5 | 30 | 4.8 | 11 | 0 | 29 | 8.8 | 11 | 0 | 16 | 1.5 | 475 | 760 | Reconsider category. Not a high priority. It is ranked by providers as a gap; consumers rank as high barrier. |
| Child Care | 41 | 5.8 | 25 | 7.3 | 10 | 5.9 | 23 | 10.8 | 7 | 23.5 | 20 | 0.5 | 501 | 933 | Not Ryan White funded. Reconsider category. |
| Substance Abuse Residential ¹ | 24 | 22.8 | 31 | 4.5 | 6 | 29.4 | 28 | 9 | 5 | 35.3 | 9 | 3.3 | 1970 | 777 | Providers consider more important than consumers. Reconsider providing alternative treatment that is sensitive. |
| Hospital Discharge | 27 | 19.3 | | | 8 | 17.6 | 30 | 8 | 8 | 17.6 | 16 | 1.5 | 1668 | 1521 | Planning project redefine "How Best to Meet Need." |
| Spiritual/Religious Services | 14 | 46.5 | 16 | 15.3 | 9 | 11.8 | 28 | 9 | 10 | 5.9 | 1 | 6.5 | 4019 | 648 | Not Ryan White funded. Case Management needs to enhance. Planning project redefine "How Best to Meet Need." |

¹. This service appeared on either only priority or utilization section of survey. The missing values reflect this.

* There is currently more unmet need than need.



OTHER STUDIES



Palm Beach County HIV/AIDS Crisis Response Team

R A R E

Rapid Assessment, Response, & Evaluation

July 2001



The Palm Beach County RARE Project would like to thank all the people who contributed their time and efforts to help improve our understanding of HIV/AIDS in Palm Beach County.

We are especially grateful to all the people who participated in focus groups, individual interviews, and street intercept surveys. May their words inspire us to use this report to let their voices be heard.

RARE PROJECT DIRECTOR
Christopher H. Bates, Deputy Director
Office of HIV/AIDS Policy
U.S. Department of Health and Human Services

CONSULTANTS
Richard Needle, Ph.D.
Robert Trotter, Ph.D.

PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS

Karen T. Marcus, District 1
Carol A. Roberts, District 2
Warren H. Newell, District 3
Mary McCarty, District 4
Burt Aaronson, District 5
Tony Masilotti, District 6
Addie L. Greene, District 7

Many thanks to the public officials in the four target areas. Their support ensured the safety and success of our field ethnography teams.

North Coastal Area

Riviera Beach
Michael D. Brown, Mayor
William E. Wilkins, City Manager
Jerry Poreba, Chief of Police

South Coastal Area

Delray Beach
David Schmidt, Mayor
David Harden, City Manager
Richard Overman, Chief of Police

Central Coastal Area

Lake Worth
Rodney Romano, Mayor
Wendy Newmyer, City Manager
William Smith, Chief of Police

Western Area

Belle Glade
Bill Mathis, Mayor
Tony Smith, City Manager
Michael Miller, Chief of Police

Palm Beach County RARE Advisory Board

| | |
|---------------------------------|---|
| William E. Smith | Chief Of Police (Lake Worth) |
| William E. Wilkins | City Manager Of Riviera Beach |
| Michael R. Miller | Director Of Public Safety (Belle Glade) |
| Marc G. Joseph | Haitian American Community Council |
| Tracy Garshell | Quantum Foundation |
| Major Keith Chambers | Main Detention Center |
| Rob Scott | Compass |
| Kathleen Wright | Palm Beach County Health Department |
| Sharon Greene | Palm Beach County Health Department |
| Barbara Feeney | Treasure Coast Health Council, Inc. |
| Barbara Jacobowitz | Treasure Coast Health Council, Inc. |
| Tim O'Connor | Palm Beach County Health Department |
| Paul T. Boisvert | Palm Beach County Health Department |
| Dr. Vikas Virkud | Palm Beach County Health Department |
| Dr. Greta Stiebel-Chin | Palm Beach County Health Department |
| Dave Kowalski | Palm Beach County Health Department |
| Serenia Beckton | Palm Beach County Health Department |
| Kim Honer | Palm Beach County Health Department |
| Jean M. Malecki, MD, MPH, FACPM | Palm Beach County Health Department |
| Connie Williams | Front Porch Community Laison |
| Anthony Plakas | Compass |
| Rev. Lewis E. White | Church- United Deliverance |
| Brent Woodham | Sugar Cane Resources |
| Autrie Moore-Williams | Executive Director |
| Danielle Henry | Haitian American Community Council |
| Alton Taylor | Drug Abuse Foundation- Palm Beach |
| Christopher Bates | Office Of Public Health Ed. Center |
| Janet Lewis, ARNP | Palm Beach County Health Department |
| Jeanette Corbett | Quantum Foundation |
| Jesus Cruz | Hispanic Human Resource Council |
| Edward L. Rich | Department Of Community Services |
| Gayle Corso | Department Of Community Services |
| Gerald Adams | HIV Care Council |
| Glenn Krabec | HIV Care Council |
| Sonja Wood-Swanson | HIV Care Council |
| Yanick Abellard-Maxeille | Inter- Cultural Family Health Ed. Center |
| Keith Jones | Community Foundation |
| Lucio Perez-Reynoso | Guatamalan-Maya Center |
| Michael B. Greene | Palm Beach County Health Care District |
| Nilsa Montanez | Hispanic Human Resource Council |
| Wayne Alexander | Urban League Of Palm Beach |
| Dr. Karen Dodge | HIV Care Council |
| Bud Tamarkin | Public Private Partnership |
| Dennis Grady | Chamber Of Commerce- West palm Beach |
| Robert Bozzone, MS, CAP, MAC | Comprehensive Alcoholism Rehabilitation |
| Sandra Chamblee | Glades Health Survey |
| Sandra White | Church- United Deliverance |
| Camille Franzone | Alcohol, Drug Abuse, & Mental Health |
| Douglas Randoph | Americans Red Cross |
| Charles A. Falana | Comprehensive Aids Program |
| Teena Wiles | Palm Beach Medical Society |
| Gregory Key | West Palm Beach Police Department |
| Kim Tisdale | Economic Council Of Palm Beach County |
| Annetta Jenkins | Local Initiative Support Corparation-CISC |
| Susan Dean | Palm Beach County Sherrif's Department |
| Dr. Alonso | Palm Beach County Health Department |

Palm Beach County Crisis Response Team

Palm Beach County Health Department
Jean Malecki, M.D., Director
Palm Beach County Health Department

Site Coordinators:
Mitchell Durant, Ph.D.
Paul Moore, MSW
Lou Reiter, B.S.

Administrative Assistants:
Ms. Rosa Clas
Ms. Annette Williams

Ethnographers

Karen Dodge, Ph.D., Principal Investigator
Barbara Feeney, M.P.A.
Michael Greene, M.P.A.

Field Ethnographers

North Coastal Team

Angrinette Hartnett, Team Leader
Annette Murzike-Dunn, Team Co-Leader
Gene Martin
Rev. Lewis White
Sandra White

Central Coastal Team

Guadalupe Mendez, Team Leader
Maria Mendez
Alfonso Mendez
Mark Paris, MD
Luiz Vazquez

South Coastal Team

Pierre Massilion, Team Leader
Barbara Petit-Homme
Kelly Fleury
Mark Paris, MD
Glory Saget

Western Team

Coretha Smith, Team Leader
Joseph Clerfond
Jay Jerome
Mary Jane Reynolds



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I. EXECUTIVE SUMMARY

In the Spring of 1999, President Clinton signed a bill releasing \$156 million to address HIV/AIDS in American minority communities. In the Summer of that same year, Secretary Donna Shalala, Department of Health and Human Services (DHHS), announced that Palm Beach County would be among the eleven first-tier metropolitan areas to receive special multi-disciplinary technical assistance from teams of experts described as Crisis Response Teams (CRT's). The Department of Health and Human Services distributed these funds through its various satellite agencies including the Office of HIV/AIDS Policy, The National Institute on Drug Abuse, and The Centers for Disease Control. The aforementioned legislation was the result of an intense lobbying effort by the Health Committees of the Congressional Black Caucus and the Hispanic Caucus. The underlying premise of this advocacy was the belief that the Federal Government was not doing enough to combat the spread of HIV/AIDS in minority communities. One of the critical components of this legislation was the Rapid Assessment Response Evaluation process (RARE), initiated by the Office of HIV/AIDS Policy.

The HIV/AIDS epidemic has disproportionately affected racial and ethnic minority populations nationally, particularly in major metropolitan areas and urban centers. The CRT program was developed to work in partnership with local community officials, public health personnel, and community leaders. Its purpose is to create a local infrastructure that can comprehensively assess the local HIV/AIDS epidemic, implement culturally effective intervention strategies, and evaluate the impact of those interventions at the local level.

The CRT program assists communities to enhance prevention and treatment intervention strategies, and to maximize community health, support, and service networks that provide access to care for the most vulnerable populations. The findings of the CRT utilizing the RARE methods are presented to local elected and health department officials, and HIV community planning groups and councils for their consideration and action.

The RARE process and methodology has been used by a broad spectrum of non-governmental organizations in assessing health and environmental problems and needs in developing countries. The cornerstone of the process is composed of the Crisis Response Teams. The CRT's are comprised of traditionally trained academic researchers and "field researchers". Field researchers are loosely defined as those who come from the areas being investigated and are usually members of the affected populations. The CRT's are capable of penetrating those areas most seriously affected by health problems because field researchers are members of the communities under examination and not exclusively "outsider" scientists.

There are eight basic features of Rapid Assessment. These eight principles make RARE useful for a wide range of community data collection and assessment initiatives: (1) speed; (2) cost effectiveness; (3) relevance to interventions and social issues; (4) strengthening of local responses; (5) use of available data; (6) multiple methods and data sources; (7) investigative orientation and inductive analyses; and (8) multi-level analyses.

3. Urge elected officials, local planners, providers, colleges, universities, and other policy makers to utilize the findings of this report when developing and implementing programs to decrease HIV/AIDS incidence, prevalence, morbidity, and mortality among high-risk populations.
4. Increase the availability of and access to HIV prevention and medical care for African American, Latino, Guatemalan, Haitian, and Caribbean Basin bisexuals and homosexuals within the identified risk pockets.
5. Establish targeted funding to address the HIV/AIDS barriers related to minority communities as identified in the Palm Beach County RARE report. This targeted funding should be used to fund minority organizations in order to meet HIV prevention and patient care needs.
6. Provide adequate funding to conduct a countywide public awareness campaign that reaches all of the targeted populations identified in this study. This campaign should be conducted in English, Spanish, several Mayan Indian dialects, Creole, and French and should address HIV/AIDS prevention and medical care issues, especially for women, infants, and children.
7. Increase the availability and access to HIV prevention and care services for substance abusers, including injection drug users, within the identified target areas.
8. Require that employees and volunteers of the local Health Department and all Community-Based Organizations that provide services to clients in communities of color, receive diversity and sensitivity training, and training regarding issues related to sexual orientation. Training should be incorporated into employee orientation and also provided as in-service training on a regular basis.
9. Recruit and train indigenous HIV/AIDS educators to raise awareness of and educate individuals about their own HIV risk, in their own languages and communities.
10. Establish HIV linkage programs for inmates in prisons and county jails to ensure they are provided with continuity of care and services upon their release.
11. Include those individuals who are engaged in high-risk behavior and those who currently work with them (e.g. community outreach workers) in policy-making decisions.
12. Develop specific strategies for reducing the risk of HIV/AIDS in the communities included in the RARE project, with an emphasis on strategies to benefit minority neighborhoods.
13. Create mentor programs to improve mutual understanding between HIV/AIDS prevention and treatment providers. Mentor programs can also be useful in developing better information to develop more effective programs. Include local colleges when considering internship programs.
14. Establish prevention and patient care programs within the RARE targeted communities. Further, consider times, days, and locations as indicated by RARE project respondents.

II. GOALS OF THE PALM BEACH COUNTY RARE PROJECT

The overall goals of Palm Beach County's RARE Project include:

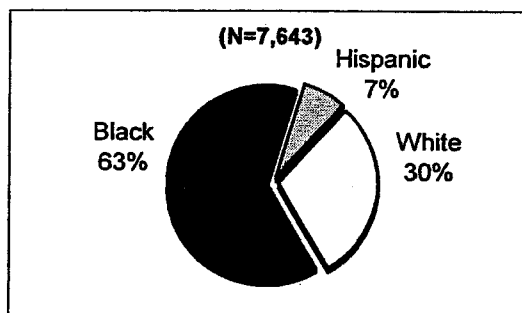
- Reducing HIV/AIDS morbidity and mortality
- Affirming the many existing efforts and current intervention strategies being utilized in Palm Beach County
- Increasing and enhancing current responses to HIV spectrum disease
- Contributing to HIV/AIDS prevention and medical treatment through a directed investigation of high risk populations using research conducted by high risk populations (i.e., injection drug users; men who have sex with men; minority males who have sex with males; minority females who have sex with men who have sex with men; those individuals who exchange sex for drugs; those individuals who exchange sex for money, etc.)
- Working in partnership with the local communities to gather information about treatment and prevention availability and effectiveness
- Presenting detailed information from people affected by a specific health problem who are seldom included in traditional research designs and implementation, yet are the people most affected by these problems.

RARE team members went to the heart of the local HIV/AIDS problem by combining traditional ethnographic field research techniques (observation, interviewing) and focus groups with innovative field research (e.g. street/village intercepts). Many of the most severely affected are considered subterranean, hidden or invisible. The RARE process and methodology raises the voices of the people to the highest levels of local and federal governments. With input from the Palm Beach County HIV CARE Council, the Palm Beach County Community Planning Partnership, and the designated RARE advisory committee, the data collected from this initiative, will be used to craft recommendations to guide the creation of an action plan to meet intervention challenges for the HIV continuum of care.

III. SELECTION OF PALM BEACH COUNTY AS A RARE STUDY SITE

DHHS targeted cities with the largest populations affected by HIV/AIDS. To be eligible for this assistance, cities had to have populations of at least 500,000 people and at least 1,500 African Americans and/or Hispanics living with HIV/AIDS. In addition, these two groups had to account for at least fifty percent of their community's HIV/AIDS cases. Once a city qualified under these criteria, the chief elected official had to make a request that DHHS dispatch a Crisis Response Team (CRT). Originally, twenty cities were eligible for this assistance. Eleven cities requested the assistance. Palm Beach County, while not a city, was one of the eleven first-tier sites selected for implementation of the RARE project.

Cumulative AIDS Cases by Race/Ethnicity in Palm Beach County, Through 2000



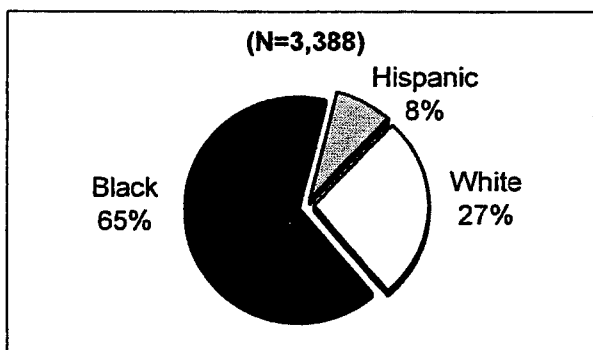
As of December 2000, a total of 7,643 residents of Palm Beach County have been diagnosed with AIDS. Sixty-three percent (4,815) were black and 7 percent (535) were Hispanic.

Of the 3,388 presumed alive adult AIDS cases in the county as of December 31, 2000, 65 percent (2,202) were black and 8 percent (271) were Hispanic.

The Advisory Board, using zip code-based HIV incidence data from the previous twelve months, identified four general areas in the county that appeared to meet the selection criteria of being areas in which HIV was having a disproportionate impact on the minority community. These four areas were initially identified as "North Coastal," "South Coastal," "Central Coastal," and "Western".

Through subsequent focus groups and individual interviews documented in the detailed findings, specific "hot spots" in the four areas were identified more precisely as specific road intersections. While, these intersections are precisely defined and documented in the findings, the terms "North Coastal," "South Coastal," "Central Coastal," and "Western" were retained in the narrative to avoid creating the misleading impression that the specific intersections are the only locations where HIV transmission is occurring.

Presumed Alive Adult AIDS Cases by Race/Ethnicity in Palm Beach County, as of 12/31/2000



IV. SELECTION OF THE PALM BEACH COUNTY CRISIS RESPONSE TEAM

Palm Beach County Health Department's Paul Moore, M.S.W. and Lou Reiter served as the project's Site Coordinators. Karen Dodge, Ph.D., Health Planner for the Palm Beach County HIV CARE Council, served as the project's Principal Investigator and Lead Ethnographer. Additional ethnographic planning and research services were provided by Barbara Feeney, M.P.A. (Health Planner for the Treasure Coast Health Council and Coordinator of the Palm Beach County HIV/AIDS Community Planning Partnership), and Michael Greene, M.P.A., (Health Planner for the Palm Beach County Health Care District).

Team Leaders and Members were selected in consultation with the local HIV/AIDS Advisory Board and the Office of HIV/AIDS Policy of DHHS from a variety of outreach and community planning resources (e.g., Palm Beach County HIV CARE Council, Palm Beach County HIV/AIDS Community Planning Partnership, community advocacy groups and individuals, and HIV testing, counseling, referral, and treatment providers).

The following RARE Team Leaders and Members implemented the five RARE data collection strategies at the RARE target sites:

North Coastal Team

Angrinette Hartnett, Team Leader
Gene Martin
Annette Murzike-Dunn, Team Co-Leader
Rev. Lewis White
Sandra White

Central Coastal Team

Guadalupe Mendez, Team Leader
Maria Mendez
Alfonso Mendez
Mark Paris, MD
Luiz Vazquez

South Coastal Team

Pierre Massilion, Team Leader
Barbara Petit-Homme
Kelly Fleury
Mark Paris, MD
Glory Saget

Western Team

Coretha Smith, Team Leader
Joseph Clerfond
Jay Jerome
Mary Jane Reynolds

V. THE SELECTION OF THE TARGET AREAS

In December 2000, the Advisory Board met and decided that the Crisis Response Team should target four distinct geographic areas as follows:

- ◆ North Coastal Area
- ◆ Central Coastal Area
- ◆ South Coastal Area
- ◆ Western Area

Although many factors were considered when selecting these areas, the major determining factor was a recent (as of mid-July 1997) epidemiological report of HIV infection in Palm Beach County by zip code. The zip codes with the highest number of HIV cases reported were considered the highest priority areas. Another factor considered was anecdotal information alluding to hidden pockets of migrant populations (e.g., Haitians and Guatemalans) who lacked knowledge of HIV risk or infection or who, for a variety of reasons, might not be receiving treatment. The Advisory Board listened to anecdotal reports of people in these areas who had never been tested and had “fallen through the cracks” of the current surveillance system or had been tested but were not receiving appropriate treatment. The Advisory Board agreed that the top priority of this initiative should be reaching those currently underserved populations.

While residents of the western portions of the County have already been the subjects of state and federal research regarding HIV/AIDS, many other sub-populations in the County have not been studied by research scientists at all. Therefore, to begin to ameliorate the gaps in knowledge about some of these other populations, this study included specific coastal populations in need of more effective prevention and treatment interventions.

**HIV Data
July 31, 1997 to September 2000
by Zip Code**

| Zip Code | 1997 - 2000 | |
|---------------------------|-----------------|---------------------|
| | Number of Cases | Percentage of Total |
| 33444 | 179 | 12.12% |
| 33401 | 156 | 10.56% |
| 33404 | 148 | 10.02% |
| 33407 | 146 | 9.88% |
| 33430 | 142 | 9.61% |
| 33460 | 102 | 6.91% |
| 33435 | 92 | 6.23% |
| 33476 | 33 | 2.23% |
| 33415 | 30 | 2.03% |
| 33445 | 26 | 1.76% |
| Total Top Ten Zip Codes | 1,054 | 71.35% |
| All P.B. County Zip Codes | 1,439 | 100.00% |

Source: Florida Department of Health, HARS Reporting System, 2000.

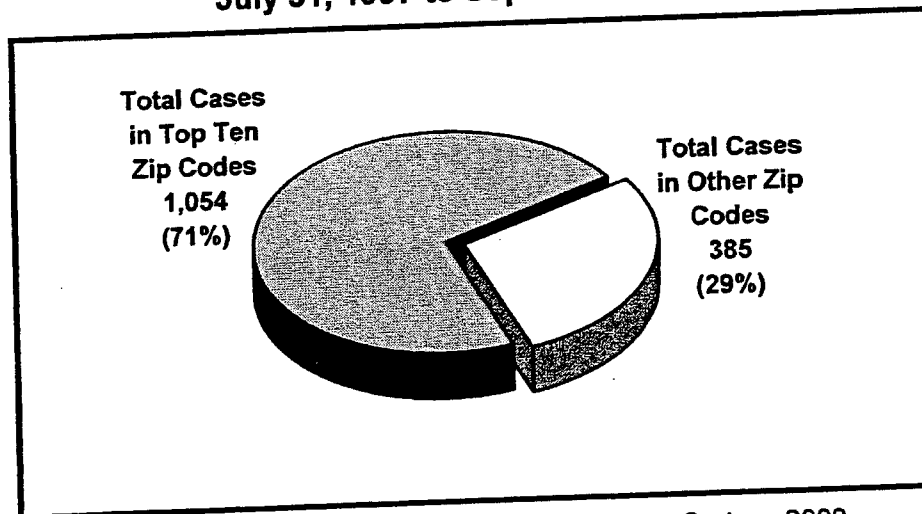
As summarized in the following table and chart, a total of 1,439 cases of HIV were diagnosed in Palm Beach County between July 31, 1997 and September 2000.

Ten zip codes accounted for 1,054 (71.35 percent) of all the cases in the County.

Of those ten zip codes, four were selected as areas to begin implementing the RARE methodology.

Note: Zip codes 33401 and 33407, which also have a high number and percentage of cases, were not selected as RARE sites because they are currently being studied through other initiatives.

**Total Cases in Top Ten Zip Codes of Palm Beach County
July 31, 1997 to September 2000**



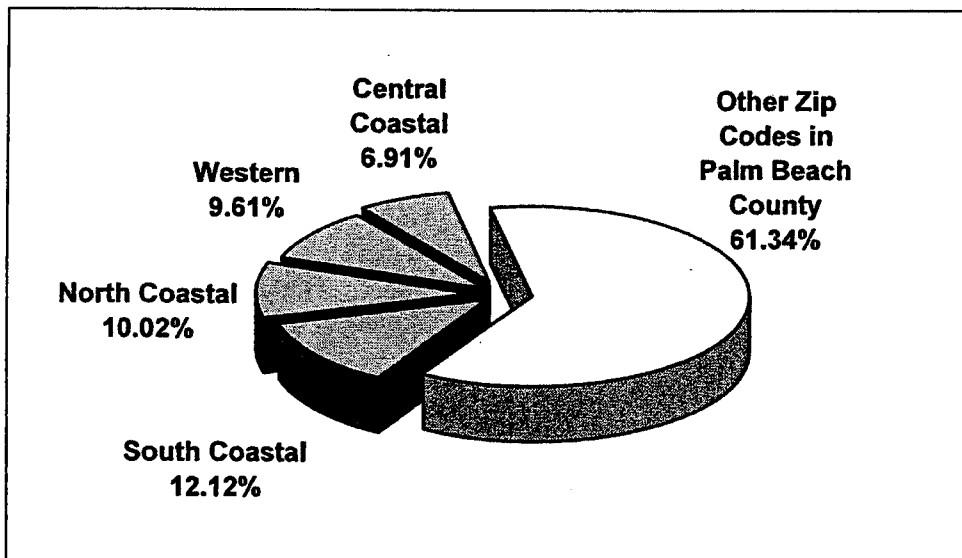
Source: Florida Department of Health, HARS Reporting System, 2000.

The four zip codes designated as the four RARE Areas accounted for 571 (38.33 percent) of all the cases in Palm Beach County during the baseline period. The following table and chart summarizes the number and percentage of cases in each zip code.

For the purpose of this study, these four areas were named “North Coastal”, “Central Coastal”, “South Coastal”, and “Western”, respectively. This wide geographic distribution was intended to identify a broad range of previously unidentified or underserved high-risk populations.

**HIV Data July 31, 1997 to September 2000 by Zip Code
for Zip Codes in Palm Beach County RARE Areas**

| RARE Area | Zip Code in Which Area is Located | 1997 - 2000 | |
|--|-----------------------------------|-----------------|---------------------|
| | | Number of Cases | Percentage of Total |
| <i>South Coastal</i> | <i>33444</i> | <i>179</i> | <i>12.12%</i> |
| <i>North Coastal</i> | <i>33404</i> | <i>148</i> | <i>10.02%</i> |
| <i>Western</i> | <i>33430</i> | <i>142</i> | <i>9.61%</i> |
| <i>Central Coastal</i> | <i>33460</i> | <i>102</i> | <i>6.91%</i> |
| Total Cases in Zip Codes Containing All Four RARE Sites | | 571 | 38.66% |
| Total Cases in P.B. Zip Codes Other Than the Four RARE Sites | | 868 | 61.34% |
| Total Cases in All P.B. County Zip Codes | | 1,439 | 100.00% |



Source: Florida Department of Health, HARS Reporting System, 2000.

VI. METHODOLOGY

A unique feature of RARE is its overall approach to data collection and analysis. Rapid assessments utilize a detective-like approach, which tends to neutralize any cultural or political incentives to deny the existence of certain activities, such as substance abuse and prostitution. The advantage of rapid assessment methods over other social science approaches is that it encourages the constant crosschecking of information from various sources. This helps uncover information that may be invisible to traditional methods of observation.

For example, the reports of Community Experts can be checked against the descriptions in Direct Observations. Investigators work inductively and build their conclusions or theories from the ground up by collating and checking from a wide array of sources. This is called "grounded theory", based on "idiographic" or "inductive" theoretical construction. This model aims at explanation through the enumeration of all the motivations and contributing factors in a given action or situation. The purpose of this type of research is to understand a particular situation as fully as possible. This type of research is considered "qualitative"; it complements and adds depth to "quantitative" research by enhancing mere numerical descriptions of people or cultures.

This research model also recognizes that, to be accurate and meaningful, researchers must view and describe a problem within its social, cultural, religious, political, and historical contexts. Thus, rapid assessments move across several levels of investigation in order to identify different potential levels of intervention. In the *Recommendations and Strategies* section of this report, the relationship between rapid assessment and intervention development will be more fully demonstrated.

In preparation for the actual fieldwork, the Advisory Board and the Field Team formulated interview questions and strategies. The questions were designed to elicit information about HIV/AIDS within the following three frameworks:

- ◆ Risk/protective factors
These questions were designed to elicit the nature of risk behavior as well as protective factors that facilitate risk reduction
- ◆ Context/environmental factors
These questions were designed to elicit information about the extent to which the environment influences HIV-related behaviors and how the environment influences access to current HIV prevention, care and treatment services
- ◆ Interventions/services
Lastly, these questions were designed to elicit information about the effectiveness of current prevention and intervention services. Care was taken to determine whether existing interventions and services were culturally appropriate and to encourage suggestions for future programmatic change

See Appendix for a complete list of the questions used in this study. Some examples of study questions are listed on the following page. Team Leaders converted the questions listed in this section into understandable, localized language.

Examples of Risk/Protective Factors Questions:

1. Who are the key groups that are vulnerable to HIV infection?
2. What are the exact risk behaviors in the vulnerable populations?
3. Where do risks occur?

Examples of Contextual/Environmental Questions:

1. What kinds of locations and social conditions produce the most intensive risk mixes or configurations?
2. When does the environment have an impact on HIV transmission?
3. Where are the physical and geographical barriers located that create risk or hinder intervention?

Examples of Intervention Questions:

1. What are the current local interventions targeting HIV risks and consequences?
2. Are current interventions adequate and effective?
3. When are these interventions available?

FIVE SPECIFIC DATA COLLECTION STRATEGIES

The five strategies described in this section were used to collect data to answer the research questions in this study.

A. FOCUS GROUPS

Focus groups were convened in each of the four geographic sites. These groups were comprised of cultural experts representing the following areas of expertise:

1. Policymakers and community leaders
2. Service providers responsible for delivering HIV services to the vulnerable populations
3. Members of the vulnerable populations

Across the four target areas, the majority of focus group participants were professionals and para-professionals working in the HIV/AIDS arena. Between four and thirteen individuals per group participated and there were approximately four groups per area of expertise. The information gathered emphasized the following aspects of HIV in the four geographic sites:

1. Identifying vulnerable populations
2. Establishing critical information on places and times of risk and intervention
3. Describing the services available and discussing the types of programs needed by and appropriate for the targeted groups
4. Identifying gaps in service that could be closed, either by changing an existing intervention or providing a new intervention

The information collected during these interviews was compared and triangulated with the key informant/community expert interviews and provided direction for direct observations, geo-mapping, and street intercept surveys.

B. KEY INFORMANT/COMMUNITY EXPERT INTERVIEWS

Individuals were selected from the three cultural expert groups described in the Focus Group section, and invited to provide one-on-one, open-ended, ethnographic interviews. The information gathered included:

1. Identification of vulnerable populations
2. Description of risks and protective factors that impact the identified populations
3. Description of available services
4. Discussion about the types of programs that might be effective for the population
5. Identification of prevention and treatment gaps that could be closed by introducing an effective and appropriate intervention.

The information gathered was compared and triangulated with focus group data and was used to design and plan the direct observations, geographical mapping, and street intercepts.

C. GEO-MAPPING

The RARE field team used observation techniques to provide information needed for all three assessment modules (i.e., Risk/Protective Factors; Contextual/Environment; and Intervention). The strategies utilized were mapping (by drawing), and verbally describing the observed risk behaviors, demographic information, service availability, and intervention sites in relation to the targeted populations.

D. DIRECT OBSERVATIONS

The RARE Field Team completed extensive direct observations at each site. After the Team had identified the primary hot spots by reviewing focus group feedback and community expert interviews, centers of HIV-risk behaviors were identified. These centers, compared to “hubs” of a wheel, became the focal points for this study. Risk behavior along pathways leading into and away from the “hubs” may be compared to “spokes” of a wheel. It is along these “spokes” of activity that various risk behaviors and factors travel and where “mixing” with other populations and behaviors occur.

Using interviews and focus groups of community experts, the risk behaviors were described, observed, and documented within their cultural context. Additionally, risk behaviors and protective factors were identified by Field Team members taking notes and/or recording the movements and behaviors of the target populations. Access routes for vulnerable populations receiving services were also observed and noted, as were barriers and facilitators for interventions. Finally, identification of changes in the environment in the context of risk was documented through primary time cycles (time of day, day of week, etc.).

E. RAPID ASSESSMENT SURVEYS/STREET INTERCEPTS

The RARE Team conducted several rapid assessment surveys to fill gaps in information for the risk, contextual, and intervention modules. These short (three to five) short-answer or closed-ended question surveys were used to collect information from small samples of individuals (approximately ten) across the three cultural expert populations. These surveys were constructed after the focus groups and interviews were completed to provide triangulation of previously unsupported data.

VII. KEY FINDINGS ACROSS ALL AREAS

1. Populations at Risk by Area

◆ North Coastal

Substance Abusers/Addicts
Prostitutes
Homosexuals
Primarily African-American

◆ Central Coastal

Guatemalans
Hispanics
Migrants
Primarily Guatemalan

◆ South Coastal

Primarily Haitians
Prostitutes
Drug Addicts
African Americans

◆ Western

Substance Abusers/Addicts
Prostitutes
African Americans
Primarily African-American, and immigrants from the Caribbean, West Indies, and Central and South America

2. The Fundamental Elements of Time and Place

In all four sites, time and place were influential factors in HIV risk, prevention, treatment, and access to services.

For example, some Haitians and Guatemalans, especially those from agrarian cultures, who have low levels of literacy, or have, recently, immigrated to the U.S., may be unfamiliar with the concept of “telling time” by a watch or a clock. Members of both populations may, instead, “tell time” in reference to an *event* rather than numbers on a clock. This is a critical factor to consider when scheduling appointments, expecting drug adherence, prescribing medications, or arranging for the delivery of social and/or medical services.

Additionally, in the southern coastal and central coastal areas, study participants reported being afraid to go to the Department of Health’s main HIV clinic because the U.S. Immigration and Naturalization Services (INS) is located the same building. Many Haitians and Guatemalans report being afraid of arrest and deportation. Thus, the proximity of patient care services to the INS appears to significantly impede access to care.

3. Beliefs, Attitudes, and Practices Relating to HIV/AIDS

At each site, study participants reported a variety of beliefs, attitudes, and practices relating to HIV/AIDS. Factors such as religious beliefs, medical practices, alternative therapies, gender-related issues, and stigmatization generated different approaches within each culture.

For example, reports of social and familial rejection were common among study participants. Testing, diagnosis, and treatment of HIV continue to be highly stigmatized within the targeted communities. HIV infected members of some target populations stated that, in their communities they are considered to be sinners or that their HIV infection is a punishment from God.

A significant disparity in power between men and women were observed within all four data collection sites but most prominently among recent Haitian and Guatemalan immigrants. Unprotected heterosexual sex, prostitution, and drug use were common themes relating to a disparity of power between men and women. Providers of clinical services reported a relatively high level of these risk behaviors and factors among Haitian and Guatemalans.

4. Variations in Language and Literacy

Study participants at three sites indicated that the inability to speak, read, and write English presented an obstacle to HIV prevention and treatment services.

For example, while some Guatemalans speak Spanish, most speak one of twenty-six Mayan Indian dialects. Unfortunately, many health care workers try to speak to them in Spanish while attempting to explain a complex HIV treatment protocol or the concept of transmission of bodily fluids.

5. The Mixing of Alcohol, Drugs, and Sex

In all four areas, study participants reported an interaction between alcohol, drugs, sex and HIV risk. The various populations interact, and HIV risk is highest, wherever high-risk sex and substance abuse meet.

As in all the major themes, there is variation in the relationship between substance abuse and sex. For example, it appears that within the Guatemalan and Haitian communities, alcohol and drugs are used to facilitate high-risk sex behavior. In contrast, within the African American communities on the coast and in the western part of the county, it appears that sex is performed to obtain drugs.

Underlying virtually all risk behaviors in all the target populations, issues related to poverty and economic incentives promote the sex-for-drugs and drugs-for-sex economy.

6. Prevention and Patient Care Services:

Lack of Awareness or Absence of Services in the Intervention Zones The Dichotomy Between Prevention and Patient Care Services

There were two major dimensions to the issue of services as follows:

1. Study participants indicated inadequate access to preventive and patient care services in the target areas.
2. Providers described a dichotomy between prevention and patient care services. Some prevention providers were critical of patient care services citing instances of perceived poor service delivery and an unwelcoming attitude toward patients from the hot spots. Likewise, some patient care providers reported being unaware of the efforts and successful outcomes of prevention services among target populations.

VIII. FINDINGS AND SUPPORTING QUOTATIONS BY AREA

This section of the report contains detailed information regarding HIV/AIDS risk/protective factors, context/environmental factors, and services/interventions in each of the four RARE study sites. The verbatim statements (with the local vernacular retained) are direct quotations from the focus group discussions, community expert interviews, and street intercept surveys.

Tables at the end of each area section summarize the qualitative data in a quantitative display. In order to convert the qualitative data into quantitative data, the ethnographers performed thematic or content analyses in which communications were analyzed in a systematic, objective, and quantitative manner. Six major themes were identified, thus creating six variables. At each site, various attributes emerged relating to the six variables, creating four unique constellations of barriers and risk factors in each of the intervention zones.

Data from all geographic areas were coded as relevant to the following themes:

- ◆ Populations at Risk
- ◆ The Fundamental Elements of Time and Place
 1. Barriers Related to Time and Place
 2. Risk Factors Related to Time
 3. Risk Factors Related to Place
- ◆ Variations in Language and Literacy
- ◆ Beliefs, Attitudes, and Practices Relating to HIV/AIDS
- ◆ The Mixing of Alcohol Sex and Drugs
- ◆ Services

It is important to note that percentages referenced in the narrative and in the tabular data were calculated by dividing the number of times a particular attribute was mentioned during a specific data collection strategy by the total number times all attributes in a particular theme were mentioned during that specific data collection strategy. Percentages do not necessarily refer to the number of individuals who mentioned specific attributes, but rather to the number of times a particular attribute was mentioned. These were tabulated across data collection strategies to produce un-weighted aggregate scores.

For example, in the North Coastal Area, there were five Focus Groups, and a total of twenty Focus Group participants. Those twenty participants had a total of sixty-eight responses relevant to *Populations at Risk*. Eighteen (26 percent) of those responses indicated that Substance Abusers/Addicts were at high risk in that target area.

Finally, *triangulation*, or *agreement* among data collection strategies is indicated by bolded type in the tables. In contrast, a "0" in one or more data collection strategies indicates *disagreement* relating to that particular attribute. For example, in the North Coastal Area, there was triangulation or agreement among all five data collection strategies that Substance Abusers/Addicts were a Population at Risk. In contrast, there was disagreement regarding Teens being a Population at Risk. Data from Focus Groups and Community Expert interviews revealed that Teens were thought to be a Population at Risk. However, data from Street Intercept Surveys did not support those findings.

North Coastal Area

Within Zip Code 33404

This area is comprised of a mix of commercial and residential properties. There are also numerous empty lots, abandoned buildings and empty houses. According to study participants, interspersed among mainstream establishments are numerous legitimate businesses that front for illegitimate enterprises. The primary function of the business site varies according to the time of day and the demands of the customers. For example, some grocery stores are also sites of drug dealing and some lawn maintenance services double as crack houses and homosexual brothels.

This area extends from Broadway on the east, to the railroad tracks on the west, and from 8th street on the South to Blue Heron Boulevard on the north.

Populations at Risk in the North Coastal Area

The populations most frequently mentioned as being at risk were Substance Abusers/Addicts (27 percent), Prostitutes (23 percent), and Homosexuals (18 percent).

- ◆ Substance Abusers/Addicts
- ◆ Prostitutes
- ◆ Homosexuals

Quotes:

“...it’s young blacks in our area...Females ages 13 on up...very young people out there.”

“...It’s not isolated because there’s a lot of drug use in this area...”

“...The prostitutes are giving it to the male clients and they take it home to their wife or girlfriend...”

“Substance abusers and also teenagers for there is a lot of insecurity going on. Substance abuse because the act itself causes you to act irresponsible and they don’t think to use protection, teenager lack of education.”

“It’s not isolated. There’s weekend warriors. The people just party on the weekend.”

“...a lot of time the black women take care for everybody but themselves.”

“...more people are using condoms...its easy to be in denial and that’s what most teenagers do.”

“...Its young blacks in our area...Females ages 13 on up...very young people out there.”

The Fundamental Elements of Time and Place in the North Coastal Area

The most frequently mentioned Barriers Related to Time and Place were "No services in hot zone" (88 percent) followed by "Black males won't go to the Health Department" (13 percent).

The most frequently mentioned Risk Factors Related to Time were "All the time" (30 percent) followed by "Evening" (26 percent), and "Weekends" (19 percent).

The most frequently mentioned Risk Factors Related to Place were "E Avenue" (21 percent), followed by "12th and 13th Streets" (16 percent) and "Broadway" (15 percent).

- **Barriers Related to Place**
 - No services in hot zone
 - Black males won't go to the Health Dep't.
- **Risk Related to Time**
 - All the time
 - Evenings
 - Weekends
- **Risk Related to Place**
 - E Avenue
 - 12th and 13th Streets
 - Broadway

Quotes:

"...Illegal drug activities...S Avnue, E Avenue, Dixie."

"...It could be any time, but say around the first of the month, Friday around pay day, you have women on AFDC they get their money once a month...It's a hard time, like 3 or 4 in the morning when they run out of money they'll do anything."

"...The white homosexual come out during the day, they don't want to be caught at night in the black neighborhoods...but the black homosexual come out any time unless the gay is in the closet and he don't want any one to know that he's gay."

"West side, 8th Street, S Avenue, 28th Street, 34th Street, [inaudible], Sam trans house, any place where you can buy drugs from is a hot spot, behind Walgreen on Broadway, Snooks bar, 26 Street, recreation place is a hot spot for teen-agers, abandon building, the Old Budget Inn, the drug dealer don't let the prostitute hang around then, [inaudible] Hall, Community Centers where people meet, Old Churches, T-rays, Singer Island."

"Avenue, Dixie Highway, wherever drug activity is going on."

"Stony Brooks low income apartments they are government apartments, 8th Street."

"S Avenue, Broadway and E Avenue, Blue Heron and 13th and back 'til bridge."

“Night action and when ever people have money.”

“There’s no special time for stuff to happen, but come to think of it I believe early in the morning hours, check time, 3rd of the month, they’re the people that get paid every two weeks, holidays, every day is a pay day to a crack head.”

“Weekends and Friday night.”

“Mostly on the weekend when the young folks are out partying and they don’t care and their using drugs are what ever that causes AIDS start from Thursday and goes on to Sunday night.”

“No special time. Early in morning, 1st and 3rd of month, everyday pay day to crack users. Fridays.”

“Anytime drugs and sex happens...night and weekends...when people have money.”

Beliefs, Attitudes, and Practices Relating to HIV/AIDS in the North Coastal Area

RARE participants in the North Coastal area indicated that the two leading beliefs and attitudes influencing HIV/AIDS are “Fatalism/Hopelessness” (20 percent), and “Denial of Risk” (19 percent).

Another major issue regarding beliefs, attitudes, and practices involves the reluctance of African-American men to access services at the local health department.

- ◆ **Fatalism/Hopelessness**
- ◆ **Denial of Risk**
- ◆ **Resentment/Vengeance**
- ◆ **Faith/church healing**
- ◆ **Denial of Risk**

Quotes:

[re: African-American men reluctant to get care at the clinic]

“Yes. Because they think they are okay.”

“If they got they don’t want to know, some feel if they got it, f_____ it I’m going to kill up the world.”

“...most of the men tend to be more stubborn, we feel like we are supermen and it does not deter us.”

“...they don’t want people to know that they got it.”

“We try and respect one another, not disrespect one another because of their condition. We try and go out of our way to make them feel a part. As far as getting any compassion from the outside, there is none, therefore the neighborhood has to take care of itself.”

[re: homosexual activity in the area]

"It's low key but it's out there...white and black."

"...It's undercover in the black community and ...don't see any white homosexual that come through."

The Mixing of Alcohol, Drugs, and Sex in the North Coastal Area

Study participants indicated that "Drugs" (28 percent), "Prostitution" (24 percent), and the "Interaction of Populations at Risk" (24 percent) were very important factors influencing HIV/AIDS in the North Coastal Area.

- **Drugs**
- **Prostitution**
- **The Interaction of Populations at Risk**

Quotes:

"...anytime drugs and sex happens..."

"...crack and unrestrained lust, heavy drug and alcohol activity contributes to contracting AIDS."

[re: prostitution] "...Broadway, E Avenue, Broadway to Silver Beach Road South to Delray Beach, black prostitutes, prostitutes are on Broadway too – in the streets, E Avenue, wherever crack is sold."

"Every prostitute smokes crack, everywhere in Palm Beach County anyway."

"...an old man...come looking for a girl every night about the same time and he [young black man, coming down from being high on drugs] said he told the old man to stop tricking with the girls because most of the girls that's in the area infected with the HIV virus and he said the man don't care and that let me know that there is awareness in the community. It seems like the drug just overpower them and their actions. Even though he was high he knew what was going on in his neighborhood."

"...Attitudes, when they're on that crack and can't get anymore they become aggressive, man they'll do anything you're talking about behavior, I mean crazy."

[re: hustlers and homosexuals] "...12th and E Avenue. Customers are people in the neighborhood...men, women, hot time to buy sex 24/7."

[re: homosexual activity in the area] "It's low key but it's out there...white and black."

Question: Are prostitutes and hustlers aware of risks? "Hell yeah, alot of people don't care. The John has move to leave. Prostitute don't care about nothing...money... a man [hustler] don't care..."

"Yes, they keep having unsafe sex because they don't care. Yes, because they don't care."

Question: Are the addicts aware of their risk for HIV? “Oh sure. A lot of people don’t believe they can catch it just because some one looks healthful he don’t believe they have it that don’t mean nothing, don’t think they can get it.”

“Everybody trying to get high, just basically trying to do everything to support it...some prostitute...some working...some stealing or either robbing.”

[re: addicts and prostitutes] “Everybody is mixed together.”

“They both the same that mix.”

“The drug addict get with the sex workers for sex and the sex workers get with the drug addicts for drug...”

“Its regular, crack, young and old people and middle age people are selling and buying the drugs.”

“Drug use is prevalent – all kinds. Businessman from work – from the sea cruises all kinds not just one kind coming through, very prevalent. This area the main drug is marijuana and cocaine – powder and hard.”

“Crack is the most widely drug that people use young, old, and middle age people use.

“Its acceptable, the white prostitute be on Broadway, and the black prostitute be on E Avenue, H Street...the customer come from out the hood, white Chinese, they buy sex any time.”

[re; prostitution in the neighborhood] Its heavy, the white prostitute has always been in the black neighborhood long before crack. The black prostitutes are in the black neighborhood. They hang on E-Avenue Broadway US 1. They work all around every day. The people that come around is middle class people, you have rich come through some time. They come from Palm Beach, Palm Beach Gardens, North Palm Beach they but sex all the time mostly at night.

“...the sex trade is everywhere...its the oldest trade since the beginning of times...”

“There are lot of Caucasian male and females that come through and they will solicit. You won’t see blacks buying sex, basically because everybody in this area sort of knows everybody. They do it discreetly but its hidden; when it comes to money and drugs they will do what they need.”

“E Avenue and Broadway – prostitution is like any other group that stick together, they move amongst each other, up and down Broadway.”

“S Avenue, Dixie Highway, wherever drug activity is going on.”

“You can see them in the drug area. Wherever you have drugs you have action. E. Avenue, S Avenue, 12th Street, its going on all in the hood man.”

"S Avenue, Broadway and E Ave., Blue Heron and 13th and back til Bridge."

"Illegal drug activities... S Ave., E Avenue, Dixie"

"Unrestrained lust, smoking crack, drug and alcohol"

"When they on crack and run out they get aggressive. Crazy behavior. [Prostitution?] Yea, that kinda thing."

[12th and E Ave.] "Crack used. Crack big time, everybody sells crack, men, women, both sell crack."

[re: prostitution] "Broadway – E Avenue – Broadway to Silver (inaudible) Beach Road (County line) south to Delray Beach. Black prostitutes on Broadway in the streets (E Avenue) wherever crack is sold."

[re: Are prostitutes and hustlers aware of risks?]

"Hell yeah, a lot of people don't care. The John has move to leave. Prostitute don't care about nothing...money... a man [hustler] don't care..."

[re: Are the addicts aware of their risk for HIV?] "Oh sure. A lot of people don't believe they can catch it just because some one looks healthful he don't believe they have it that don't mean nothing, don't think they can get it."

"Everybody trying to get high, just basically trying to do everything to support it...some prostitute...some working...some stealing or either robbing."

Services in the North Coastal Area

Although some of the respondents indicated knowledge of HIV services in the target area, a greater proportion was unaware of such services. Sixty-five percent of responses indicated the perception of the absence of HIV services in the hot zone and 35 percent indicated lack of awareness of existing services.

- **Lack of Awareness of HIV Services**
- **Absence of HIV Services in the Hot Zone**

Quotes:

"...CAP...the services that they provide is Education, Prevention, Out Reach, some Housing...by the time a person get to CAP they already have the HIV virus..."

"...George Place has been helping the homeless people and people with the HIV virus...Hope

House provide housing...the stigma needs to be address and lack of understanding among the general population..."

"CAP is doing Out Reach in the later hours now."

"If you go to the Health Department, most people know you got AIDS."

"The awareness is in the schools, Civil Court, CAP, continual education programs. The awareness is affected..."

"[Jay's Ministry] working in conjunction with C.A.P. every two months C.A.P. come to Jay's Ministry and do testing. He has been preaching for 4 years..."

"...If you're talking about on E Avenue, S Avenue, there's nothing in those areas, they need testing in those areas day and night, promoting prevention they don't have anything in place in those areas."

"...They have programs now, treatment program, these people who have this disease will go to the program which they will get help with al the paper work. And there are nurses and doctors there to help to prevent the disease from spreading. It's even in the school they have people that comes out from different organizations to talk to the students and some churches have programs also to help people with the knowledge about the disease"

" Now it's [i.e. information] mostly within all Communities because they know theirs a big need, school has the health program, ...church has a program that helps, the walk-in clinic's such as the health department. It's available all a person has to do is seek for it and you do have representatives that go out and speak to people about the disease...Grace Episcopal 3600 Australian."

"Don't know of services. At least not in areas I just mentioned... E Ave., S Ave., nothing."

"They effective if they're used. Awareness is there. It lies now at level of responsibility of individuals."

"Schools, Partnership for Drug-Free Community, civil courts, CARP, continuing ed. programs, C.A.P. [Awareness?] Very effective. [Stopping spread of virus?] Very effective."

"[at 12th and Ave. E) CAP up here and Health Department, but they don't have people come out in the field anymore. Services are available from 9-4 I think. Last time you saw anyone doing street outreach – 8 days ago. Never got HIV results. Some people from the church passing out condoms."

"None really, I don't see none come out. Last time I saw one of them was 11 months, the church giving out condoms and rubbers."

[re: awareness of hustlers and prostitutes]

"Yes I feel like they do because they know the consequences you can die, some people have

AIDS and you can tell they have it...some just don't care, they live for the moment and just go at it."

"Of course, it's been here so long, if you honestly say that you don't know what you're dealing with you have to be real naive."

"Yes they are aware of the risky behaviors. It's the person mind set...there's a lot of people using safe precautions he know that because the people ask [him] if they could by a condom from him They just don't care and they feel like it can't happen to them.

[re: awareness of addicts]

"Don't be in the right state of mind, they be high."

"Health Department, Salvation Army, couple of rehabs that help people out, I was just in one myself, couple of them are available 24 hours with an open door policy...hasn't seen anybody in a while."

"Agencies in the neighborhood [12th and E Avenue] no never have. Fellows or ladies that have been to the clinic and come back may give out some but any agencies, no."

"None that [he] know of and [he] been living in Riviera Beach all of his life and he has never seen anyone come in the neighbor concerning HIV."

"...one church group...came out to do testing about three or four months ago...don't remember the name of the church."

Factors that Influence HIV Prevention/Treatment in the North Coastal Area

| Factors that Influence HIV Prevention / Treatment | | Aggregated Responses from Five Data Collection Strategies | | | | | | | | | | | |
|---|--|---|-----|---------------------------------------|-----|-----------------------------------|-----|--------------------------------|-----|--------------------------------|-----|---------------------------------|-----|
| | | Focus Groups (N=5, n=20) | | Community Expert Interviews (N=10) | | Street Intercept Surveys (N=8) | | Direct Observations (N=2) | | Geo-mapping (N=7) | | Total (N=32) | |
| | | total number of responses = 68 | | total number of responses = 77 | | total number of responses = 56 | | total number of responses = 22 | | total number of responses = 33 | | total number of responses = 256 | |
| Populations at Risk | | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| African Americans | | 7 | 10% | 9 | 11% | 6 | 11% | 1 | 5% | 2 | 6% | 25 | 10% |
| Nationalities | | 4 | 5% | 0 | 0% | 0 | 0% | 1 | 5% | 0 | 0% | 5 | 2% |
| Hispanics | | 1 | 1% | 2 | 2% | 0 | 0% | 0 | 0% | 0 | 0% | 3 | 1% |
| Whites | | 1 | 1% | 5 | 6% | 3 | 5% | 0 | 0% | 0 | 0% | 9 | 4% |
| Men | | 2 | 2% | 5 | 6% | 0 | 0% | 1 | 5% | 3 | 9% | 11 | 4% |
| Women | | 4 | 5% | 5 | 6% | 3 | 5% | 1 | 5% | 2 | 6% | 15 | 6% |
| Homosexuals | | 11 | 16% | 9 | 11% | 11 | 20% | 1 | 5% | 13 | 39% | 45 | 18% |
| Prostitutes | | 15 | 22% | 12 | 15% | 16 | 29% | 8 | 36% | 7 | 21% | 58 | 23% |
| Johns | | 0 | 0% | 2 | 2% | 4 | 7% | 0 | 0% | 0 | 0% | 6 | 2% |
| Substance Abusers/Addicts | | 18 | 26% | 23 | 29% | 13 | 23% | 8 | 36% | 6 | 18% | 68 | 27% |
| Teens | | 4 | 5% | 6 | 7% | 0 | 0% | 1 | 5% | 0 | 0% | 11 | 4% |
| Unemployed | | 1 | 1% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 0% |

Factors that Influence HIV Prevention/Treatment in the North Coastal Area

| The Fundamental Elements of Time and Place | | Aggregated Responses from Five Data Collection Strategies | | | | | | | | | | | |
|--|--|---|------|------------------------------------|-----|--------------------------------|-----|-------------------------------|------|--------------------------------|-----|---------------------------------|-----|
| | | Focus Groups (N=5, n=20) | | Community Expert Interviews (N=10) | | Street Intercept Surveys (N=8) | | Direct Observations (N=2) | | Geo-mapping (N=7) | | Total (N=32) | |
| Barriers Related to Time and Place | | total number of responses = 6 | | total number of responses = 5 | | total number of responses = 6 | | total number of responses = 0 | | total number of responses = 0 | | total number of responses = 16 | |
| | | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| No services in hot zone | | 6 | 100% | 4 | 80% | 4 | 80% | 0 | 0% | 0 | 0% | 14 | 88% |
| Black males won't go to Health Dept. | | 0 | 0% | 1 | 20% | 1 | 20% | 0 | 0% | 0 | 0% | 2 | 13% |
| Risk Factors Related to Time | | total number of responses = 19 | | total number of responses = 23 | | total number of responses = 11 | | total number of responses = 1 | | total number of responses = 0 | | total number of responses = 54 | |
| | | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| Early Morning | | 4 | 21% | 3 | 13% | 0 | 0% | 0 | 0% | 0 | 0% | 7 | 13% |
| Lunch | | 1 | 5% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 2% |
| Evenings | | 5 | 26% | 4 | 17% | 4 | 36% | 1 | 100% | 0 | 0% | 14 | 26% |
| Weekends | | 4 | 21% | 4 | 17% | 2 | 18% | 0 | 0% | 0 | 0% | 10 | 19% |
| All the time | | 4 | 21% | 8 | 35% | 4 | 36% | 0 | 0% | 0 | 0% | 16 | 30% |
| Payday | | 1 | 5% | 1 | 4% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 4% |
| First of the month (when the checks come) | | 0 | 0% | 3 | 13% | 1 | 9% | 0 | 0% | 0 | 0% | 4 | 7% |
| Risk Factors Related to Place | | total number of responses = 35 | | total number of responses = 33 | | total number of responses = 17 | | total number of responses = 4 | | total number of responses = 25 | | total number of responses = 114 | |
| | | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| Trick houses | | 2 | 6% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 2% |
| Gay brothels | | 10 | 29% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 10 | 9% |
| Cars | | 1 | 3% | 0 | 0% | 0 | 0% | 1 | 25% | 5 | 20% | 7 | 6% |
| Back Rooms of Bars | | 3 | 9% | 1 | 3% | 0 | 0% | 1 | 25% | 1 | 4% | 6 | 5% |
| E Avenue | | 1 | 3% | 9 | 27% | 8 | 47% | 1 | 25% | 5 | 20% | 24 | 21% |
| 12th and 13th Streets | | 0 | 0% | 5 | 15% | 4 | 24% | 1 | 25% | 8 | 32% | 18 | 16% |
| S Avenue | | 3 | 9% | 5 | 15% | 1 | 6% | 0 | 0% | 1 | 4% | 10 | 9% |
| Dixie Highway | | 0 | 0% | 2 | 6% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 2% |
| Broadway | | 5 | 14% | 7 | 21% | 2 | 12% | 0 | 0% | 3 | 12% | 17 | 15% |
| 8th Street | | 2 | 6% | 1 | 3% | 2 | 12% | 0 | 0% | 0 | 0% | 5 | 4% |
| Bathrooms | | 6 | 17% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 6 | 5% |
| Abandoned Buildings | | 2 | 6% | 2 | 6% | 0 | 0% | 0 | 0% | 2 | 8% | 6 | 5% |
| Motels | | 0 | 0% | 1 | 3% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 1% |

Factors that Influence HIV Prevention/Treatment in the North Coastal Area

Aggregated Responses from Five Data Collection Strategies

| Factors that Influence HIV Prevention / Treatment | Focus Groups (N=5, n=20) | | Community Expert Interviews (N=10) | | Street Intercept Surveys (N=8) | | Direct Observations (N=2) | | Geo-mapping (N=7) | | Total (N=32) | |
|---|--------------------------------|-----|------------------------------------|-----|--------------------------------|-----|--------------------------------|-----|--------------------------------|-----|---------------------------------|-----|
| | total number of responses = 46 | % | total number of responses = 20 | % | total number of responses = 8 | % | total number of responses = 0 | % | total number of responses = 0 | % | total number of responses = 75 | % |
| Beliefs, Attitudes, & Practices | (f) | | (f) | | (f) | | (f) | | (f) | | (f) | |
| Resentment/Vengeance | 4 | 9% | 3 | 15% | 2 | 22% | 0 | 0% | 0 | 0% | 9 | 12% |
| Stigmatization | 14 | 30% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 14 | 19% |
| Faith/church healing | 4 | 9% | 3 | 15% | 1 | 11% | 0 | 0% | 0 | 0% | 8 | 11% |
| Homophobia | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Gender/power disparities | 3 | 7% | 3 | 15% | 0 | 0% | 0 | 0% | 0 | 0% | 6 | 8% |
| Fatalism / Hopelessness | 7 | 15% | 5 | 25% | 3 | 33% | 0 | 0% | 0 | 0% | 15 | 20% |
| Denial of Risk | 5 | 11% | 6 | 30% | 3 | 33% | 0 | 0% | 0 | 0% | 14 | 19% |
| Domestic Violence | 2 | 4% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 3% |
| Wanting Love | 6 | 13% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 6 | 8% |
| No condoms | 1 | 2% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 1% |
| The Mixing of Alcohol, Drugs, and Sex | total number of responses = 62 | | total number of responses = 62 | | total number of responses = 61 | | total number of responses = 27 | | total number of responses = 20 | | total number of responses = 232 | |
| Alcohol | 4 | 6% | 1 | 2% | 0 | 0% | 1 | 4% | 1 | 5% | 7 | 3% |
| Drugs | 19 | 31% | 22 | 35% | 12 | 20% | 8 | 30% | 4 | 20% | 65 | 28% |
| Prostitution | 15 | 24% | 12 | 19% | 16 | 26% | 8 | 30% | 5 | 25% | 56 | 24% |
| Other High Risk Sexual Behavior | 15 | 24% | 11 | 18% | 15 | 25% | 3 | 11% | 5 | 25% | 49 | 21% |
| The Interaction of Populations at Risk | 9 | 15% | 16 | 26% | 18 | 30% | 7 | 26% | 5 | 25% | 55 | 24% |
| Services | total number of responses = 11 | | total number of responses = 9 | | total number of responses = 6 | | total number of responses = 0 | | total number of responses = 0 | | total number of responses = 26 | |
| Lack of Awareness of HIV Services | 5 | 45% | 3 | 33% | 1 | 17% | 0 | 0% | 0 | 0% | 9 | 35% |
| Absence of HIV Services in Hot Zone | 6 | 55% | 6 | 67% | 5 | 83% | 0 | 0% | 0 | 0% | 17 | 65% |

Central Coastal Area

Within Zip Code 33460

The Central Coastal RARE site is located in a mixed Latino and Guatemalan neighborhood near the downtown area. It extends from Lucerne Avenue to the north with surrounding alleys and streets, to Lake Avenue on the south with surrounding alleys and streets. The eastern boundary is U.S. 1 and the western boundary is Avenue C.

Populations at Risk in the Central Coastal Area

Unlike in the North Coastal Area, respondents in the Central Coastal Area identified ethnicity as an indicator of risk. Guatemalans were mentioned most frequently (20 percent), followed by Hispanics (15 percent).

Quotes:

"...Guatemalans and Hispanics combined."

"...Puerto Ricans, Cubans, Hispanics with Guatemalans folded in."

"...Migrant Guatemalans."

- ♦ **Guatemalans**
- ♦ **Hispanics**
- ♦ **Prostitutes**
- ♦ **Substance Abusers/Addicts**

The Fundamental Elements of Time and Place in the Central Coastal Area

The Guatemalans and Latinos in the Central Coastal Area report that going to the Health Department in Riviera Beach is problematic for two reasons. First, the U.S. Immigration and Naturalization Service (INS) is located in the same building as the Health Department's HIV clinic. Study participants reported being afraid to go there because they were unsure of their citizenship status and did not want to be detained, arrested, and deported. 31 percent of the responses alluded to the INS at Broadway as a barrier to services.

Second, the Health Department in

- ♦ **Barriers**
 - INS at Broadway**
 - No services in the hot zone**
 - No services in Lantana**
 - No transportation**
- ♦ **Risk Factors related to Time**
 - High-risk behavior occurs on weekends**
- ♦ **Risk Factors related to Place**
 - Brothels in the Neighborhood**
 - Near the markets**

Riviera Beach is approximately twenty miles from the target area in the central coastal area. Participants indicated that this distance is a major barrier to access. Instead, participants indicated they would prefer HIV services to be available at the Health Department in Lantana. Not only is the Health Department in Lantana perceived to be safer and more welcoming, it is close to home and participants are accustomed to walking there to access health care services for their children.

Quotes:

“...The clinic at Broadway is right next to INS. The people won’t go. They are afraid of getting deported. I am afraid of being without papers...”

“...The people are afraid of the department of health. It is hard to find. Immigration is there. People afraid to go to D.O.H. ‘cause of Immigration being in the same building...”

“...The Hispanic people don’t go to the ‘clinic’ at Broadway because Immigration is there. We don’t want to be put in prison then sent back...”

“...They can’t get there because there is no transportation.”

“...Money is a big part of life. A few hours spent at the Health Department is not considered important to me. Add a few hours for transportation...its not worth it. Money is scarce... We don’t see medical services as important until we get so sick...”

“...There are no HIV services in Lantana where the people are. There are no services in the Labor Camps. We need to get services there. There are Costa Rican, El Salvadoran, Guatemalan and other Hispanic groups. We all need services. It’s a headache. But we must find a way.”

Cultural Beliefs, Attitudes, and Practices Relating to HIV/AIDS in the Central Coastal Area

Faith/Church healing (24 percent) and Gender/power disparities (14 percent) were the two most frequently mentioned factors in this category in the Central Coastal Area.

The Mixing of Superstition, Santeria, Faith-Healings, and Catholicism

- **Faith/Church Healing**
- **Gender/Power Disparities**
- **Santeria**
- **Homophobia**

While HIV/AIDS presents an array of complex problems within the Guatemalan and Hispanic populations, an understanding of the cultures is essential to developing effective interventions. As in all cultures, spiritual and religious beliefs play a central role in Guatemalan and Hispanic social behavior, including some of the behaviors influencing HIV risk.

For example, most Guatemalans and Hispanics have been deeply influenced by Catholicism. Some aspects of Catholicism, for example, its support of monogamous marriage and sex, are

strong protective factors against HIV. However, some respondents suggested that in its opposition to artificial birth control, Catholicism may impede access to the use of condoms, a major protective factor against the transmission of HIV.

The situation is further complicated in that the mixing of Catholicism and Santeria (a form of Voodoo) exerts a profound influence on HIV risk. Like the Haitians in the South Coastal Area, the Guatemalans and Hispanics in the Central Coastal Area believe that a combination of Santeria and/or Catholic rituals can render the HIV-infected individual "healed" and, therefore, incapable of spreading the disease.

Another example of the influence of the mixing of Catholicism and Santeria is the belief that those who are infected with the "virus" are believed to have done something wrong, or that a family member has committed a sin and that the HIV infection is the punishment. The recommended cure is a mix of Catholicism and Santeria, specifically, penance and expensive faith healings, respectively.

Because the Hispanic culture believes that the infected person has done something to deserve the infection of the HIV virus, the stigma of HIV has dire spiritual and social implications. Therefore, this population goes to great lengths to deny diagnosis and tends to report their illnesses are due to causes other than HIV infection.

Quotes:

"...The 'disease' is viewed as a punishment. I did something wrong or my sister did something wrong. My parents did something wrong. That is why I am sick. We Guatemalans believe in Santeria. There is no 'germ' concept. Our people view a lot of disease as punishment. It doesn't make sense to take medicine...we don't believe it's a 'virus'; we believe it's a curse for sin. We have a belief about what needs to be done...going back to Guatemala, some kind of ritual, some kind of cure with herbs or cleansing."

"...I visit religious healer when children are sick with the 'evil eye'. I will pay her about \$100.00 per visit. I won't go for myself. I can't afford it..."

"...The healings of HIV are based on the power of your faith in God. We don't take our meds. The Guatemalans believe meds is the cause of death. Dentists can provide alternative care in here for HIV. He said he can test people for HIV. Not one person showed up for the test. You can buy medicine here. For \$20.00 you can buy a shot of penicillin or a box of birth control pills. If you get the shot of penicillin you get through with HIV..."

"...I am a religious healer. I practice Gods' gift. I see about 16 people a day. Most of my patients are pregnant women. They come to me to make sure the fetus is okay. The people know about some services in the community but they will not go for it because they never had it in Guatemala. The most common illness they got is the evil eye...diarrhea, nausea, fever...I give them an herb bath (ruda), tea and some herbs. Patient only needs to see me about 5 or 6 times. Guatemalans are at risk because of alcoholism. When they are under the influence of alcohol then they get involved with prostitutes. There are some Guatemalan prostitutes and some American prostitutes."

“...Our people sell their meds on the street. Those who are HIV sell their meds to others who are sick with the same symptoms...treating themselves....”

“...I don't pay anyone to do the healings for me. I believe in the power of God to heal me of HIV and my faith will improve my health. The members of my church will heal me...”

“...I'm going back to Guatemala to get healed. They can there. Guatemalans go see Natural Healers...”

“...I can get healed of HIV by going back to Guatemala. I believe I don't require meds...”

“...When will I be healed of HIV? My mom says that she can cure me if I go back to Guatemala...”

Gender and Power Disparities in the Central Coastal Area

Two of the HIV risk factors adversely affecting Guatemalan and Hispanic women are that their perceptions that they are not at risk at all, and that it would be inappropriate for them to protect themselves from risk by insisting on risk reduction practices. Specifically, they are in denial regarding the possibility of HIV transmission from their sexual partners. Although the women are expected to be monogamous, faithful, and never refuse a request for sexual relations, there is tacit acceptance of more varied sexual behavior for their husbands or boyfriends and asking men to use condoms is taboo.

Study participants also reported situations in which a group of men or a family “adopt” a young vulnerable woman or adolescent and use her as a communal sexual partner. Women in these high-risk arrangements tend to believe that there are no viable options for them. Even more troubling, these women feel powerless to ask their partners to use prophylactics. They believe that making such a request; much less a demand would undermine their entire economic and social support system. Therefore, these women refrain from making such a request out of fear that if they are perceived as too demanding and aggressive their partners will leave them. This is tantamount to abandonment and the loss of financial support for this extremely vulnerable population of women and their children.

Quotes:

“...Many homeless people living in the same house. The women must have sexual relations with the men to stay there under their protection. They have relations; sexual with each other. One lady, her husband died of AIDS. She had nowhere to go. A house with 3 families took her in. Within one year, everyone in the house is infected with HIV. Investigation of the house happened. People all disappeared without a trace. They were gone...”

“...Relations with all men in the house is common. We as Hispanic males do not pay attention to our health. We only seek help when we are really sick. Diarrhea, fever, cold and infection of the our genitals...”

“...Men don't really talk to women about sexual. I asked a man if he was married. After eight months he said he was living with a girl; 17 years old. I said we must test her because you're HIV. He said 'no'. 'I'll bring a Spanish case worker because she's pregnant', I say. She's six

months pregnant. He won't let anyone near her. She needs to go to the 'Clinic'. No doctor. Finally she goes to clinic. She starts asking him questions. He won't say anything to her. She's positive. The baby's okay. Man dies of AIDS. She started to realize what was going on. He went back to Guatemala to be cured and came back. He died of AIDS..."

"...There's lots of drinking, domestic violence and unprotected sex. It is disrespectful to discuss sex with a woman. I won't do it..."

"...Often the men will have sex with young girls who are members of the original house they stayed in. That is how it goes in my community..."

"...I do not discuss sex with my husband..."

The stigmatization, social isolation, and ostracism associated with HIV risk behavior, diagnosis, and treatment, deeply affects the population in the Central Coastal Area.

"...If we're sick, we go to the emergency room. That's how we get services. Hispanics believe that HIV is for homosexuals, so the heterosexual males don't want to go to 'Clinic'. We're afraid someone will see us. We cross the county to avoid contact. Our families don't know we're positive. Which is probably why they don't take meds. Most of our families write us off if they find out we're HIV..."

"...Often, our men will have sex with the young children in the house of the original house they stayed in. The parents then abandon them. Kick them out into the street because they're no longer clean. It's survival for the children, then..."

"...There is in our Migrant community loneliness. It makes our man go to the prostitutes..."

"...Guatemalans have a hard time admitting they are gay. Puerto Ricans who are here admit. Not Guatemalans."

Variations in Language and Literacy as Barriers to Services in the Central Coastal Area

Language Barriers were the single most frequently mentioned barriers to services in the Central Coastal Area. Seventy-five percent of the responses indicated "language barriers" and 25 percent indicated "literacy barriers".

- ◆ Language Barriers
- ◆ Literacy Barriers

Non-English speaking Guatemalans and Hispanics face enormous barriers to accessing HIV prevention and treatment services. Difficulties in removing these barriers are complicated by the ethnic, cultural, and linguistic diversity in immigrant populations in Palm Beach County.

For example, approximately twenty-two distinct Guatemalan dialects are spoken in the Central

Coastal Area. Indeed, this diversity even impedes communication among Guatemalans, one of the groups that have most recently immigrated to the Central Coastal Area of Palm Beach County. Further, many Guatemalans do not speak Spanish at all, so that health care information provided in Spanish is as inadequate as information provided in English.

Reportedly, Spanish-speaking Health Department staff used hand signals and drew pictures to communicate with Guatemalans about the transmission of HIV. The effectiveness of this method is uncertain.

An important cultural finding is that, among Hispanics and Guatemalans, discussions related to sex are taboo. Compounding the effect of this taboo among Guatemalans, the Guatemalan language does not have a word for "semen", making it difficult to discuss one important way in which HIV is transmitted.

Quotes:

"...I've heard the totally wrong translation. Also people don't tell time. Every 8 hours means nothing to them. You have to use your hands to tell them. People who are Spanish speaking use their hands to try to communicate with Guatemalan. They use their hands to describe the HIV transmission and protease. It doesn't get through without language and cultural beliefs..."

"...The language can't be faked. They're trying to fake the Mayan dialects. It's hard enough in English..."

"...We are migrant people. We move around the country depending on the season. We don't go to the school. We don't read..."

"...I never have a problem communicating with the immigrants. I explain in my own way, using hands or draw pictures..."

"...We need and don't have Spanish speaking with knowledge of HIV and disease..."

"...We used to go to Labor Camps with services; no more..."

"...Sex is not spoken of among Guatemalans. The Hispanic and Guatemalan communities are very different. There's diversity so, uncommon goals. I speak Konkobal. This is different from Spanish..."

"...Language is the biggest barrier we have."

"...A lack of respect that authorities ask these people to bring young sons and daughters to translate even for STD classes where they show parents how to use condoms."

The Mixing of Alcohol, Drugs, and Sex in the Central Coastal Area

The behavioral intersect, or “mixing” between substance abusers/addicts and commercial sex workers in the target areas increases the risk of HIV transmission in the hot spots and to the broader community.

“Prostitution” was cited in 40 percent of the responses, followed by “Alcohol” (26 percent) and the “Interaction of Populations at Risk” (19 percent).

- **Prostitution**
- **Alcohol**
- **The Interaction of Populations at Risk**
- **Drugs**

Initially, when questioned, study participants denied drug abuse among the Hispanics and Guatemalans. Further probing revealed that the influence of indigenous taboos against illegal drug use has weakened, and youth of the Guatemalan and Hispanic cultures, like their American counterparts, are indeed using and abusing drugs.

Commercial sex workers in this neighborhood are set up in “cat” houses. Alcohol is served while the men await their sexual encounters. Additionally, legitimate neighborhood businesses front as drug distribution centers and sex procurement operations. The RARE field team observed an all male “cat house” adjacent to one of the markets.

Quotes:

“...Whenever the Guatemalans have a family here they don’t search for prostitutes. When they alone here they seek prostitutes. The males come to the US first. Alcohol and prostitutes starts in USA for solitary Guatemalans males. It’s the US teenagers that show how it is done in the US Teenagers as a group. There’s a mix now of drug behaviors...”

“...Sex is not spoken of in the Guatemalan culture. Barely in the Hispanic. Parents don’t want their children participating in the sex education at school. If the parents don’t read or write then children can’t take sex education at school. No permission if it’s not written permission. We need alcohol counseling. Every body drinks now, then, has sex. While they’re waiting for sex in the Whore houses, they drink alcohol to get ready...”

“...Alcoholism, prostitution and drugs. That’s how it goes. The drugs are marijuana and crack...”

“...Black and white American prostitutes come to stay at the labor camps. We come from the Broadway and Northwood areas, south. Us prostitutes like living on the labor camps. It is good job for us. It’s better than walking Broadway ...”

“...The prostitutes live in the same house with 20 people. Everybody drinks a lot. We get the women in the city, then bring them to the house...”

“...Friday night is pay day. They continue on Saturday and Sunday. They buy everything at the two stores...or behind the two stores. Behind the stores is where all the drug activities happen 6:00 p.m. ‘til midnight.

“...Behind the two stores you can buy drugs and prostitutes. That’s where we offer the services. In our community it is alcoholism and prostitution that puts them at risk. We offer it most on Friday and Saturday evenings...”

“...Guatemalans have a hard time admitting they are gay. Puerto Ricans who are here admit, not Guatemalans. In Guatemala, people are gay in the city not in rural with same sex. When gay is sick they go to emergency room that’s how they hear of clinic...”

“...Here there is prostitution for commodities... Sex for phone, sex for food, sex for rent. Prostitutes are drug addicts. There is prostitution for drugs, Prostitutes can’t make it. We can’t do any better. It’s survival for us. It’s a way to pay off people who brought you here. About \$5,000.00 to pay off the debt of bringing you here...”

“...Prostitutes are Guatemalan, Mexican and White girls. It happens payday, Friday, on into Saturday and Sunday. The black prostitutes are in the Labor Camps...”

“...There are three houses of prostitution here. They charge about \$20.00 per client. Each one is for a different sex...”

“...Alcohol, prostitution, and drugs...That’s how it goes. The drugs are marijuana and crack.”

“...At the whorehouse the people bring you there. People answer the door and check you out and let you in. You enter a room. They sell beers to you and you wait for sex. Two women and twenty men. Clients go two times a week. The price is ten to twenty-five dollars. Depends on the service.”

“...Here there is prostitution for commodities. Prostitution for a house. Prostitutes are drug addicts. There is prostitution for drugs. Prostitutes can’t make it. Who can’t do any better.

Services in the Central Coastal Area

Many study participants reported being unaware of the availability or provision of HIV-related services in the target area.

“Lack of Awareness of HIV Services” was cited in 66 percent of the responses and “Absence of HIV Services in the Hot Zone” was cited in 34 percent of the responses.

- ♦ **Lack of Awareness of HIV Services**
- ♦ **Absence of HIV Services in the Hot Zone**

Quotes:

“...Money is a big part of life. A few hours spent at DOH. is not considered important to me. Add a few hours for transportation...it’s not worth it. Money is scarce. We don’t see medical services as important until we get so sick...the clinic has no night hours...after work so we can work and then go...or early in the A.M.”

“...There are no HIV services in Lantana where our people are. There are no services in the Labor Camps. We need to get services there. There are Costa Rican, El Salvadoran, Guatemalan and other Hispanic groups. We all need services. It’s a headache. But, we must find a way...”

“...African Americans work with African Americans because of grants. There’s outreach and education with Blacks. No grants for Spanish education and outreach. It doesn’t happen here in the neighborhood. No Spanish speaking. Only three or four who speak Spanish for all of West Palm area. Caseload is enormous. Not enough workers...”

“...There used to be an Hispanic organization and outreach workers from Health Department used to educate and outreach a long time ago. At the present time, I’m not familiar with any HIV program in the area...”

“...I’ve been living in the neighborhood for about six months. There’s no HIV services here...”

Factors that Influence HIV Prevention/Treatment in the Central Coastal Area

| Factors that Influence HIV Prevention / Treatment | Responses from Various Data Collection Techniques | | | | | | | | | | | |
|---|---|-----|-----------------------------------|-----|--------------------------------|-----|--------------------------------|-----|-------------------------------|-----|---------------------------------|-----|
| | Focus Group Participants (N=4, n=26) | | Community Expert Interviews (N=4) | | Street Intercepts (N=13) | | Direct Observation (N=3) | | Geo-mapping (N=4) | | Total (N=28) | |
| | total number of responses = 56 | % | total number of responses = 25 | % | total number of responses = 58 | % | total number of responses = 21 | % | total number of responses = 9 | % | total number of responses = 169 | % |
| Populations at Risk | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) |
| Guatemalans | 14 | 25% | 4 | 16% | 13 | 22% | 1 | 5% | 1 | 11% | 33 | 20% |
| Hispanics | 10 | 18% | 2 | 8% | 5 | 9% | 7 | 33% | 1 | 11% | 25 | 15% |
| Mexicans | 4 | 7% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 4 | 2% |
| Migrants | 11 | 20% | 1 | 4% | 5 | 9% | 3 | 14% | 1 | 11% | 21 | 12% |
| Teens | 7 | 13% | 2 | 8% | 3 | 5% | 0 | 0% | 0 | 0% | 12 | 7% |
| Lonely | 2 | 4% | 1 | 4% | 7 | 12% | 0 | 0% | 0 | 0% | 10 | 6% |
| Men | 4 | 7% | 5 | 20% | 2 | 3% | 0 | 0% | 1 | 11% | 12 | 7% |
| Women | 2 | 4% | 2 | 8% | 3 | 5% | 3 | 14% | 1 | 11% | 11 | 7% |
| Prostitutes | 1 | 2% | 5 | 20% | 10 | 17% | 2 | 10% | 3 | 33% | 21 | 12% |
| Substance Abusers/Addicts | 1 | 2% | 3 | 12% | 10 | 17% | 5 | 24% | 1 | 11% | 20 | 12% |

Factors that Influence HIV Prevention/Treatment in the Central Coastal Area

| Factors that Influence HIV Prevention / Treatment | | Responses from Various Data Collection Techniques | | | | | | | | | | | |
|---|--|---|------|---------------------------------------|-----|--------------------------------|-----|--------------------------------|------|--------------------------------|------|---------------------------------|-----|
| | | Focus Group Participants (N=4, n=26) | | Community Expert Interviews (N= 4) | | Street Intercepts (N=13) | | Direct Observation (N=3) | | Geo-mapping (N=4) | | Total (N=28) | |
| Barriers Related to Time and Place | | total number of responses = 19 | | total number of responses = 7 | | total number of responses = 13 | | total number of responses = 0 | | total number of responses = 0 | | total number of responses = 39 | |
| | | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| INS at Broadway | | 7 | 37% | 0 | 0% | 5 | 38% | 0 | 0% | 0 | 0% | 12 | 31% |
| No transportation | | 5 | 26% | 0 | 0% | 2 | 15% | 0 | 0% | 0 | 0% | 7 | 18% |
| Long wait at clinic | | 2 | 11% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 5% |
| No services in hot zone | | 1 | 5% | 4 | 57% | 3 | 23% | 0 | 0% | 0 | 0% | 8 | 21% |
| No services in Lantana | | 2 | 11% | 3 | 43% | 3 | 23% | 0 | 0% | 0 | 0% | 8 | 21% |
| Inability to tell time | | 2 | 11% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 5% |
| Risk Factors Related to Time | | total number of responses = 1 | | total number of responses = 7 | | total number of responses = 6 | | total number of responses = 1 | | total number of responses = 1 | | total number of responses = 16 | |
| | | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| Weekends | | 1 | 100% | 4 | 57% | 3 | 50% | 1 | 100% | 0 | 0% | 9 | 56% |
| Evenings | | 0 | 0% | 3 | 43% | 3 | 50% | 0 | 0% | 1 | 100% | 7 | 44% |
| Risk Factors Related to Place | | total number of responses = 8 | | total number of responses = 5 | | total number of responses = 36 | | total number of responses = 28 | | total number of responses = 27 | | total number of responses = 104 | |
| | | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| Lake Avenue | | 0 | 0% | 0 | 0% | 8 | 22% | 5 | 18% | 3 | 11% | 16 | 15% |
| Lucerne Avenue | | 0 | 0% | 0 | 0% | 3 | 8% | 3 | 11% | 3 | 11% | 9 | 9% |
| Avenues D, E, and F | | 1 | 13% | 0 | 0% | 6 | 17% | 6 | 21% | 4 | 15% | 17 | 16% |
| Near the markets | | 4 | 50% | 3 | 60% | 7 | 19% | 5 | 18% | 4 | 15% | 23 | 22% |
| At the Taqueria | | 1 | 13% | 0 | 0% | 0 | 0% | 4 | 14% | 3 | 11% | 8 | 8% |
| Bars | | 2 | 25% | 0 | 0% | 0 | 0% | 1 | 4% | 3 | 11% | 6 | 6% |
| Brothels in the neighborhood | | 0 | 0% | 2 | 40% | 12 | 33% | 4 | 14% | 7 | 26% | 25 | 24% |

Factors that Influence HIV Prevention/Treatment in the Central Coastal Area

| Factors that Influence HIV Prevention / Treatment | | Responses from Various Data Collection Techniques | | | | | | | | | | | |
|---|--|---|-----|-----------------------------------|-----|--------------------------------|-----|-------------------------------|-----|--------------------------------|-----|---------------------------------|-----|
| | | Focus Group Participants (N=4, n=26) | | Community Expert Interviews (N=4) | | Street Intercepts (N=13) | | Direct Observation (N=3) | | Geo-mapping (N=4) | | Total (N=28) | |
| Beliefs, Attitudes, and Practices | | total number of responses = 16 | | total number of responses = 40 | | total number of responses = 22 | | total number of responses = 0 | | total number of responses = 0 | | total number of responses = 78 | |
| | | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| Santeria | | 1 | 6% | 6 | 15% | 3 | 14% | 0 | 0% | 0 | 0% | 10 | 13% |
| Return to Guatemala | | 3 | 19% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 3 | 4% |
| HIV Viewed as Punishment | | 1 | 6% | 4 | 10% | 2 | 9% | 0 | 0% | 0 | 0% | 7 | 9% |
| Stigmatization | | 0 | 0% | 3 | 8% | 1 | 5% | 0 | 0% | 0 | 0% | 4 | 5% |
| Faith / Church Healing | | 5 | 31% | 8 | 20% | 6 | 27% | 0 | 0% | 0 | 0% | 19 | 24% |
| Homophobia | | 0 | 0% | 4 | 10% | 4 | 18% | 0 | 0% | 0 | 0% | 8 | 10% |
| Gender / power disparities | | 3 | 19% | 3 | 8% | 5 | 23% | 0 | 0% | 0 | 0% | 11 | 14% |
| Domestic Violence | | 3 | 19% | 2 | 5% | 1 | 5% | 0 | 0% | 0 | 0% | 6 | 8% |
| Black Market Pharmaceuticals | | 0 | 0% | 10 | 25% | 0 | 0% | 0 | 0% | 0 | 0% | 10 | 13% |
| Variations in Language and Literacy | | total number of responses = 34 | | total number of responses = 6 | | total number of responses = 12 | | total number of responses = 0 | | total number of responses = 0 | | total number of responses = 52 | |
| Language Barriers | | 27 | 63% | 4 | 67% | 8 | 67% | 0 | 0% | 0 | 0% | 39 | 75% |
| Literacy Barriers | | 7 | 16% | 2 | 33% | 4 | 33% | 0 | 0% | 0 | 0% | 13 | 25% |
| The Mixing of Alcohol, Drugs, and Sex | | total number of responses = 31 | | total number of responses = 27 | | total number of responses = 47 | | total number of responses = 9 | | total number of responses = 25 | | total number of responses = 139 | |
| Prostitution | | 17 | 55% | 16 | 59% | 13 | 28% | 6 | 67% | 3 | 12% | 55 | 40% |
| Alcohol | | 10 | 32% | 7 | 26% | 18 | 38% | 0 | 0% | 1 | 4% | 36 | 26% |
| Drugs | | 4 | 13% | 4 | 15% | 13 | 28% | 0 | 0% | 1 | 4% | 22 | 16% |
| The Interaction of Populations at Risk | | 0 | 0% | 0 | 0% | 3 | 6% | 3 | 33% | 20 | 80% | 26 | 19% |
| Services | | total number of responses = 22 | | total number of responses = 6 | | total number of responses = 32 | | total number of responses = 5 | | total number of responses = 0 | | total number of responses = 65 | |
| Lack of Awareness of HIV Services | | 16 | 73% | 4 | 67% | 19 | 59% | 4 | 80% | 0 | 0% | 43 | 66% |
| Absence of HIV Services in Hot Zone | | 6 | 27% | 2 | 33% | 13 | 41% | 1 | 20% | 0 | 0% | 22 | 34% |

South Coastal Area

Within Zip Code 33444

The South Coastal RARE site is in a predominantly Haitian neighborhood extending from East Atlantic Boulevard to S.E. 5th street and from South Swinton Avenue to S.E. 4th Avenue.

The target area consists of a main street (S.E. 2nd Avenue) running parallel to the railroad tracks. A hot spot of HIV risk activity is located just west of the tracks. This area resembles a Caribbean village with many shops, including several Voodoo (Haitian for Voodoo) shops, selling Haitian products. Homes and businesses appear to be Haitian due to the reliquaries displayed in the yards and visible from the windows. Atlantic Avenue, on the north side of this corridor, is a burgeoning business district well known for fine dining, an abundance of art galleries, and numerous up-scale gift and clothing shops. The southern boundary is S.E. 5th Street, which intersects the railroad. The eastern boundary is S. Federal Highway, which is lined with mainstream American businesses and fast food restaurants.

Along the western boundary, close to Swinton Avenue, mixing of African Americans and Haitians occurs. This is the hub of sexual and drug-related activity for South Coastal Palm Beach County. Despite this mixing, Haitians participating in this project reported a distinct division between Haitians and African Americans characterized by ethnic and racial tensions, fear, and mistrust.

Crack use, commercial sex work, and unprotected sexual practices are the main HIV/AIDS risk behaviors detected in this zone. Although the area initially appears clean and well kept, the RARE team gathered information suggesting that sexual and drug practices among Haitians are arranged in the businesses along the main strip of S.E. 2nd Avenue and practiced in rundown tenements on the streets designated for sex and drug activities.

The Health Department clinic is approximately three miles from this zone, yet residents report that they know little about the Health Department and do not know how to get there. *Hope House of the Palm Beaches* operates a small office on S.E. 4th Avenue and provides case management but no medical services are offered in the zone at all. There are several soup kitchens and missions north of Atlantic Avenue, but, reportedly, few Haitians will go there. St. Marks Episcopal Church operates a new after-school program on Swinton Avenue and has expressed a desire to expand services to include other Haitian-related activities. This parish is considered to be one of the most socially prominent, well-funded Episcopal parishes in Florida, and is located at the epi-center of the HIV/AIDS disease in south coastal Palm Beach County.

Populations at Risk in the South Coastal Area

The most frequently cited populations at risk in the South Coastal Area were Haitians (27 percent), Prostitutes (20 percent), Drug Addicts (13 percent), and African Americans (12 percent).

- ♦ **Haitians**
- ♦ **Drug Addicts**
- ♦ **Prostitutes**
- ♦ **African Americans**

Quotes:

“...Many of our Haitian here are mountain Haitian people from the mountain villages.”

“... Young people from ages 15 to 35.”

“...Predominately its minorities, blacks, mostly Haitians...”

The Fundamental Elements of Time and Place in the South Coastal Area

The most frequently mentioned factors related to time and place included “No services in the hot zone” (49 percent), “Evenings” (38 percent), “Payday” (25 percent), “Along 2nd Avenue” and “Along 4th and 5th” (each 21 percent).

Notably, Haitian participants perceived the fundamental element of time differently than most HIV prevention and patient care service providers. Initially, the Field Team identified this factor during a focus group of health care providers.

For example, not only would their Haitian clientele fail to keep scheduled appointments, but patients who were instructed to adhere to strict pharmaceutical regimens were unable to comply with the required timing of medications. This was explained by reference to the Haitian concept of the temporal dimension of life whereby reference to an *event*, which is part of the overall pattern and sequence of life, is used to schedule activities. Numbers on a clock have little meaning to Haitian immigrants.

The RARE Field Team itself had to consider the Haitian temporal concept in order to conduct this study. The Haitian members of the RARE team, familiar with the Haitian timeframe, knew this would be a factor in planning and conducting interviews and focus groups. The Team explained they would need to go to participants’ residences and wait for them to return from work and bring them to the prearranged appointments. The Team predicted that, on their own, Haitian participants would show up at their own convenience and not at a pre-arranged clock-time.

We explored this concept at greater depth by inquiring about it during community expert interviews. Apparently, the Haitian emphasis of *event*, rather than linear clock-time, is entirely consistent with the agrarian, non-literate, and village culture of Haiti.

Barriers Related to Time & Place

- ◆ No Services in the Hot Zone
- ◆ Inability to Tell Time
- ◆ Immigration Status & Location of Services

Risk Factors Related to Time

- ◆ Evenings
- ◆ Payday

Risk Factors Related to Place

- ◆ Along 2nd Avenue
- ◆ Along 4th and 5th
- ◆ Trick Houses

Quotes:

“...Many of our Haitian here are Mountain Haitian people; from the mountain villages. We don’t tell time like in the U.S. in the villages. We go by the thing happening...”

“...I cannot read. My friend help me with my appointment. I take my med but not on time because I cannot read the label or the time...”

“...Most of the Haitian do not tell time. Even the one who read does not put emphasis on time...”

“...I do not tell time because I do not read. I cannot really show of the time...”

“...We don’t tell time like in the U.S. in the villages. We go by the thing happening.”

“...I take my med, but not on time, because I cannot read the label or the time.”

“...There are no HIV services that I’m aware of in the community. I know that some center tried to answer the need of the community.”

“...No street level access. No service in language people understand. I don’t know where the clinic is.”

“...Not many HIV services. I do not know of anyplace in the community. We need it. We need for a special center for HIV/AIDS and at present time no services for Haitian patients.”

Beliefs, Attitudes, and Practices Relating to HIV/AIDS in the South Coastal Area

“Voodoo”, at 27 percent, and “Stigmatization” at 16 percent, were the most frequently cited Beliefs, Attitudes, and Practices related to HIV/AIDS. Other factors in this category included “Homophobia” (15 percent) and “Faith/Church Healing” (12 percent).

- ♦ **Voodoo**
- ♦ **Stigmatization**
- ♦ **Homophobia**
- ♦ **Faith/Church Healing**

Quotes:

“...Most of the Haitians care for they self and give they self they own medicine.”

“We Haitians sell our meds and our condoms.”

“...Voudou is all we have...as high as five thousand dollars.”

“...Most of our people when we get sick most of us buy ticket and fly to Haiti to look for Voudou priest or faith healer. Very expensive.”

“...We, Haitian believed that Voudou can heal the HIV disease.”

“...In our community, if someone is infected, you're out. Plus HIV bring on the TB infection.”

Voudou

The majority of community experts interviewed from this area were Haitian and, in general, they demonstrated a lack of understanding about HIV/AIDS prevention, risk, diagnosis, and treatment. Clearly, their beliefs about HIV/AIDS and their preferred methods of treatment did not conform to current mainstream medical protocols. The Haitians who were interviewed tend to believe that HIV/AIDS is the result of a curse cast upon the infected individual or a member of their family. Treatment, therefore, involves paying a Voudou Healer to lift the curse through a series of “healings”. These “healings” can cost between two and twenty thousand American dollars and is a very lucrative local industry. The “healings” can be performed either in the United States or in Haiti. The “healings” performed in the U.S. are less expensive and are considered less effective. The “healings” are customized for each individual. The common elements are prayer; bathing with a variety of unguents, oils and colognes; the burning of scarred smoking leaves or sticks; the drinking of teas; the eating of blessed foods and herbs; and the rituals of dance, song and sacrifice. Many Haitians believe that once they have completed the “healing”, they are cured, rendering protected sex and drug practices irrelevant and unnecessary.

Quotes:

“Naturally, all Haitians, whether they admit it or not, request this counseling and/or help. It is in the thousands of thousands.”

“...It is the premier source of help most of us Haitians look whenever one get sick to consult one of the Voudou Priests...”

“...Even though they may have the knowledge, they would still visit Voudou priest for any sickness. But, that the mentality, concept, culture...”

Black Market Pharmaceuticals

Participants described self-diagnosis, peer-diagnosis and Voudou practitioner-diagnosis as the most frequently used diagnostic approaches for HIV infection. Likewise, recommendations for and dispensing protease inhibitors, antibiotics and other HIV/AIDS related drugs are made through these same channels. Reportedly, some Haitians will receive clinical services, including prescribed medications at the local Health Department, take a small dose and sell the rest. Sales are made on the street to those who have similar symptoms, or to local Voudou Practitioners who make substantial profits by using some of the drugs in their practice and re-selling the rest in their shops.

Quotes:

“...The Haitians do not have enough. That is why we share and sell medicine...”

“...Most of us do not have insurance. We won't go to hospitals. We use our own medicines 'cause they're affordable and we prefer it. We use the herbs and leaves...”

“...It is part of our culture to self-diagnosis and share medicine...”

Gender and Power Disparities in the South Coastal Area

Reportedly, the Haitian culture is patriarchal and polygamous. Men are socially, economically, and sexually dominant. During individual interviews, Haitian women, reported that they had no right to ask their male partners about fidelity. Nor did they feel comfortable requesting that the men wear condoms. Their fears were that they would jeopardize their households, their children, and financial support. In addition, the Haitian women did not feel that they had the right to refuse sexual requests from their partners.

Quotes:

“...Males have always been dominant over the females. Females are afraid that their partners will leave them; we can't tell our husbands about condoms...”

“...Haitian males are polygamous. Our females are not allowed to ask to have protected sex... I do not ask either...”

“...Females cannot ask the men to have protected sex. Our women are nothing in the eyes of the man. Man has one wife but can have mistresses. The female can't force the male to wear condoms because the male is supporting her financially so she does what he wants...”

“...Even though women are well regarded in this society, men are the leaders. Males tend to be polygamous especially if they come from the countryside. Women tend to be reluctant for two main reasons. 1. Belief in having a child ...”(the rest of the sentence was left incomplete).

Stigmatism, Social Isolation, and Ostracism in the South Coastal Area

The Haitians participating in this project revealed that being observed entering into the Health Department clinic would cause social isolation and ostracism. Because community support is so important, visiting to the clinic is avoided. In fact, to avoid social stigma, seeking medical treatment is often delayed until a person is near death. Stigmatization occurs because the community believes that the HIV/AIDS diagnosed individual is cursed. Further, if it is determined that a Haitian male is homosexual, the isolation and ostracism is intensified and can become dangerous, even deadly, for that individual. The Haitians participating in this study said that if a male is seen entering the clinic to get tested, it is assumed that he is HIV+ and a homosexual. The result is social isolation and all the ramifications associated with stigmatization.

Quotes:

...”I’m afraid of people who are sick. Humiliation is still prevalent. Discrimination is still practiced against Haitians because of no Haitian HIV providers. Haitians is a very macho society Homosexuality is not viewed as something positive. Men who are homosexual try to hide the fact...”

“...Haitians with the HIV virus do not get family support. We fear of getting the virus by eating or drinking out of the same cup or from being in the same house as the diarrhea or touching diarrhea or smelling diarrhea when cleaning the person...”

“...In our community, if someone is infected, you’re out. Plus AIDS brings on the TB infection. If the woman is a big woman, that means she is healthy and not sick with AIDS. If she is thin, you stay away. In Haiti, people hate homosexuals. Some people, even if you’re their own family, they’ll kill you...”

“...There is the impact of the stigma. Our people don’t want to be seen going into the clinic. If they are men and they think they are gay. Homosexuality is not a good thing in our culture. Sometimes you can be killed for that...”

Variations in Language and Literacy in the South Coastal Area

“Language Barriers” were indicated in 75 percent of the responses and “Literacy Barriers” in 25 percent. There was agreement across four of the data collection strategies identifying language and literacy as barriers.

- **Language Barriers**
- **Literacy Barriers**

Quotes:

“...About 80% of our Haitian does not read.”

“...Language is a barrier for us. Our culture is also a barrier. Most people who work do not reflect the population. To have someone to translate for you – it is a major problem.”

The Field Team reported that language barriers impeded access to prevention services, clinical services, and adherence to treatment protocols. Although the target population in this area is composed of predominately Creole-speaking Haitian immigrants and a small, French-speaking minority, study participants indicated there are few Creole-speaking social workers and even fewer Creole-speaking health care workers providing HIV related services.

Compounding the literacy problem is the fact that Creole became a written language only three years ago. Therefore, not only is translation itself difficult, most Haitian immigrants cannot read

the newly created language. Because HIV prevention and patient care information written in English or Creole has a relatively small readership among this population, most HIV information is presented vocally, person-to-person.

Quotes:

“...There is not enough Creole information...”

“...There’s not enough people who speak Creole that provide the HIV services...”

“....We, as Haitians, are able to relate to their own. Need more Haitian educators...”

The Mixing of Alcohol, Drugs, and Sex in the South Coastal Area

The Mixing of Alcohol, Drugs, and Sex was a frequently cited theme in the South Coastal Area. Forty percent of responses mentioned “Prostitution”, 26 percent mentioned “Alcohol”, and 19 percent cited “The Interaction of Populations at Risk.”

- **Prostitution**
- **Alcohol**
- **The Interaction of Populations at Risk**
- **Drugs**

The economies of sex in exchange for money, sex in exchange for drugs, sex in exchange for money and drugs and/or the practices of either unprotected sex or shared intravenous injection equipment is practiced among the Haitian population in the target area. Haitian participants initially reported that intravenous drug abuse does not occur in their culture. Upon further probing, it was found that the assimilation and integration occurring among African American and Haitian youth in this target area promotes the sharing of drug practices, thus creating a bond of IDU substance abuse between the two cultures. During nighttime direct observations, young male Haitians were observed dealing drugs on the street corners and alleys alongside their African American counterparts. Thus, relationships are often cultivated within a context of high-risk behavior and activity.

This mixing is also noted with regard to the marketing of commercial sex. Reportedly, negotiations for covert Haitian prostitution (purchased at seemingly legitimate storefronts and enacted at close proximity in designated private homes) is occurring in the same area as street solicitation (usually associated with prostitution observed in inner city neighborhoods). The street solicitation was observed most frequently during the early morning hours. All the street prostitutes were women. There was a noticeable absence of male prostitution.

Another finding was that sex in exchange for commodities (rather than cash) was not considered prostitution. Rather, the Haitians viewed it as a form of “family contribution.”

Thus, the intersection between sex, alcohol, drugs, and cash create numerous risk factors for HIV transmission within the Haitian community in this South Coastal “hot spot”.

Quotes:

“... We Haitians do not use condoms. Sex is bigger than drugs...”

“... Sex for money here does not play a role. No money, no sex...”

“... Drug use play a major role causing one to lose control. I need clean needles when drugs are injected. The young Haitians imitate the Black Americans, so we take drugs and buy sex from the Americans and do other things...”

“... For Haitians it's hard to tell when they are homosexual because it's taboo. And it's taboo for the homosexual's to buy any sex...”

“... Haitian buy sex from Americans. The tendency in our community is that older Haitians will drink alcohol, while younger ones might tend to use drugs...”

“... I sell sex for cheap; as low as \$10.00 an act. I am having unprotected sex It is between American, Black American and Haitian. The young Haitians males buy sex from Americans. So they'll take drugs too and do other things that Americans...”

Services in the South Coastal Area

Many participants mentioned inadequate access to services. Sixty-six percent of responses indicated “Lack of Awareness of HIV Services” and 34 percent mentioned “Absence of HIV Services in Hot Zone.”

- ♦ **Lack of Awareness of HIV Services**
- ♦ **Absence of HIV Services in Hot Zone**

When community experts were asked if they knew of HIV/AIDS related services in their neighborhood, the majority was not able to describe such provisions. Some Haitians were able to reference the public health clinic; yet, they didn't know where it was. The participants were quick to request church-based services, noting that in their culture, churches provide everything, including health care. They further clarified this request by explaining that in Haiti, churches were trustworthy and did not represent the government. Community experts said services were provided at Haitian churches, it must be done in a way to assure safety from government influence. Otherwise, the community would stay away, fearing reprisal.

Quotes:

“... There are no HIV services that I'm aware of in the community. I know that some center try to answer the needs of the community...”

“... Some HIV services are available but, we need more services. There's not enough...”

“... Not many HIV services. I do not know of any place in the community. We need it. We need for a center special for HIV /AIDS and at present time no services for Haitian patients...”

“... No street level access. No service in language people understand. I don't know where the 'clinic' is...”

Factors that Influence HIV Prevention/Treatment in the South Coastal Area

Responses from Various Data Collection Techniques

| Factors that Influence HIV Prevention/ Treatment | Focus Group Participants (N=5, n=20) | | Individual Interviews with Cultural Experts (N=9) | | Street Intercepts (N=18) | | Direct Observation (N=4) | | Geo-mapping (N=2) | | Total (N=38) | |
|--|---------------------------------------|-----|---|-----|--------------------------------|-----|--------------------------------|-----|--------------------------------|-----|---------------------------------|-----|
| | total number of responses = 34 | | total number of responses = 43 | | total number of responses = 74 | | total number of responses = 34 | | total number of responses = 10 | | total number of responses = 195 | |
| | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| Populations at Risk | | | | | | | | | | | | |
| Haitians | 15 | 44% | 6 | 14% | 21 | 28% | 8 | 24% | 2 | 20% | 52 | 27% |
| Mountain Haitian | 0 | 0% | 1 | 2% | 3 | 4% | 0 | 0% | 0 | 0% | 4 | 2% |
| African Americans | 5 | 15% | 2 | 5% | 12 | 16% | 4 | 12% | 0 | 0% | 23 | 12% |
| Men | 0 | 0% | 4 | 9% | 11 | 15% | 3 | 9% | 1 | 10% | 19 | 10% |
| Women | 1 | 3% | 3 | 7% | 3 | 4% | 1 | 3% | 2 | 20% | 10 | 5% |
| Young People (15-35) | 0 | 0% | 4 | 9% | 3 | 4% | 4 | 12% | 1 | 10% | 12 | 6% |
| Prostitutes | 4 | 12% | 10 | 23% | 13 | 18% | 9 | 26% | 3 | 30% | 39 | 20% |
| Drug Addicts | 4 | 12% | 8 | 19% | 8 | 11% | 5 | 15% | 1 | 10% | 26 | 13% |
| Homosexuals | 4 | 12% | 4 | 9% | 0 | 0% | 0 | 0% | 0 | 0% | 8 | 4% |
| Bisexuals | 1 | 3% | 1 | 2% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 1% |

Factors that Influence HIV Prevention/Treatment in the South Coastal Area

| Factors that Influence HIV Prevention/ Treatment | | Responses from Various Data Collection Techniques | | | | | | | | | | Total (N=38) | | |
|---|---|---|---|--|----|--------------------------------|---|-------------------------------|---|-------------------------------|---|--------------------------------|----|-----|
| | | Focus Group Participants (N=5, n=20) | | Interviews with Cultural Experts (N=9) | | Street Intercepts (N=18) | | Direct Observation (N=4) | | Geo-mapping (N=2) | | | | |
| | | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | | | |
| The Fundamental Elements of Time and Place | | | | | | | | | | | | | | |
| Barriers Related to Time and Place | | total number of responses = 18 | | total number of responses = 3 | | total number of responses = 22 | | total number of responses = 1 | | total number of responses = 1 | | total number of responses = 45 | | |
| No transportation | 2 | 11% | 0 | 0% | 3 | 14% | 0 | 0% | 0 | 0% | 0 | 0% | 5 | 11% |
| Clinic is too far away | 3 | 17% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 3 | 7% |
| Long wait at clinic | 2 | 11% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 4% |
| No services in hot zone | 5 | 28% | 3 | 100% | 12 | 55% | 1 | 100% | 1 | 100% | 1 | 100% | 22 | 49% |
| Inability to tell time | 0 | 0% | 0 | 0% | 6 | 27% | 0 | 0% | 0 | 0% | 0 | 0% | 6 | 13% |
| No papers re: immigration status | 5 | 28% | 0 | 0% | 1 | 5% | 0 | 0% | 0 | 0% | 0 | 0% | 6 | 13% |
| Government presence in health clinics | 1 | 6% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 2% |
| Risk Factors Related to Time | | total number of responses = 3 | | total number of responses = 1 | | total number of responses = 1 | | total number of responses = 3 | | total number of responses = 0 | | total number of responses = 8 | | |
| Early Morning | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 33% | 0 | 0% | 0 | 0% | 1 | 13% |
| Daytime | 1 | 33% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 13% |
| Evenings | 0 | 0% | 1 | 100% | 0 | 0% | 2 | 67% | 0 | 0% | 0 | 0% | 3 | 38% |
| Weekends | 1 | 33% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 13% |
| Payday | 1 | 33% | 0 | 0% | 1 | 100% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 25% |
| Risk Factors Related to Place | | total number of responses = 4 | | total number of responses = 3 | | total number of responses = 0 | | total number of responses = 9 | | total number of responses = 8 | | total number of responses = 24 | | |
| Trick houses | 1 | 25% | 1 | 33% | 0 | 0% | 0 | 0% | 1 | 11% | 0 | 0% | 3 | 13% |
| Along 2nd Avenue | 0 | 0% | 0 | 0% | 0 | 0% | 3 | 33% | 3 | 33% | 2 | 25% | 5 | 21% |
| Nightclubs | 1 | 25% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 11% | 0 | 0% | 2 | 8% |
| Crackhouses | 1 | 25% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 4% |
| Cheap Motels | 1 | 25% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 4% |
| Along 4th and 5th | 0 | 0% | 2 | 67% | 0 | 0% | 3 | 33% | 0 | 0% | 0 | 0% | 5 | 21% |
| Alleys | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 11% | 0 | 0% | 1 | 4% |
| Cars | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 6 | 75% | 6 | 25% |

Factors that Influence HIV Prevention/Treatment in the South Coastal Area

| Responses from Various Data Collection Techniques | | | | | | | | | | | | |
|---|---------------------------------------|-----|--|-----|--------------------------------|-----|-------------------------------|------|-------------------------------|----|---------------------------------|-----|
| Factors that Influence HIV Prevention/ Treatment | Focus Group Participants (N=5, n=20) | | Interviews with Cultural Experts (N=9) | | Street Intercepts (N=18) | | Direct Observation (N=4) | | Geo-mapping (N=2) | | Total (N=38) | |
| | total number of responses = 39 | % | total number of responses = 30 | % | total number of responses = 53 | % | total number of responses = 1 | % | total number of responses = 0 | % | total number of responses = 123 | % |
| Beliefs, Attitudes, & Practices | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| Voodoo | 3 | 8% | 13 | 43% | 16 | 30% | 1 | 100% | 0 | 0% | 33 | 27% |
| Stigmatization | 16 | 41% | 4 | 13% | 0 | 0% | 0 | 0% | 0 | 0% | 20 | 16% |
| Faith / church healing | 3 | 8% | 3 | 10% | 9 | 17% | 0 | 0% | 0 | 0% | 15 | 12% |
| Homophobia | 5 | 13% | 4 | 13% | 10 | 19% | 0 | 0% | 0 | 0% | 19 | 15% |
| Gender / power disparities | 1 | 3% | 1 | 3% | 4 | 8% | 0 | 0% | 0 | 0% | 6 | 5% |
| Hate condoms | 4 | 10% | 0 | 0% | 2 | 4% | 0 | 0% | 0 | 0% | 6 | 5% |
| Black market pharmaceuticals | 0 | 0% | 0 | 0% | 11 | 21% | 0 | 0% | 0 | 0% | 11 | 9% |
| Side effects of HIV meds | 6 | 15% | 1 | 3% | 1 | 2% | 0 | 0% | 0 | 0% | 8 | 7% |
| Mistrust of government | 0 | 0% | 4 | 13% | 0 | 0% | 0 | 0% | 0 | 0% | 4 | 3% |
| Suicide as solution to HIV status | 1 | 3% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 1% |
| Variations in Language and Literacy | total number of responses = 24 | % | total number of responses = 4 | % | total number of responses = 14 | % | total number of responses = 2 | % | total number of responses = 0 | % | total number of responses = 44 | % |
| Language Barriers | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| Language Barriers | 17 | 71% | 2 | 50% | 8 | 57% | 1 | 50% | 0 | 0% | 28 | 64% |
| Literacy Barriers | 7 | 29% | 2 | 50% | 6 | 43% | 1 | 50% | 0 | 0% | 16 | 36% |

Factors that Influence HIV Prevention/Treatment in the South Coastal Area

| Factors that Influence HIV Prevention/ Treatment | Responses from Various Data Collection Techniques | | | | | | | | | | Total (N=38) | |
|--|---|-----|--|-----|--------------------------------|-----|--------------------------------|-----|-------------------------------|-----|--------------|-----|
| | Focus Group Participants (N=5, n=20) | | Interviews with Cultural Experts (N=9) | | Street Intercepts (N=18) | | Direct Observation (N=4) | | Geo-mapping (N=2) | | | |
| | total number of responses = 15 | % | total number of responses = 31 | % | total number of responses = 63 | % | total number of responses = 31 | % | total number of responses = 7 | % | | |
| The Mixing of Alcohol, Drugs, and Sex | | | | | | | | | | | | |
| Prostitution | 4 | 27% | 12 | 39% | 25 | 40% | 10 | 32% | 2 | 29% | 53 | 36% |
| Alcohol | 2 | 13% | 1 | 3% | 4 | 6% | 1 | 3% | 0 | 0% | 8 | 5% |
| Drugs | 8 | 53% | 11 | 35% | 16 | 25% | 11 | 35% | 2 | 29% | 48 | 33% |
| The Interaction of Populations at Risk | | | | | | | | | | | | |
| Services | 1 | 7% | 7 | 23% | 18 | 29% | 9 | 29% | 3 | 43% | 38 | 26% |
| Lack of Awareness of HIV Services | | | | | | | | | | | | |
| Absence of HIV Services in Hot Zone | 22 | 73% | 5 | 71% | 13 | 52% | 3 | 60% | 0 | 0% | 43 | 64% |
| | 8 | 27% | 2 | 29% | 12 | 48% | 2 | 40% | 0 | 0% | 24 | 36% |

Western Area Within Zip Code 33430

The center of the target site in the Western Areas is near the intersection of Martin Luther King Boulevard and 5th Street. The local name for this area is the "Loading Ramp". The surrounding streets and alleys are also part of the target site.

Populations at Risk in the Western Area

The populations mentioned most frequently were "Substance abusers/addicts" (27 percent), "Prostitutes", (18 percent), and "African Americans", (10 percent). It is noteworthy to report that study participants anecdotally reported that anal sex is now preferred in order to reduce the risk of unintended pregnancy.

- ◆ Substance abusers/addicts
- ◆ Prostitutes
- ◆ African Americans

Quotes:

"...Haitians, Mexicans, blacks, whites."

"...Prostitutes who engage in back to back sex without using protection. All races in the area...a lot of anal sex is going on in the community now."

"...when the [prostitutes] are high they don't care what they do."

"The people who are not getting these types of sexual activity from their wives, seek on the street. School teachers, doctors, whatever kinds of professions you have in Belle Glade, these are the people that comes out late at night."

The Fundamental Elements of Time and Place in the Western Area

The most frequently mentioned Barrier Related to Time and Place was "No services in the hot zone" (29 percent).

The most frequently mentioned Risk Factors Related to Place was "5th Avenue" (25 percent), followed by "Around markets" (16 percent) and the "Loading Ramp" (15 percent). Significantly, there are few HIV/AIDS prevention or treatment services being provided in this area.

The target site in the Western Area included the Loading Ramp, a large open square where buses and trucks pick up and

- ◆ Barriers Related to Place
 - No services in hot zone
 - Black males won't go to the Health Dep't.
 - No recreation center
- ◆ Barriers Related to Time
 - Night
- ◆ Risk Related to Place
 - 5th Avenue
 - Around Markets
 - The Loading Ramp

drop off workers. The workers provide day labor in the surrounding sugar cane fields, growing cooperatives and/or construction jobs. The Loading Ramp, at the intersection of Martin Luther King and S.E. 5th Street, is also the site of gang gatherings. Each ethnicity, fiercely competitive for business, has staked out one of the four corners of the loading ramp. The represented ethnicities are African American, Haitian, West Indian (including Jamaican), and Hispanic/Latino.

While the hub of the sex and drug economies converge at the loading ramp, it is important to note there are spokes of the same activities extending to the surrounding areas and, indeed, to the entire Western community.

When community experts were asked where the most vulnerable areas of the Glades were they laughed, and then explained that the entire Glades was at risk. With further probing, community experts identified the Loading Ramp as the site with the most HIV risk activity in the Western Area. For example, within the vicinity of the Ramp, "crack heads" (suppliers and customers) buy and sell drugs. Likewise, there are specific areas in which sex and a variety of controlled substances are marketed.

Convenience stores in the vicinity of the Loading Ramp appear to be high-risk sites, serving as de facto one-stop shopping centers for in alcohol, drugs, and prostitution.

Of particular concern, unsupervised young teenagers (e.g., 12-14 years old), both males and females, hang around the Ramp after dark and high-risk behavior continues throughout the night.

Western Palm Beach County has limited educational and employment opportunities. Furthermore, the residential area is geographically small and, like many small towns, privacy is limited. Several participants mentioned that they would not go to the local Health Department for HIV services because their privacy would be compromised. Many employees live in the community and participants believe their "business" would be spread all over the neighborhood within a matter of moments. Therefore, community experts indicated they prefer going to private clinics or doctors to preserve their privacy and avoid stigmatization. The participants also mentioned that they travel to other towns to get tested and treated for HIV/AIDS.

Direct Observations of the Target Site in the Western Area

6:15 a.m. "...people are drinking and playing dominos, cards, and dices. The women are walking around whispering in some men ears and money appears to changed hands with two women and four men..."

6:45 a.m. "the guy that were talking to the young lady came back with a bag of weed and roll a joint with her. And another guy come over and talked with the young lady and the guy."

9:40 p.m. "Haitian man passing by CPL and Fifth Street. He putting his hand across his throat like he cutting it off. This appears to means, 'I don't have no more drugs.' Then the next Haitian man walks off going in the direction that the woman went."

9:57 p.m. "White lady appears to walk across the street...in her car, back out and drove away toward sixth street and very slow to the end of sixth street and circle to the loading ramp. She going down the corner of Martin Luther King Boulevard and Fifth Street to a black guy...it looks like a transaction in progress. This guy sell weed in the community."

6-9 P.M. "Activities remained constant throughout the time spent mapping activities."

11:30 P.M. "...a lady's trying to make a trick; she tell the guys to meet her in the alley..."

3:30 A.M. "...people on the side of Hall's store having sex in the dark."

4:15 A.M. "...Drug people are walking around the ramp looking and observation of the area."

5:00 A.M. "Police on the loading ramp watching the activity going on [in the middle of the ramp]..."

7:00 A.M. "White female prostitution selling her body on 5th and C Place."

7:00 A.M. "White female prostitution gets in another car with a black man."

8:45 A.M. "More people pull up to the loading ramp and talking, passing weeds, and drugs from one person to another."

Sat., 2:00 P.M. Description of drug deal in progress. Per local resident of 11 years, "...the woman is the runner came to buy some stuff..." Area mostly frequented by "Haitians, Jamaicans, and African Americans."

Quotes from study participants in the Western Area

In response to the question, "Where is the hot area for sex and drugs in Belle Glade?"

"Probably Fifth and Sixth Streets."

"Fifth and Sixth."

"Probably down on Fifth and Sixth Street. In the area down on Martin Luther King."

"I would say on Fifth and Sixth..."

"On Sixth Street and on Fourth Street and sex in abandoned buildings."

"...we don't have enough people in the field to do the work to provide HIV education and prevention."

"...people come to the Glades, get information, and do nothing about that. We need more actions in the Glades. More education, more involvement in the community."

"...the guys on the side of the road who are selling drugs often offer money to young girls who come from school."

"...these activities take place more likely in sex clubs and after school dances, parties."

“...these kinds of risky sex are going on in a lot of the damaged or condemned buildings in 6th Street and 5th Street. In SW Belle Glade where the buildings are empty.”

“...risky sex take place everywhere in Belle Glade. Even places that they don't know about.”

“...on the street and these dilapidated houses...where a lot of people gather sometime.”

“...in isolated areas such as houses that have been condemned.”

“...sometimes they get drunk in the bar and they have backrooms in the bars and they go back there or even at their rooms.” This phrase is also cited in the section regarding the mixing of risk factors.

“...late at night and before day at mornings.”

“...any hour of the day or night whenever is convenient for those who want these activities.”

“...at 1 o'clock in the morning people are outside drinking, socializing, and doing whatever they feel like doing.”

“It's not a question of time. It's a question of sex for favor to pay for bills or food, clothes, or rent.”

Many program participants stated that prevention activities and protective factors (e.g., responsible adult supervision) are needed when HIV risk behavior is occurring.

“...young people have sex after school and at dances. Some others pretend they go to school and they don't. They miss school so that they can go and have sex.”

“...some young kids wait when their parents aren't home and have sex at their own home.”

“...any hour of the day or night whenever is convenient for those who want these activities. It's a twenty-four hour business.

“...at 1:00 in the morning people are outside drinking, socializing, and doing whatever they feel like doing.”

“...Its a question 24/7 and 365 days a year.”

“...late at night and before day at mornings.”

Beliefs, Attitudes, and Practices Related to HIV/AIDS in the Western Area

“Faith/Church Healing” was the most frequently mentioned belief (18 percent) followed by “Conspiracy Theories” (12 percent).

- ♦ **Faith/Church Healing**
- ♦ **Conspiracy Theories**
- ♦ **No Adult Supervision**

Participants from the Western RARE site expressed a variety of beliefs regarding the inception of and the continued spread of AIDS. The community tends to believe that the “aliens” or “nationalities” brought the virus to the area as part of an intentional effort to eradicate the community. It is also believed that white prostitutes, who are infected with the “virus”, are somehow encouraged to continue to practice their craft, locally.

It is believed that having a Western Community Recreation Center would curtail the spread of HIV/AIDS by occupying the teens and young adults with positive community activities rather than sex partner trading, prostitution and alcohol/drug abuse and dealing. Reportedly, young teens become involved in sexual activities as a form of after school recreational activity.

Many local residents indicated their belief that an external, powerful consortium - that is only interested in financial gain - controls drug dealing. Community experts voiced the hopeful expectation that Federal Government would arrive to eradicate the HIV/AIDS virus, provide affordable housing, set up financial development training centers and build new schools.

Quotes:

“...People believe when Caucasian prostitutes come down here they already infected.”

“...AIDS don't come over here until different nationalities come over here.”

“...nobody knows what causes AIDS, no one has the cure...we just have to pray.”

“...you can't tell until they do it a long time, then you can tell because people are watching you.”

In response to the question, “Is it true that African American males are uneasy going to the Health Department? Why?”

“Yes, cause they don't have no way and they scared of the people working there cause they in this area.”

“...Women are more vulnerable because they tend to be more dependent.”

“...here in Belle Glade they don't have a special place where this [drugs] is sold because the police have control over this activities.”

“a lot of people have several partners without even thinking of with whom these people were having affairs. People don't care to know who the other partner went with.”

"...because the city is too small. If a man has it and he has three, four, or five women, he can spread it easily in the community."

"...since it's not a big place, nine out of ten somebody will bump up to somebody who got it."

"...you can't tell [what causes HIV] until they do it a long time, then you can tell because people are watching you."

In response to the question, "Is it true that African American male are uneasy going to the department of health? Why?"

"Yes, cause they don't have no way and they scare of the people working there cause they in this area."

The Mixing of Alcohol, Drugs, and Sex in the Western Area

Study participants repeatedly cited the influence of drugs, high-risk sex, and the interaction between those who engage in both activities, as major factors in HIV infection. "Drugs" was mentioned in 31 percent of the responses, "Other High Risk Sexual Behavior" was mentioned in 21 percent, and "The Interaction of Populations at Risk" was referenced in 21 percent of responses.

- **Drugs**
- **Other High Risk Sexual Behavior**
- **The Interaction of Populations at Risk**

Many respondents did not necessarily consider sex for sale to be prostitution. Instead, sex for survival or to enhance family coffers was considered quite legitimate. "Sliding" into sex for survival as a result of financial crises was a recurring theme. When asked about homosexual sex for sale, street experts acknowledged it occurs. Locals reported observing homosexuals soliciting sex from each other from their cars parked in a certain area around the loading ramp.

Most street prostitutes were female and black, but all races were referenced and observed. Prostitutes were observed soliciting on the streets mainly in the late afternoon until the late evening hours. Study participants observed drugs and sex purchased at two convenience stores, from street vendors (i.e., pimps and/or dealers) or from independent entrepreneurs.

Many young men were out on the loading ramp well into the night and were interviewed by the RARE Team. Initially, they reported just being out there for entertainment and to do a little drinking. Further probing revealed that they were soliciting or selling sex and/or drugs.

Quotes:

"...Its not a question of time. It's a question of sex for favor to pay for bills or food, clothes, or rent."

"...there are people who are on drugs and are HIV positive who exchange sex for money or drug and spread it that way."

“...there is some kind of exchange. A six pack of Corona beer or drug is enough for the exchange.”

“...it doesn't take much. Once the guy who is pushing dope has the money, a lot of women can get some and get some disease at the same time.”

“...a lot of men don't stay honest. By going to the street, you don't know who they meet and what they can bring home.”

“...rifa, rocks, marijuana...”

“...cocaine, marijuana...”

“...the minds aren't well set when someone is under drug influence.”

“...drugs make people don't care about HIV or AIDS. We don't stop people from selling drugs, young people look and want what the drug pushers have money...”

“...when a person that is using drugs is not themselves – it's a different person – unclean needles transfer it to the veins.”

“...sometimes they get drunk in the bar and they have backrooms in the bars and they go back there or even at their rooms.”

“...all types of people are involved...you would be surprised to know that some people are involved in sexual activities and drugs. I believe the white more than the blacks are involved because they have the money to engage in all these activities.”

“...One thing the community needs education on drugs and AIDS...they need to be aware of the dangers of drugs and AIDS.”

“...Prostitutes who engage in back to back sex without using protection...All races in the area...A lot of anal sex is going on in the community now.”

“...A lot of people are having sex for drugs – a wide variety of sex...10-15 people per night.”

“...Haitians, Mexicans, Blacks, and Whites.”

“...where the drug trade is sold at...SW 6th Street is mostly where the drug trade is”

“...easy access to prostitution and the price is very low”

“...marijuana, cocaine, and a little speed.”

re: alcohol “...its a drug but its legal. It leads to a lot of sexual activities.”

"Target all the liquor stores, that's where they get drunk to ease their mind...Alcohol is dangerous man, alot of people don't know that, you have a lot of alcohol in Belle Glade."

In response to question, "Do you believe drug abuse makes the prostitutes more likely to have unprotected sex?"

"...cocaine, marijuana..."

"...alcohol... it's a drug but its legal. It leads to a lot of sexual activities."

Services in the Western Area

As in the other RARE sites in Palm Beach County, in the Western Area there was a high rate of responses regarding either the "Lack of Awareness of HIV Services" (57 percent) or "Absence of HIV Services in the Hot Zone" (43 percent).

- Lack of Awareness of HIV Services
- Absence of HIV Services in the Hot Zone

The local Health Department is approximately four miles from the target site in the Western Area. While transportation is available, pick-up times are infrequent. Reportedly, prevention and medical services are needed closer to the Loading Ramp.

Several participants indicated they believe that having a Western Community Recreation Center would curtail the spread of HIV/AIDS by providing teens and young adults with positive community activities rather than sex partner trading, prostitution and alcohol/drug abuse and dealing.

Young teens appear to become engaged in sexual activities as a method of recreation or a form of after school activity. Community experts express hope that the federal government will eradicate the HIV/AIDS virus, provide affordable housing, set up financial development training centers, and build new schools.

Quotes:

"...the government should give some funding specially to educate people about the seriousness of AIDS...There should be some workshops in schools and work places to let people know that AIDS isn't a game..."

"...AIDS should be taught in schools to let the children know that AIDS is a disease that doesn't play..."

“...there is a great need of people to go door to door to give education sessions about HIV and they can prevent it.”

“...there should be a program of education to break the silence because a lot are affected by those who are infected...need HIV positive speakers to go to schools and talk about their status.”

“...Education. There’s no recreation for teens. There’s nothing for teens to do. Lack of recreation promotes greater interest in sex.”

“...Corner hanging out leads to drugs which leads to sex. Unprotected sex.”

In response to question, “What HIV services are available here on Martin Luther King Blvd. and Fifth Street?”

“None.”

“None.”

“To my knowing none.”

“...education sessions should be provided in different languages such as Creole, French, Spanish, etc., because there are people with different cultural backgrounds.”

“...outreach workers that are multicultural with all languages that people speak in the Glades.”

Factors that Influence HIV Prevention/Treatment in the Western Area

| Factors that Influence HIV Prevention / Treatment | Responses from Various Data Collection Techniques | | | | | | | | | | | |
|---|---|---------------------------------|---------------------------------------|---------------------------------|--------------------------------|---------------------------------|------------------------------|-----|----------------------|-----|-----------------|-----|
| | Focus Group Participants (N=5, n=36) | | Community Expert Interviews (N=11) | | Street Intercepts (N=11) | | Direct Observations (N=7) | | Geo-mapping (N=7) | | Total (N=41) | |
| | total number of responses = 58 | total number of responses = 102 | total number of responses = 69 | total number of responses = 138 | total number of responses = 25 | total number of responses = 402 | (f) | % | (f) | % | (f) | % |
| Populations at Risk | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % |
| Haitians | 6 | 9% | 5 | 5% | 1 | 1% | 21 | 15% | 0 | 0% | 33 | 8% |
| African Americans | 8 | 12% | 6 | 6% | 3 | 4% | 20 | 14% | 3 | 12% | 40 | 10% |
| Mexicans | 1 | 1% | 3 | 3% | 0 | 0% | 2 | 1% | 1 | 4% | 7 | 2% |
| West Indies | 2 | 3% | 2 | 2% | 0 | 0% | 2 | 1% | 2 | 8% | 8 | 2% |
| Hispanics | 6 | 9% | 5 | 5% | 0 | 0% | 6 | 4% | 0 | 0% | 17 | 4% |
| Whites | 4 | 6% | 8 | 8% | 2 | 3% | 12 | 9% | 1 | 4% | 27 | 7% |
| Nationalities | 0 | 0% | 2 | 2% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 0% |
| Farmworkers | 7 | 10% | 2 | 2% | 4 | 6% | 0 | 0% | 0 | 0% | 13 | 3% |
| Truckers | 0 | 0% | 1 | 1% | 0 | 0% | 8 | 6% | 0 | 0% | 9 | 2% |
| Unemployed | 0 | 0% | 3 | 3% | 0 | 0% | 0 | 0% | 0 | 0% | 3 | 1% |
| Male | 4 | 6% | 0 | 0% | 3 | 4% | 8 | 6% | 6 | 24% | 21 | 5% |
| Female | 9 | 13% | 0 | 0% | 11 | 16% | 7 | 5% | 1 | 4% | 28 | 7% |
| Teens | 2 | 3% | 8 | 8% | 0 | 0% | 0 | 0% | 0 | 0% | 10 | 2% |
| Homosexuals | 0 | 0% | 1 | 1% | 0 | 0% | 2 | 1% | 0 | 0% | 3 | 1% |
| Substance Abusers / | | | | | | | | | | | | |
| Addicts | 6 | 9% | 34 | 33% | 31 | 45% | 30 | 22% | 7 | 28% | 108 | 27% |
| Prostitutes | 13 | 19% | 22 | 22% | 14 | 20% | 20 | 14% | 4 | 16% | 73 | 18% |

Factors that Influence HIV Prevention/Treatment in the Western Area

Responses from Various Data Collection Techniques

| Factors that Influence HIV Prevention / Treatment | Focus Group Participants (N=5, n=36) | | Community Expert Interviews (N=11) | | Street Intercepts (N=11) | | Direct Observations (N=7) | | Geo-mapping (N=7) | | Total (N=41) | |
|---|--------------------------------------|-----|------------------------------------|-----|--------------------------------|-----|-------------------------------|------|-------------------------------|-----|--------------------------------|-----|
| | total number of responses = 16 | % | total number of responses = 6 | % | total number of responses = 36 | % | total number of responses = 0 | % | total number of responses = 0 | % | total number of responses = 58 | % |
| Barriers Related to Time and Place | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) |
| Small town, lack of confidentiality | 8 | 50% | 0 | 0% | 3 | 8% | 0 | 0% | 0 | 0% | 11 | 19% |
| No recreation center | 0 | 0% | 4 | 67% | 8 | 22% | 0 | 0% | 0 | 0% | 12 | 21% |
| No services in hot zone | 2 | 13% | 2 | 33% | 13 | 36% | 0 | 0% | 0 | 0% | 17 | 29% |
| Black males won't go to Health Dept. | 5 | 31% | 0 | 0% | 7 | 19% | 0 | 0% | 0 | 0% | 12 | 21% |
| Lack of transportation to services. | 1 | 6% | 0 | 0% | 5 | 14% | 0 | 0% | 0 | 0% | 6 | 10% |
| Risk Factors Related to Time | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) |
| Early Morning | 3 | 14% | 1 | 4% | 0 | 0% | 0 | 0% | 0 | 0% | 4 | 8% |
| Night | 3 | 14% | 8 | 32% | 0 | 0% | 0 | 0% | 0 | 0% | 11 | 22% |
| Weekends | 5 | 24% | 1 | 4% | 0 | 0% | 0 | 0% | 0 | 0% | 6 | 12% |
| 24/7 | 5 | 24% | 12 | 48% | 0 | 0% | 0 | 0% | 0 | 0% | 17 | 33% |
| Payday | 3 | 14% | 1 | 4% | 0 | 0% | 5 | 100% | 0 | 0% | 9 | 18% |
| First of the month (when the checks come) | 2 | 10% | 2 | 8% | 0 | 0% | 0 | 0% | 0 | 0% | 4 | 8% |

larges

Factors that Influence HIV Prevention/Treatment in the Western Area

Responses from Various Data Collection Techniques

| Factors that Influence HIV Prevention / Treatment | Focus Group Participants (N=5, n=36) | | Community Expert Interviews (N=11) | | Street Intercepts (N=11) | | Direct Observations (N=7) | | Geo-mapping (N=7) | | Total (N=41) | |
|---|--------------------------------------|-----|------------------------------------|-----|--------------------------------|-----|--------------------------------|-----|--------------------------------|-----|---------------------------------|-----|
| | total number of responses = 16 | % | total number of responses = 21 | % | total number of responses = 29 | % | total number of responses = 50 | % | total number of responses = 13 | % | total number of responses = 129 | % |
| Risk Factors Related to Place | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) |
| SW 6th Avenue | 1 | 6% | 3 | 14% | 7 | 24% | 6 | 12% | 1 | 8% | 18 | 14% |
| 5th Avenue | 2 | 13% | 4 | 19% | 13 | 45% | 12 | 24% | 1 | 8% | 32 | 25% |
| Martin Luther King Blvd. | 2 | 13% | 1 | 5% | 1 | 3% | 0 | 0% | 1 | 8% | 5 | 4% |
| Loading Ramp | 5 | 31% | 3 | 14% | 3 | 10% | 5 | 10% | 3 | 23% | 19 | 15% |
| Abandoned Buildings | 0 | 0% | 3 | 14% | 2 | 7% | 0 | 0% | 0 | 0% | 5 | 4% |
| Around Markets | 0 | 0% | 1 | 5% | 0 | 0% | 18 | 36% | 2 | 15% | 21 | 16% |
| Trick houses | 0 | 0% | 1 | 5% | 0 | 0% | 1 | 2% | 1 | 8% | 3 | 2% |
| In Cars | 0 | 0% | 1 | 5% | 0 | 0% | 1 | 2% | 3 | 23% | 5 | 4% |
| In School | 5 | 31% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 5 | 4% |
| Sex Clubs | 1 | 6% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 1% |
| Bars | 0 | 0% | 1 | 5% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 1% |
| Alleys | 0 | 0% | 2 | 10% | 2 | 7% | 5 | 10% | 0 | 0% | 9 | 7% |
| Up under the trees | 0 | 0% | 1 | 5% | 1 | 3% | 2 | 4% | 1 | 8% | 5 | 4% |

Factors that Influence HIV Risk/Prevention in the Western Area

| Factors that Influence HIV Prevention / Treatment | | Responses from Various Data Collection Techniques | | | | | | | | | | | |
|---|-----|---|-----|------------------------------------|-----|--------------------------------|-----|-------------------------------|-----|-------------------------------|-----|--------------------------------|---|
| | | Focus Group Participants (N=5, n=36) | | Community Expert Interviews (N=11) | | Street Intercepts (N=11) | | Direct Observations (N=7) | | Geo-mapping (N=7) | | Total (N=41) | |
| | | total number of responses = 26 | % | total number of responses = 27 | % | total number of responses = 21 | % | total number of responses = 0 | % | total number of responses = 0 | % | total number of responses = 74 | % |
| Beliefs, Attitudes, & Practices | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | (f) | (%) | |
| Resentment and Vengeance | 0 | 0% | 2 | 7% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 3% | |
| Stigmatization | 1 | 4% | 2 | 7% | 1 | 5% | 0 | 0% | 0 | 0% | 4 | 5% | |
| Faith/church healing | 1 | 4% | 2 | 7% | 10 | 48% | 0 | 0% | 0 | 0% | 13 | 18% | |
| Homophobia | 1 | 4% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 1% | |
| Gender/power disparities | 2 | 8% | 0 | 0% | 4 | 19% | 0 | 0% | 0 | 0% | 6 | 8% | |
| Conspiracy theories | 5 | 19% | 4 | 15% | 0 | 0% | 0 | 0% | 0 | 0% | 9 | 12% | |
| Fatalism / Hopelessness | 3 | 12% | 2 | 7% | 1 | 5% | 0 | 0% | 0 | 0% | 6 | 8% | |
| Denial of Risk | 8 | 31% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 8 | 11% | |
| No adult supervision | 0 | 0% | 5 | 19% | 3 | 14% | 0 | 0% | 0 | 0% | 8 | 11% | |
| Expecting government intervention | 3 | 12% | 4 | 15% | 0 | 0% | 0 | 0% | 0 | 0% | 7 | 9% | |
| Non-adherence to medicine | 2 | 8% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 3% | |
| No condoms | 0 | 0% | 6 | 22% | 2 | 10% | 0 | 0% | 0 | 0% | 8 | 11% | |

Factors that Influence HIV Prevention/Treatment in the Western Area

Responses from Various Data Collection Techniques

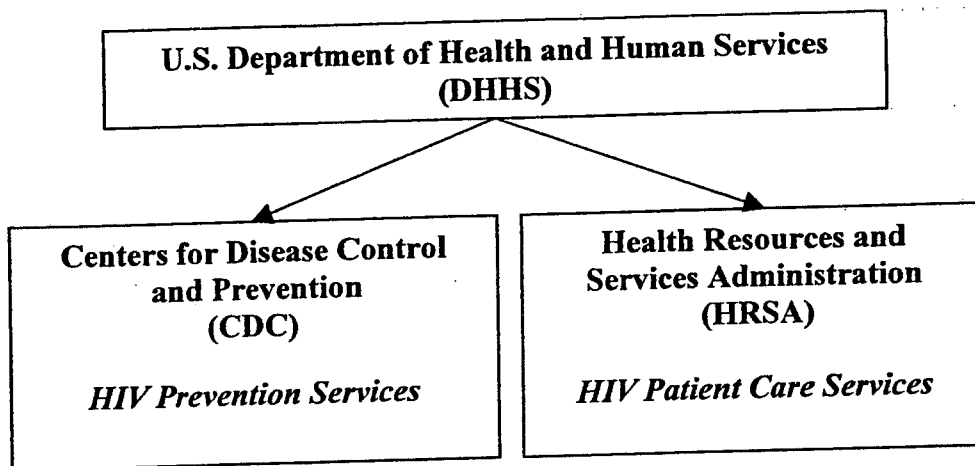
| Factors that Influence HIV Prevention / Treatment | Focus Group Participants (N=5, n=36) | | Community Expert Interviews (N=11) | | Street Intercepts (N=11) | | Direct Observation (N= 7) | | Geo-mapping (N= 7) | | Total (N=41) |
|---|--------------------------------------|-----|------------------------------------|-----|--------------------------------|-----|--------------------------------|-----|--------------------------------|-----|---------------------------------|
| | total number of responses = 74 | % | total number of responses = 137 | % | total number of responses = 84 | % | total number of responses = 92 | % | total number of responses = 37 | % | |
| The Mixing of Alcohol, Drugs, and Sex | (f) | % | (f) | % | (f) | % | (f) | % | (f) | % | total number of responses = 424 |
| Alcohol | 9 | 12% | 4 | 3% | 0 | 0% | 23 | 25% | 10 | 27% | 46 |
| Drugs | 13 | 18% | 42 | 31% | 32 | 38% | 33 | 36% | 10 | 27% | 130 |
| Prostitution | 12 | 16% | 15 | 11% | 15 | 18% | 19 | 21% | 3 | 8% | 64 |
| Other High Risk Sexual Behavior | 25 | 34% | 41 | 30% | 16 | 19% | 6 | 7% | 3 | 8% | 91 |
| The Interaction of Populations at Risk | 15 | 20% | 28 | 20% | 21 | 25% | 11 | 12% | 8 | 22% | 83 |
| Gambling | 0 | 0% | 7 | 5% | 0 | 0% | 0 | 0% | 3 | 8% | 10 |
| Services | total number of responses = 12 | % | total number of responses = 17 | % | total number of responses = 22 | % | total number of responses = 0 | % | total number of responses = 0 | % | total number of responses = 51 |
| Lack of Awareness of HIV Services | 7 | 58% | 14 | 82% | 8 | 36% | 0 | 0% | 0 | 0% | 29 |
| Absence HIV Services in Hot Zone | 5 | 42% | 3 | 18% | 14 | 64% | 0 | 0% | 0 | 0% | 22 |

IX. The Dichotomy Between Prevention and Patient Care Services in Palm Beach County

In Palm Beach County, as throughout Florida and the country as a whole, HIV prevention services and HIV patient care services are funded, planned, and implemented through two distinct systems.

On the federal level, the U.S. Department of Health and Human Services (DHHS) implements many policies related to HIV/AIDS. While DHHS' Centers for Disease Control and Prevention (CDC) implements policies related to HIV prevention, DHHS' Health Resources and Services Administration (HRSA) implements policies related to HIV patient care.

Likewise, at the state and local level, divided prevention and patient care services are the norm. As might be expected in this divided structure, prevention workers have little knowledge of patient care services, and vice versa. Not surprisingly, project participants who specialize in prevention, as well as project participants who specialize in patient care expressed their frustration and lack of confidence in the other "side of the house."



Unlike previous planning projects, the RARE Project attempts to bridge the division between HIV prevention and HIV patient services in order to develop a more coordinated and effective network of services.

Quotes from Prevention Workers

Question: What are some of the problems (at the Health Department) ?

"...The quality of staff, need to address everything, not just AIDS, recruitment of doctors who want to stay, they burn out the doctors..."

"...I don't trust the medical world. I'm not sure an African American would. This is it - you go to the clinic or you don't get nothing."

Question: Do you think the clinicians believe in spending of prevention dollars?

"Not if it wasn't politically correct... We have no way to measure prevention... No one wants to

see it through...”

“There are no HIV medical services after school; there are no family-centered medical services...this needs to start with Mom and kids...”

“Funding for all [HIV] services is driven by data. Data existing is very low. Prevention shouldn't have to rely on 'epi' data to support efforts. Focus group information needs to be indicator of need.”

Question: What are we doing with testing [for HIV]? Do we have a count [of people tested]?
“...No. We don't have a count.”

Question: Do we know what we need?

“... We need accurate data [on testing/prevention]. We should be able to find out how many tests are given...Prevention is needed regardless of HIV status.”

“... We have to ask hidden populations for their feedback... We have certain goals for prevention we're not able to do.”

“... We must get churches involved. If you offer HIV medical services with other services, only then will they come...”

“Prevention requires education. This education piece gets lost. You can't change behavior unless education is with it...”

“... We need to incorporate tradition with medicine.”

Quotes from Patient Care Workers

“...Part of reducing risk would be to have your outreach worker working with those people [prostitutes in the Northern Coastal site]. Having a presence in those areas where the pairing off occurs.”

Question: Aren't they doing that?

“...No...”

“... There is not a lot of support in the prevention aspects of this disease at any level...”

Question: What about prevention interventions? Are they effective here [i.e., in Palm Beach County]?

“...No. They rely most heavily on knowledge and education. Not always transferring that knowledge to behavior...”

X. Recommendations and Strategies for Palm Beach County HIV/AIDS Prevention and Treatment

On July 20, 2001, the RARE Community Advisory Board recommended that the Palm Beach County Department of Health convene a committee to consider the findings of this report in realigning existing resources and refining and prioritizing the following recommendations and strategies:

Goal 1. Demonstrate the continued commitment of Palm Beach County to HIV prevention and clinical care activities by taking a leadership role in identifying and securing additional funding to address and implement the recommendations.

Strategies:

1. Commit and/or provide through the county, the mechanism to secure additional funding to support harm reduction and HIV care and prevention outreach initiatives, including but not limited to:

- The dissemination of wound care items
- Water and condom distribution
- Syringe/needle kits
- Expanded HIV/AIDS, STD and family planning, counseling, testing, and referral services
- Expanded HIV primary care, case management, and other supportive services

2. Dedicate and secure funding through the Board of County Commissioners and through each municipality to provide HIV liaisons with local, state, and national HIV/AIDS networks.

3. Provide funding and other support to ensure organizations targeting high-risk populations have the technical assistance necessary for capacity building, preparing them for future expansion.

Goal 2. Educate County and City Commissioners, community leadership, and all health care providers in the county about high-risk communities and the special needs of their residents regarding HIV/AIDS prevention and treatment. Emphasize the importance of commitment to a systemic and systematic planning process for change.

Strategies:

1. Establish an HIV/AIDS Round Table Forum comprised of elected officials and administrators from the four RARE team sites, the RARE Ethnographers and Team Leaders, Department of Health officials, HIV-related Service Providers, other health care providers, and other stakeholders necessary to the development and implementation of effective solutions. The inclusion of representatives of economic development and educational services is imperative to developing comprehensive and meaningful change.

2. Integrate ongoing HIV/AIDS care and prevention as an integral part of Palm Beach County's community health agencies and other city and county agencies and entities that provide services to the targeted populations at-risk for contracting HIV disease. Such entities include, but are not limited to:

- City of West Palm Beach Community Development Office
- grantees for HOPWA
- Palm Beach County School District
- Palm Beach County Sheriff's Office
- Palm Beach County Mental Health Board

3. Issue a county "Call for Action on HIV/AIDS Prevention and Medical care" that demands partnerships between community service providers and city, county, state, and federal agencies requesting both programmatic and fiscal resources.

Goal 3. Urge elected officials, local planners, providers, colleges, universities, and other policy makers to utilize the findings of this report when developing and implementing programs to decrease HIV/AIDS incidence, prevalence, morbidity, and mortality among high-risk populations.

Strategies:

1. Establish an advisory group to develop and/or review national and local programs that provide peer-based HIV training and mentoring.
2. Form a research collaborative with colleges and universities to explore and examine HIV/AIDS literature, interventions, policies, program evaluations, and analyses.
3. Provide local training updates on a quarterly basis for all involved in HIV/AIDS service provision at a local college and/or university. Offer class credits or credentials for successful participation.
4. Disseminate the findings of this ethnographic report to local and regional educational institutions to develop support and feedback.

Goal 4. Increase the availability of and access to HIV prevention and medical care for African American, Latino, Guatemalan, Haitian, and Caribbean Basin bisexuals and homosexuals within the identified risk pockets.

Strategies:

1. Develop and sustain street level interventions which are based on epidemiologic and ethnographic trends. Evaluate these interventions on an on-going basis. These interventions should concentrate on hidden populations living in or frequenting the RARE-identified risk pockets.

2. Contact, establish, and/or make services accessible through African American and Latino gay organizations which are targeted to the behaviors occurring in the risk pockets as well as the risk behavior initiation points that are identified in this report. These services need to be formally linked with opportunities for HIV testing and counseling.

3. Mobilize HIV prevention and medical outreach services. Services must be provided in non-traditional settings and at non-traditional hours (not just 9-5) or days (not just Monday-Friday) to effectively reach targeted populations in their geographic pockets.

Goal 5. Establish targeted funding to address the HIV/AIDS barriers related to minority communities as identified in the Palm Beach County RARE report. This targeted funding should be used to fund minority organizations in order to meet HIV prevention and patient care needs.

Strategies:

1. Encourage collaboration between established HIV/AIDS providers, Public Health, Community-Based Organizations and emerging minority agencies.

2. Provide adequate funding for HIV education for providers, especially in areas that are identified as having high concentrations of high-risk behaviors and vulnerable individuals.

3. Reinstate HIV/AIDS prevention and patient care services in the labor camps.

4. Form a collaborative of minority organizations that can develop proposals to apply for grants and contracts on a unified basis. The collaborative should establish rapport with well-established agencies that will provide accurate data upon request.

Goal 6. Identify a funding source to conduct additional investigational studies of specific geographic areas having high concentrations of individuals engaging in high-risk behaviors.

Strategies:

1. Obtain funding or make opportunities available to implement the RARE methodology in other risk pockets in Palm Beach County.

2. Provide additional funds to increase capacity building efforts to expand the Palm Beach County Minority Network, and provide training and technical assistance for community-based organizations to facilitate their access to local funding.

3. Identify and encourage collaboration between private sector and public health to maximize the effectiveness of currently available HIV/AIDS funding streams.

Goal 7. Provide adequate funding to conduct a countywide public awareness campaign that reaches all of the targeted populations identified in this study. This campaign should be conducted in English, Spanish, several Mayan Indian dialects, Creole, and French and should address HIV/AIDS prevention and medical care issues, especially for women, infants, and children.

Strategies:

1. Encourage a partnership between the State of Florida, local cultural organizations, the Port of Palm Beach, private enterprises and the Public Health system to fund and infiltrate the media with information about HIV/AIDS.
2. Recruit Latino, Guatemalan and Haitian volunteers to deliver written, audio, and visual messages relating to HIV/AIDS via the church, radio, and television.
3. Increase funding or utilize available sources to provide educational outreach to our county's public school system, prison systems, substance abuse treatment facilities, mental health agencies, foster care and other child welfare systems and local government officials.
4. Educate the populations identified in this study that HIV/AIDS is a public health threat and that the upward trend of other sexually transmitted diseases and teen pregnancies are indicators of high rates of HIV risk behavior.
5. Provide educational opportunities for clinical providers regarding people in their caseloads who are risk

Goal 8. Increase the availability and access to HIV prevention and care services for substance abusers, including injection drug users, within the identified target areas.

Strategies:

1. Produce and implement substance abuse interventions that can be introduced and sustained at the street level, based on the ethnographic and epidemiologic trends noted in the study. These interventions need to focus on the hidden and target populations living in or frequenting these risk pockets without diluting current countywide efforts.
2. Make services available through organizations having a proven track record with the populations identified in this project. Services must be targeted to the behaviors occurring in the neighborhoods represented in this report. These services need to be formally linked with opportunities for HIV counseling and testing and primary medical care.
3. Explore implementing a pilot program of harm reduction strategies that includes a needle exchange program designed to combat the spread of HIV through intravenous drug abuse.

4. Establish minority-based substance abuse treatment programs with an outreach component to address HIV and substance abuse among minority clients in urban and rural settings. Additionally, interventions need to be specifically developed to meet the needs of Guatemalan, Haitian, and Latino substance abusers.

Goal 9. Require that employees and volunteers of the local Health Department and all Community-Based Organizations that provide services to clients in communities of color, receive diversity and sensitivity training, and training regarding issues related to sexual orientation. Training should be incorporated into employee orientation and also provided as in-service training on a regular basis.

Strategies:

1. Encourage a partnership between Palm Beach County and Florida's black colleges and universities to educate incoming students via peer mentoring. Likewise, cultivating a relationship with colleges and universities in Puerto Rico and other Caribbean islands might yield similarly beneficial results.

2. Require that all state HIV/AIDS contracts have a staff training component, which includes HIV testing standards, train the trainer courses, and AIDS 101. If the agency is a test site, it must conform to all requirements set by the Centers for Disease Control and the State of Florida.

3. Recruit Guatemalan, Spanish, and Haitian workers to provide HIV/AIDS prevention and intervention services to their respective communities in a culturally appropriate manner.

Goal 10. Recruit and train indigenous HIV/AIDS educators to raise awareness of and educate individuals about their own HIV risk, in their own languages and communities.

Strategies:

1. Expand the implementation of HIV education in Palm Beach County Schools, grades K-12.

2. Establish a formal linkage to the Palm Beach County HIV/AIDS Community Planning Partnership.

3. Produce culturally appropriate prevention messages and services including messages transmitted by radio and posters utilizing visual art and illustration for those who are unable to read.

4. Expand current messages to include individuals who may be at risk but who do not identify themselves at risk (e.g., teens, women, drug addicts).

5. Deliver messages by sources respected and understood by individuals engaging in the identified risk behaviors.

Goal 11. Establish HIV linkage programs for inmates in prisons and county jails to ensure they are provided with continuity of care and services upon their release.

Strategies:

1. Provide training to employees of prisons and jails about HIV/AIDS and provide a current list of agencies and services available for HIV positive inmates (and their families) upon their release from prison.
2. Create a system to ensure continuity of care for HIV positive persons who relocate to other parts of the county as well as to and from other counties.
3. Recruit and train HIV positive persons to serve as "free-world liaisons" with penal institutions, to help prepare those to be released with services and support.

Goal 12. Include those individuals who are engaged in high-risk behavior and those who currently work with them (e.g. community outreach workers) in policy-making decisions.

Strategies:

1. Recruit indigenous, "natural leaders" in risk areas to develop and participate in interventions. Many people, including RARE team members, who live in the neighborhoods where the risk occurs, have expressed their willingness to help. It is important that "natural leaders" receive training and modest material support to help protect their neighborhoods.
2. Conduct a quarterly meeting involving county health departments, AIDS service organizations, community-based organizations, and faith-based organizations to share successes, barriers, and strategies in reaching communities being served.
3. Extend treatment teams to include other disciplines such as mental health workers, substance abuse counselors, nutritionists, and other community stakeholders. All providers should be properly trained and credentialed to ensure professional standards of practice.

Goal 13. Develop specific strategies for reducing the risk of HIV/AIDS in the communities included in the RARE project, with an emphasis on strategies to benefit minority neighborhoods.

Strategies:

1. Provide continual funding for the Black Leadership Conference on HIV/AIDS and the Hispanic Summit on HIV/AIDS to allow minority agencies to exchange ideas.
2. Fund innovative health services and consider redeploying health service vehicles that place outreach services in high-risk locales, and/or satellite community-based services in the identified risk pockets.

3. Conduct prevention activities in high-risk locales, such as condom distribution and HIV testing on strolls. This should include providing condoms to individuals engaged in sex trade and on-site HIV-testing. This should also include the provision of condoms to substance abusers and distribution of other HIV prevention materials.

Goal 14. Create mentor programs to improve mutual understanding between HIV/AIDS prevention and treatment providers. Mentor programs can also be useful in developing better information to develop more effective programs. Include local colleges when considering internship programs.

Strategies:

1. Ensure that HIV/AIDS training in the Department of Children and Families includes ample instruction regarding raising children orphaned due to HIV/AIDS, care of HIV/AIDS children, being a teen with HIV/AIDS, and how to get support as parents of HIV positive children.
2. Expand and modify service delivery system to accommodate individuals from the targeted risk areas, including sex workers and substance abusers. Provide incentives in a harm reduction format introducing a "Model of Change Philosophy" to Palm Beach County.
3. Recruit community experts and "natural helpers" such as owners of local businesses, pimps and drug pushers who share a vested interest in preserving the health of their customers. Use every opportunity to promote health and prevention interventions – keep an open-mind to effective non- traditional methods.

Goal 15. Establish prevention and patient care programs within the RARE targeted communities. Further, consider times, days, and locations as indicated by RARE project respondents.

Strategies:

1. Develop and sustain satellite community-based services in neighborhoods where high-risk behaviors occur. Staff these offices with trained members of the surrounding indigenous communities.
2. Utilize the Risk Related to Time information gathered from this project to guide planning and implementation of prevention and intervention time schedules, e.g. nights and weekends. Outreach agents should be available to provide services at hours when clientele are receptive to services and education, e.g. nights and weekends.
3. To avoid the stigma attached to AIDS-only venues and services, provide venues and services that are health-generic. Offer these services in places associated with generic health concerns.

Goal 16. Because this methodology enabled us to discover aspects of HIV in Palm Beach County of which we were previously unaware, we should continue to use this methodology to further develop our understanding of HIV and develop more effective prevention and treatment interventions for our most vulnerable communities.

Strategies:

1. Utilize RARE methodology to identify the needs of those who are not receiving treatment, those that receive care outside the conventional system of treatment, the needs of high-risk groups, and the needs of other hard-to-reach populations.
2. Continue and extend the process of Rapid Assessment Response and Evaluation to other high frequency reported HIV zip codes.
3. Use the RARE technique to identify opportunities for appropriate, targeted interventions including the ability to identify, test and refer people to HIV services in a manner that they themselves have created.
4. Provide resources for a full-time ethnographer and team of assessment specialists to identify other public health issues of acute concern and conduct rapid assessments in Palm Beach County.
5. Incorporate ongoing Rapid Assessment, Response, and Evaluation into Palm Beach County's Comprehensive Plan and into the Palm Beach County HIV/AIDS Community Planning Partnership's Plan.

Goal 17. Embark on an educational campaign targeting minority and high-risk populations with emphasis on testing and prevention messages.

Strategies:

1. Place posters in key places in targeted neighborhoods to educate community members about HIV and direct those individuals to community-based testing and referral sites.
2. Sex workers, Johns, substance abusers and drug distributors should receive HIV training. When any of these individuals is arrested, they should be required to successfully complete an HIV education program.
3. Distribute and broadcast audio tapes containing messages on the prevention of HIV and appropriate testing and referral information.
4. Develop a program to disseminate prevention messages via mass-mailing audiocassettes.
5. Place condoms and needle/syringe sets in zones where the assessment teams worked. Additionally, provide information where individuals can be tested for HIV and referred for services.

Goal 18. Develop and implement protocols to ensure that persons who test positive for HIV/AIDS are provided with access to clinical care and secondary prevention services.

Strategies:

1. Improve access to HIV primary medical care for those who test positive for HIV.
2. Continue to provide outreach efforts to those who have tested positive yet, are refusing services. This is critical to preventing the spread of the disease and protecting the health of those who are positive.
3. Ensure that health care providers integrate HIV/AIDS services with other medical services (e.g., primary care and family planning services) in the RARE targeted neighborhoods.
4. Use methods and information described in this report to develop and implement plans for HIV/AIDS testing and referral in the RARE target areas.
5. Provide a more effective and efficient transportation system to improve clients' access to services.
6. Establish linkage and follow-up systems between the local health department and emergency rooms, crisis centers, and hot lines.
7. Coordinate efforts with local and state educational institutions to train and recruit health care providers from high-risk communities.

Goal 19. Design specific strategies to help reduce or eliminate high-risk behaviors in persons who test negative but continue to practice high-risk behaviors.

Strategies:

1. Form support groups for high-risk individuals (i.e., prostitutes, drug addicts, minority bisexual and homosexual males, sexually active teens). Provide incentives for attendance and creative risk reduction behaviors and suggestions.
2. Consider supplying high-risk individuals with an arts-based, harm reduction intervention. Include ideas from neighborhoods and local artists.
3. Provide a one-stop-shop for risk reduction education.
4. Earmark funding that allows the purchase of food vouchers as an incentive for individuals to be tested for HIV.

Goal 20. Design a plan to evaluate the implementation of the recommendations of the RARE Project Advisory Board.

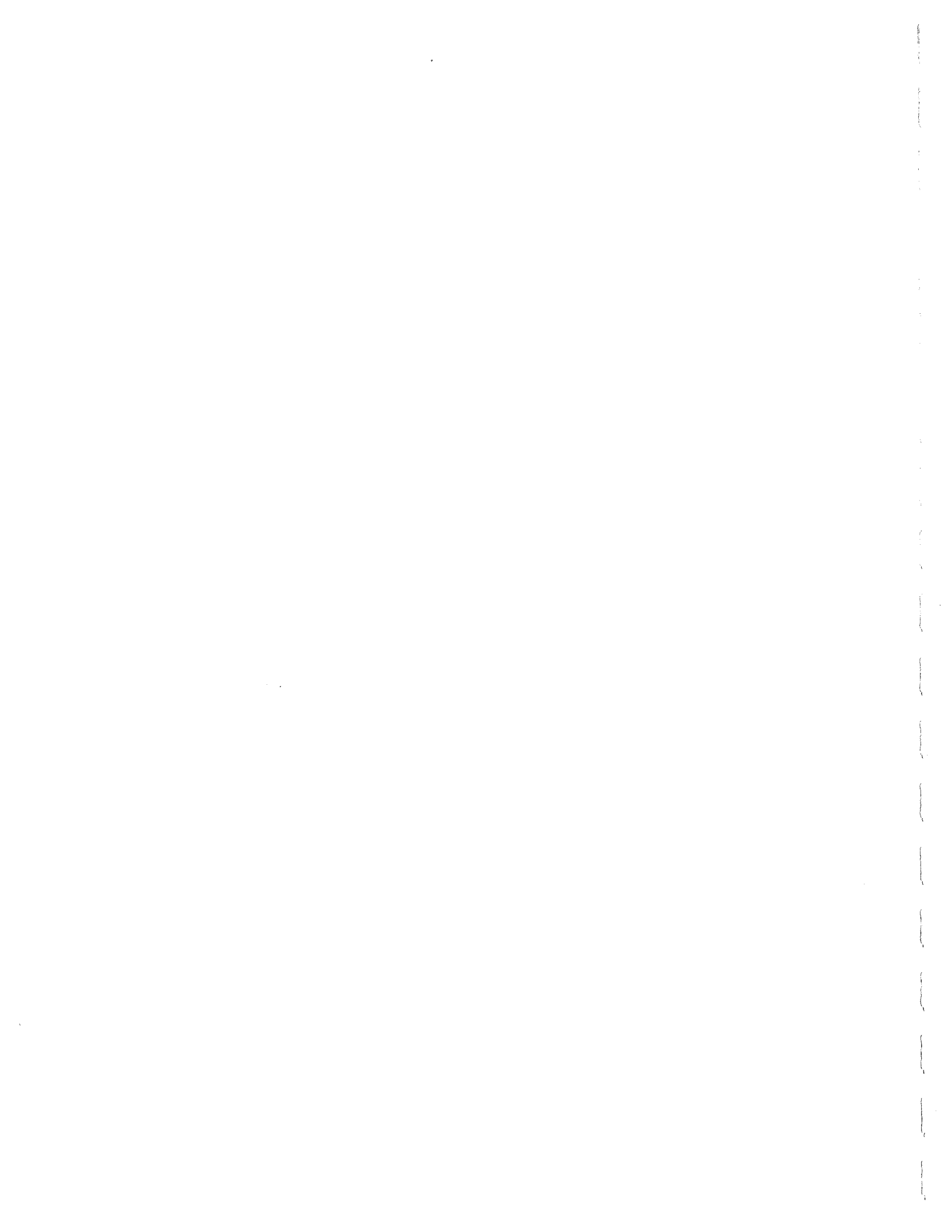
Strategies:

1. Include the outcomes of the RARE Project and attendant recommendations in the Comprehensive Plans of the local Community Planning Partnership and the Palm Beach County HIV CARE Council.
2. Conduct a secondary analysis with the data collected by the CARE Council's Comprehensive Three Year Needs Assessment to determine whether or not the qualitative data collected in the RARE Project is congruent with the HRSA required analysis of HIV/AIDS need in Palm Beach County. Utilize information relevant to the four zip codes explored by the RARE Field Teams.
3. Analyze data on the number of positive tests, negative tests, and post-test counseling rates relevant to RARE target sites and the imminent testing/counseling/referral piece of the RARE project as the CDC continuation of the RARE Project to do follow-up testing.
4. Compile a list of minority community-based organizations applying for and receiving HIV prevention dollars through federal, state, local and private funding.
5. Identify the number of new testing sites given to minority organizations.

APPENDIX

11

RARE



Notes on RARE Research Methodologies and Questions

Risk Factors, Protective Factors, and Consequences Module

Answers to questions in this module were used to elicit descriptions of the risk factors, protective factors (which enabled people to reduce the risk), and consequences regarding the transmission of HIV for individuals in the target area. Methods included focus groups and individual interviews.

1. What are the different patterns of risk and proactive behaviors that influence the transmission of HIV and morbidity and mortality associated with HIV?
2. What are the different configurations of risk that people are engaging in? e.g., sex for sex, sex for money, sex for drugs, etc.
3. What are the levels of knowledge that people have about the causes and treatment of HIV? e.g., What are the risk and protective factors associated with the indigenous medicinal/healing/religious/spiritual myths and traditions (e.g., Voodoo, Santeria, or the African - American belief that having a child makes them complete.) of specific subgroups or cultures.
4. Where do the specific risks for specific sub-populations occur?
5. When do these risks occur? What is the frequency or temporal variation in the risk behavior (daily, hourly, weekly, seasonal)?
6. Why are these people taking these risks? What is their motivation?
7. Who, in the community, knows about these risks? Who does something increase or decrease the risks? For example, are owners or employees of local grocery stores aware of these risks? Do they offer free condoms? Do local pastors open the church

for some protective activity? Do police chase harm reduction activists offering clean needles and condoms out of the area?

8. How can the risks in the neighborhood be reduced?
 - a. From the perspective of the individuals directly involved. For example, ask a drug addict, "What can we do for you to reduce the risk of HIV transmission?"
 - b. From the perspective of neighborhood leaders, e.g. grocery store owners, beauty salon owners, wash house owners or employees, church leaders.
 - c. From the perspective of public health agencies, governmental organizations, police, etc.
9. What are the attitudes and values about the risks associated with HIV transmission and how do they affect HIV transmission? (e.g. "My family doesn't have sex before marriage." "My son would never have 'homo sex'.") In the African American and Hispanic communities, if you're giving anal sex you're not gay but if you're on the receiving end you're gay, you're the fag (you're the girl).
10. How do society's do's and don'ts influence risk behavior?
11. What impact does economic and legal environment have on risk behavior?

Contextual

Answers to the questions in this module helped describe the impact of the environment on the transmission of HIV, the interaction between environment and the people.

Methods included street intercepts and geo-mapping.

1. What social groups are vulnerable to HIV risks? (e.g. low income, low socio-economic status, immigrants, migrants, uneducated, can't speak English, drug addicts, ex-inmates, sex workers, disadvantaged, disenfranchised, unemployed, mentally ill, minority groups, homeless, MSM, etc.)

2. Describe the features of the geographical environment that either facilitate or constrain the spread of HIV. (e.g. Intracoastal Waterway)
3. What are the significant movements of the population that are relevant to the spread of HIV risks? (e.g., commuters, tourism, trucking lanes, migrant workers)
4. What economic conditions are important to understanding HIV risks and consequences? (e.g., income inequalities, drug and sex economy)
5. Where and when, in the neighborhood, does the health care system provide care and treatment for HIV risks? (local health departments, clinics, ER's, etc)
6. What health care services are available and accessible in the neighborhood? What types of health care workers are there? Are there alternative health providers (e.g. Latin American outpost of the Department of Health)? What are the relevant priorities for the Department of Health?
7. What are the different views held about HIV risks and consequences by different sectors of the population? Are there any racial/ethnic divisions in society that have an impact upon HIV risk at the neighborhood level?
8. Do households and families support or constrain HIV risks and consequences?
9. What aspects of the roles of men and women affect the consequences of HIV risk? (e.g. , If you're a woman, are you afraid to ask your partner(s) if he/she/they is (are) having sex with anyone else. In the Haitian culture, which is polygamous; the man is allowed to have many households; sometimes they all live under one roof.)
10. What are the local powerful groups/organizations that effect the implementation of intervention? (e.g., church, health department, health care district, police, schools)

11. How influential are religious groups? What are their views on HIV risks, consequences? How strongly to they hold those views?
12. Who are key informants among health care providers and local community leaders/stakeholders?
13. Are there any racial, ethnic, or language divisions that help or hinder the development of interventions? (e.g. 22 dialects of Guatemalan Mayans in schools; truckloads of prostitutes brought to service migrant workers on weekends.)
14. Are there sources of media communication (radio, television, newspapers) accessible to and believed by the various sub-populations?
15. Is there capacity for research on HIV risks, consequences, and interventions within or accessible to the community?

Intervention Module

Answers to these questions helped determine the type of interventions needed and that would work well in the community.

1. What are the current local interventions being used to target HIV risks and consequences?
2. Are current interventions effective and is the vulnerable population actually receiving effective interventions?
2. Where are these interventions available and to whom are they not available?
3. When are these interventions available and not available?

4. Why are some interventions available while some are not available?
5. How does the local community evaluate the characteristics of these interventions?
6. What new or expanded interventions are needed?
7. What new or expanded policies are needed?



BLACK HETEROSEXUAL MALE/FEMALE



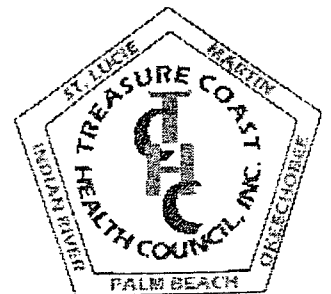
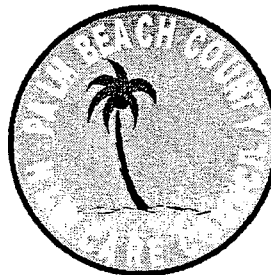
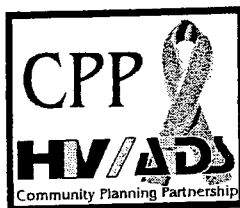
PALM BEACH COUNTY



**“SPEAK OUT -
BE HEARD”**

**BLACK HETEROSEXUAL MALES &
BLACK HETEROSEXUAL FEMALES IN PALM BEACH COUNTY
APRIL 2002**

**A Joint Project of the
Florida Department of Health
Treasure Coast Health Council
Palm Beach County HIV CARE Council
&
Palm Beach County HIV/AIDS Community Planning Partnership**





“SPEAK OUT -

BE HEARD”

**BLACK HETEROSEXUAL MALES &
BLACK HETEROSEXUAL FEMALES IN PALM BEACH COUNTY
APRIL 2002**

Karen Dodge, Ph.D., Treasure Coast Health Council, CARE Council Planner and Barbara Feeney M.P.A., Treasure Coast Health Council, Planner, CPP Coordinator, extend our sincere thanks to all the people who contributed their time and efforts to this project. It is our sincere hope that our work will contribute to improved HIV/AIDS prevention and patient care services for Blacks in Palm Beach County.

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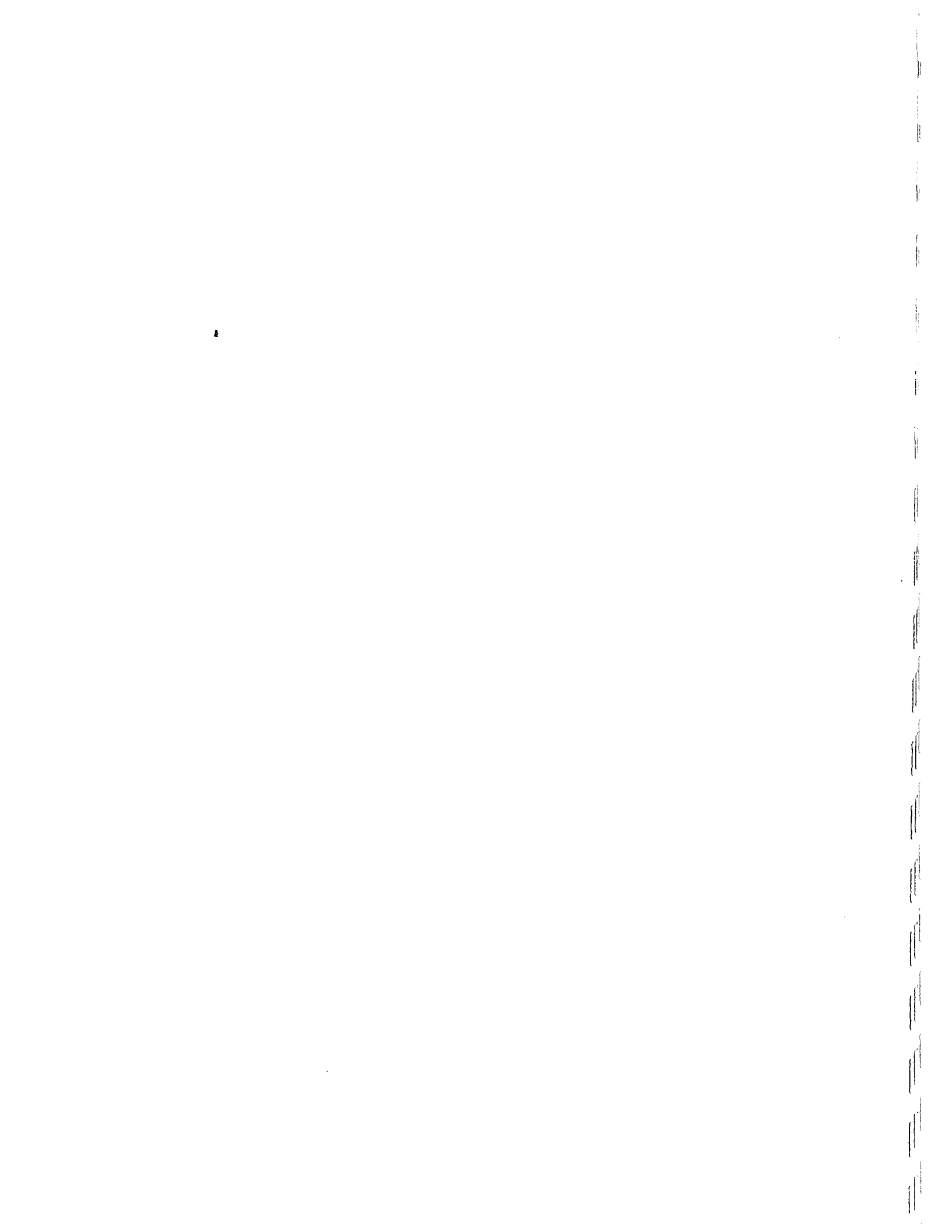


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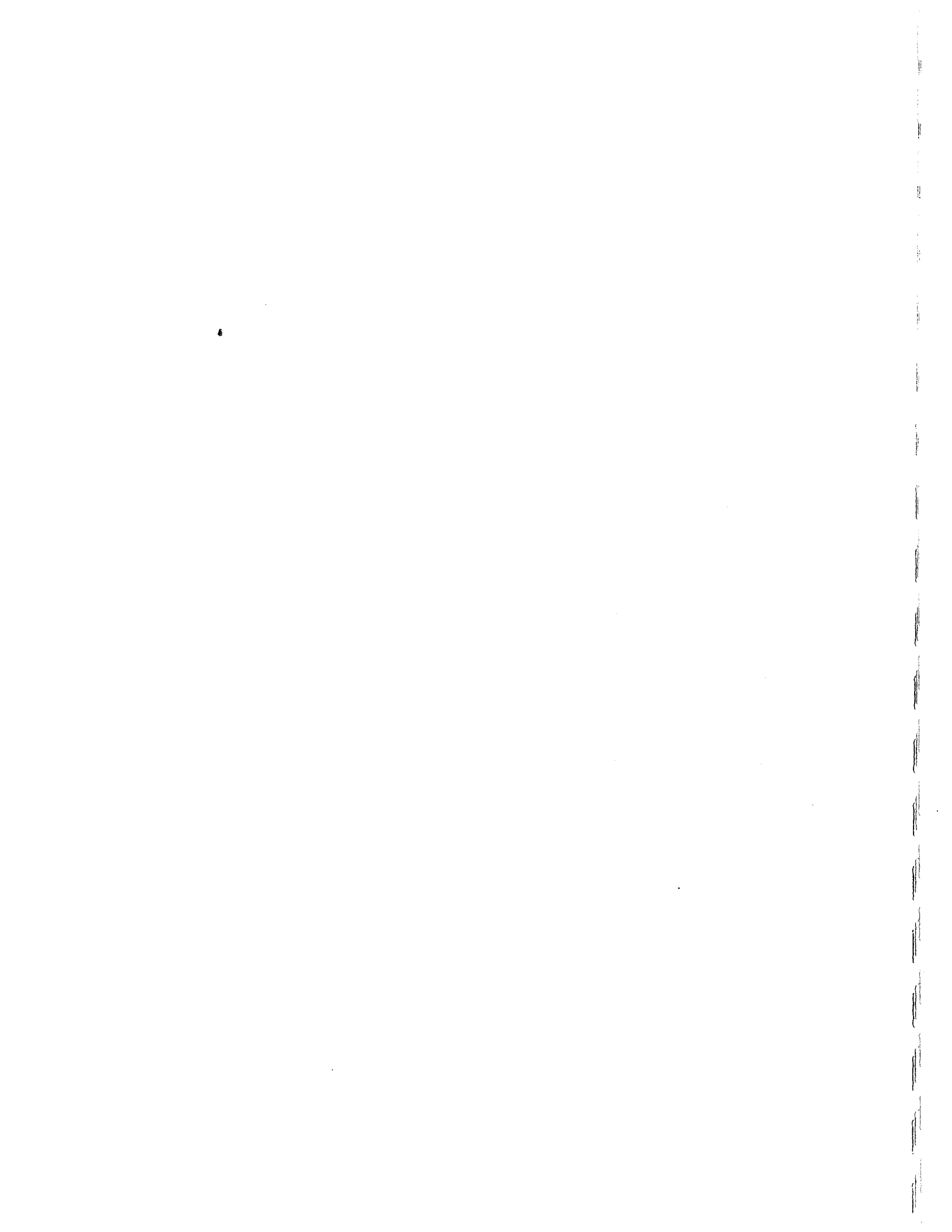
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I. EXECUTIVE SUMMARY

In our continuing effort to develop a comprehensive HIV/AIDS prevention and care plan, the Palm Beach County HIV/AIDS Community Planning Partnership (CPP) and the Palm Beach County HIV CARE Council (CARE Council) embarked upon a joint study of Black Heterosexual Males and Black Heterosexual Females in Palm Beach County.

The Chairs of the CARE Council and the CPP provided strong leadership as they guided this project through their respective groups. The CARE Council Planner and the CPP Coordinator worked together to plan, train the data collectors, implement data collection protocols, analyze data, and write the final report. CARE Council members, CPP members, and other members of Palm Beach County's Black community served as survey interviewers. The results were outstanding – a response rate of 100% with relatively few unanswered questions on a 375-item survey. Data from this survey will be used to inform the CPP, the CARE Council, and the entire community with the ultimate goal of improving HIV prevention and patient care services for Blacks in Palm Beach County.

This report includes data analyses of particular relevance to HIV prevention. However, the data base contains approximately 400 elements and it is anticipated that additional analyses will focus more specifically on patient care issues and, of great importance, issues related to the intersect of HIV prevention and patient care.

Respondents were selected from five distinct geographic areas and zip codes (Riviera Beach, 33404; West Palm Beach 33401; Boynton Beach, 33435; Delray Beach, 33444, and Pahokee, 33476) in which HIV/AIDS is having a disproportionate impact on Blacks. Every attempt was made to select respondents so that a fairly equal number of respondents from each geographic area were in each of the following categories:

- Male
- Female
- Infected
- Affected
- General Public

Additionally, efforts were made to ensure representation of the ethnic and linguistic diversity of Blacks in Palm Beach County – especially by including African-Americans, Haitians, Jamaicans, and other Caribbean Islanders.

Findings of particular interest include:

- Overall, 19% identified their sexual orientation as other than heterosexual.
- Less than half (49%) of those who indicated they were HIV positive, were receiving HIV-related services.
- Fewer than half (48.6%) of respondents indicated they always use a condom when they have sex with a casual partner.
- 35 (46%) of respondents are having sex with regular and casual partners, and that 18 (24%) of respondents have sex with regular and casual partners and use condoms less than all the time.
- The three most frequently cited reason for not using a condom were, “do not like”, “not available”, and “partner does not like”. Some respondents cited more than one reason.
- Thirteen (17.3%) indicated that the reason they don’t use condoms is that they are high (on drugs).
- Tobacco is the most frequently used substance, followed by alcohol and marijuana. However, daily usage of the various forms of stimulants (excluding tobacco; while including cocaine, crack, crystal meth, and speedball) is equal to the daily usage and exceeds the weekly usage of marijuana.
- The most frequently mentioned source of information about HIV/AIDS and HIV/AIDS services was “doctor”, followed by “friend”, “TV/radio”, “reading materials”, and “community”. Notably, “HIV services provider” was the second least frequently mentioned source of information about HIV or HIV services.
- 40% of HIV positive respondents missed at least one medical appointment in the past year due to transportation problems.
- All the survey respondents who indicated they used Palm Tran or Palm Tran Connection (n=13, 17.3%) were HIV positive.
- Less than a third (n=11, 31.4%) of HIV positive respondents indicated they received psychiatric treatment since being diagnosed with HIV and only 25.7% indicated they received mental health or substance abuse treatment.

II. INTRODUCTION

State and federal systems which address HIV/AIDS were developed primarily to meet the needs of white homosexual males and have not adequately addressed the different and special needs of women, children and minorities (Aday, Pounds, Marconi, & Bowen, 1999). Increasingly, we have come to recognize that HIV prevention and patient care needs vary across race, age, ethnicity, and gender lines (Fleishman, Mor, & Laliberte, 2001). This study attempts to describe some of the factors affecting Black males and Black females in Palm Beach County so that more effective HIV prevention and treatment services can be provided for this vulnerable population.

Throughout the State of Florida and Palm Beach County, data indicate that at least up to 2002, the prevalence of AIDS and the incidence of HIV among white homosexual males has lessened while the greatest increases in both AIDS prevalence and HIV incidence occurs among minorities, particularly, among the Black populace (HIV/AIDS Surveillance Reports: HARS, State of Florida Department of Epidemiological Reports, Tallahassee, Florida, March, 4, 2002).

In the United States as a whole, the rate of HIV infection is two and one half times higher among Hispanics than among non-Hispanic Whites (Diaz, 1999). HIV and AIDS also disproportionately affect blacks. Cowart (1998), estimates that 32 % of all AIDS cases nationally are now female; roughly 1% are children under 13 years of age; and 49% to 52% are "non-Caucasian." Further, Cowart (1998), noted that the prevalence and incidence of AIDS and HIV in Florida is significantly higher than national averages for both females and Blacks. In Florida, "...AIDS is no longer a gay, white disease" (Cowart, 1998). Specific Palm Beach County Epidemiological data will be presented in the next paragraph, which will serve to illustrate the broad constructs outlined in this section.

The State of Florida Department of Health: HIV/AIDS Surveillance (2002) provides an HIV prevalence estimate for Palm Beach County that suggests a plausible range of between 2,400 and 5,400 with a mid-point estimate of 3,900. Current CDC estimates that Palm Beach County has a plausible range of between 5,500 and 10,300 live cases of HIV/AIDS and a mid-point of 7,900 persons presumed to be living with HIV/AIDS. If the State of Florida-modeled HIV prevalence estimate of 3,900 is added to the CDC'S AIDS prevalence of 3,400 for Palm Beach County, the minimum number of persons with HIV (including those unaware of their infection) is 7,300 or close to the CDC-generated mid-point estimate of 7,900 persons living with HIV/AIDS. According to CDC calculations, the mid-point estimate for HIV/AIDS prevalence includes 3,745 live AIDS cases and 1,707 live HIV cases. Adding the total of live AIDS cases (n=3,745) and live HIV cases (n=1,707), for a total (n=5452), and computing an additional thirty percent (n=1,635.6) for unknowns and an additional twelve percent (n=654.2) for unreported cases, equals a grand total of (N=7739.8) close to the originally forecasted calculation of 7,900 provided by CDC. This reflects the prediction models referenced by CDC and authored by Karon and Rosenberg (JAMA, 1996).

Based on the aforementioned mid-point estimate of 7,900 and a 2000 census population estimate of 1,131,184, the State of Florida Bureau of HIV/AIDS estimates that Palm Beach County has an HIV/AIDS prevalence rate of 766 presumed to be living with HIV/AIDS per 100,000 residents. This is higher than the State of Florida prevalence rate for live HIV/AIDS per 100,000 residents of 548 and the United States HIV/AIDS prevalence rate for presumed living of 287 per 100,000.

A recent CDC publication (HIV/AIDS Quarterly Surveillance Report: CDC March, 2002) states that Palm Beach County ranks fourth in the U.S. relative to live AIDS cases per 100,000 residents; Miami ranks first, with 60.1 live AIDS per 100,000; N.Y.C. ranks second, with 52.2 live AIDS per 100,000; Broward ranks third, with 49.4 live AIDS per 100,000; and Palm Beach County ranks fourth with 43 live AIDS cases per 100,000 residents.

Karon and Rosenberg (1996), suggest that 1 in 333 Americans are living with HIV/AIDS. Florida Department of Health HIV/AIDS Surveillance (1998) estimates that 1 in 156 Floridians are HIV/AIDS infected. The State of Florida Bureau of HIV/AIDS Surveillance, states that 1 in 143 residents of Palm Beach County are now living with HIV-spectrum disease. Overall, 1 in 286 Whites, 1 in 50 Blacks, and 1 in 127 Hispanics are living with HIV/AIDS in Florida.

Recent data suggest that in Palm Beach County, HIV/AIDS disproportionately impacts women, people of color and heterosexuals, while White men who have sex with men and injection drug users are a less significant proportion of recently diagnosed cases as follows:

- Women account for 33% of the presumed living cases of AIDS through September 20, 2000 (AIDS prevalence).
- Women account for 34% of the recent AIDS cases in the past two years (AIDS Incidence).
- Women account for 47% of the HIV cumulative incidence cases (corresponds to HIV prevalence) as of September 30, 2000.
- Injection drug users account for 11% of the cumulative presumed live cases of AIDS as of September 30, 2000.
- Injection drug users account for 8% of recent AIDS reports for the past two years, and 6% of HIV cases through September 30, 2000.

In Palm Beach County, Blacks (collapsing African Americans with Haitians, Jamaicans and all Caribbean Islanders) continue to account for an increasingly large proportion of the epidemic. Through March 2002 in Palm Beach County, blacks account for a majority of cumulative (live and deceased) HIV and AIDS cases as follows:

- Black males account for 60.2% of cumulative male HIV cases.
- Black females account for 78.7% of cumulative female HIV cases.
- Blacks males and females) account for 63.6% of all (male and female) cumulative AIDS cases.
- Black males account for 56% of cumulative male AIDS cases.
- Black females account for 81.3% of cumulative female AIDS cases.

Cumulative Number of Black HIV Cases in Palm Beach County, Through March 2002

| Gender | Black Cases | Percentage of Total (Male or Female) Cases | Total (Male & Female) Cases |
|--------|-------------|--|-----------------------------|
| Male | 635 | 60.2% | 1,054 |
| Female | 700 | 78.7% | 890 |
| Total | 1,335 | 68.7% | 1,944 |

Notably, Blacks account for a total of 65% of the living AIDS cases in Palm Beach County, 73% of the cases diagnosed in the past two years, and 70% of the live AIDS cases through September 30, 2000.

Cumulative Number of Black AIDS Cases in Palm Beach County, Through March 2002

| Gender | Black Cases | Percentage of Total (Male or Female) Cases | Total Cases |
|--------|-------------|--|-------------|
| Male | 3,275 | 56.0% | 5,847 |
| Female | 2,035 | 81.3% | 2,504 |
| Total | 5,310 | 63.6% | 8,351 |

Source: Florida Department of Health, March 2002

As summarized in the following table, "Heterosexual Contact" is the single largest HIV/AIDS exposure category for both Black males and females. This is in sharp contrast to white males, for whom "Heterosexual Contact" accounts for only 7% of the cumulative HIV cases among white males and 3.5% of the cumulative AIDS cases among white males in Palm Beach County.

HIV exposure by IV Drug Use is also a significant mode of transmission among Black males and females.

Cumulative HIV and AIDS Cases (among Blacks in Palm Beach County) by Exposure Category and Sex Through March 2002

| Mode of Exposure | Male | | | | Female | | | |
|----------------------|-----------------|---------------------------|-----------------|---------------------------|-----------------|-----------------------------|-----------------|-----------------------------|
| | HIV | | HIV | | HIV | | AIDS | |
| | Number of Cases | % of all black male cases | Number of Cases | % of all black male cases | Number of Cases | % of all black female cases | Number of Cases | % of all black female cases |
| Homo-Bi Male | 93 | 14.6% | 635 | 19.4% | | | | |
| IV Drug User | 25 | 3.9% | 487 | 14.9% | 32 | 4.6% | 351 | 17.2% |
| Heterosexual Contact | 309 | 48.7% | 1235 | 37.7% | 454 | 64.9% | 1201 | 59.0% |
| Other | 208 | 32.8% | 918 | 28.0% | 214 | 30.6% | 483 | 23.7% |
| Total | 635 | 100.0% | 3275 | 100.0% | 700 | 100.0% | 2035 | 100.0% |

Source: Florida Department of Health

III. IMPLICATIONS OF CHANGING DEMOGRAPHICS

Changes in the demographics of HIV/AIDS have important implications for the delivery of services because HIV/AIDS is now affecting populations that are economically poorer and have fewer formal HIV care-giving support networks compared to the white homosexual community. It is generally recognized in the research literature that, overall, white homosexual males have been more affluent and better educated than many segments of the population. The white male homosexual community also has demonstrated its willingness to provide a high level of caregiver support for those who became infected with HIV disease. Ethnic minorities Living With HIV/AIDS not only are more likely to be of a lower socioeconomic status, but they also tend to view HIV/AIDS as especially stigmatic (Dunlop, Rothman, Condon, Parise-Reynolds, & Alonzo, 2000). Disclosure of HIV infection can result in family abandonment and community ostracism, leaving the person living with HIV/AIDS without support. Therefore, the changing demographics of HIV/AIDS sets the stage for a population of People Living with HIV/AIDS that is especially vulnerable and increasingly reliant on the public funding "system" for all forms of support. Additionally, as the needs of People Living with HIV/AIDS are likely to change over time, their service needs will also vary. Since changes in health status and service needs can occur very rapidly, it is important that a comprehensive system of services is readily available and culturally appropriate. (Smith, Knickman, & Oppenheimer, 2000).

Given the current demographic description of HIV/AIDS in Palm Beach County, and the recognition that, in general, health care and outcome disparities adversely affect Blacks, the Palm Beach County HIV/AIDS Community Planning Partnership and the Palm Beach County HIV CARE Council have initiated a joint needs assessment process to gain a better understanding of the Black population in Palm Beach County. It is hoped that this needs assessment will contribute towards the ultimate goal of providing more culturally appropriate and effective prevention and patient care services to Blacks in the area.

IV. METHODOLOGY

Design

This study utilized an interview survey design administered in the form of a questionnaire. Rather than requiring that respondents read and respond to questionnaires and enter their own answers, interviewers were trained to anticipate the need to read questions orally to participants and record their answers if necessary. Additionally, interviewers were trained to probe for responses if participants omitted an answer or answered inappropriately. The interviewer technique for administering this survey questionnaire produced a response rate of 100% and there were relatively few unanswered questions.

Data Collection and Sampling

Because the target group is known to be relatively reticent about disclosing information relevant to the topic of HIV/AIDS (Denis, Wechsberg, McDermeita, Campbell & Rasch, 2001), clients were recruited using variants of convenience sampling (Carlson, Wang, Siegal, Falck, & Guo, 1994) combined with purposive sampling strategies. Ten (10) members, combined, from the CPP and the Palm Beach County HIV CARE Council, were selected from within their respective committees for their ethnographic expertise of HIV/AIDS relative to their neighborhoods. The ten (10) data collectors were trained in face-to-face survey interviewing techniques and selection criteria of the study participants. Data collectors received \$10.00 for each completed survey questionnaire. Selection criteria included choosing five (5) infected individuals from each site; five (5) affected or care-giver individuals from each site; and five (5) members of the general population from within their neighborhood site. The five data collection sites were chosen by selecting the five highest zip code ranked areas for HIV incidence (from mid-1997 to 2001) in Palm Beach County and then further selecting from within each zip code a smaller "hot zone" determined by the CPP and Palm Beach HIV CARE Council committees.

The sample of 75 Black people was drawn from Riviera Beach, West Palm Beach, Boynton Beach, Delray Beach, and Pahokee, Florida, between January 2002 and February 2002. Data collectors recruited fifteen (15) participants from each site in the manner described above for a total N of 75. After completing the survey, participants received a \$20.00 gift certificate.

Sample Characteristics

Demographically, the sample of Black participants (N=75), was predominantly female (n=40, 53%), heterosexual (n=61, 81%), between 30-to-49 years of age (n= 41, 55%), received some high school (n=34, 45%), were single and never married (n=30, 40%), and

35 study participants or 47 percent indicated that they were infected with HIV. Sample demographics are presented in greater depth in the following section of the report.

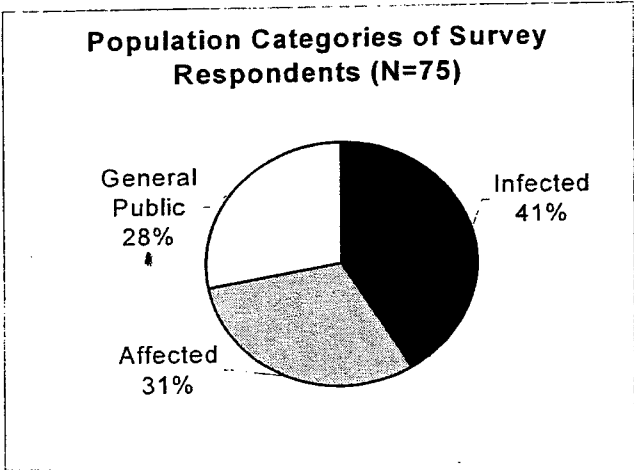
Instrumentation

Data were collected using a 375-item survey instrument constructed to collect information relating to HIV/AIDS and substance abuse, mental health, co-morbidities for HIV/AIDS, transportation, housing, medical services, social services, and case management. Additionally, issues relating to being “in care” in relation to access to services and utilization of services were explored. There was an extensive sociodemographic section, which aimed at gathering information on variables such as education, income, age, race, and marital status. The survey took about 45 minutes to complete and was pretested on individuals similar to survey respondents.

Data Analyses

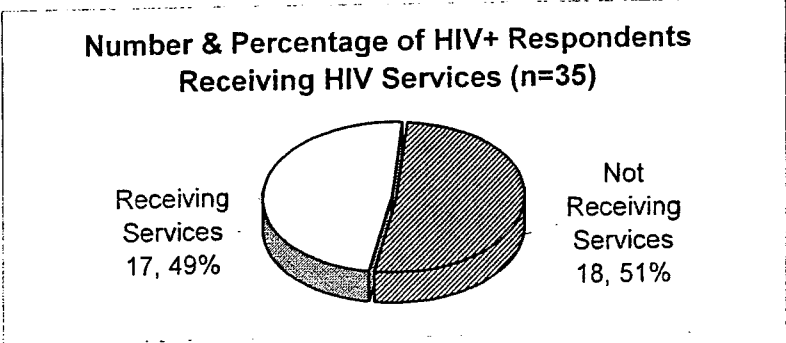
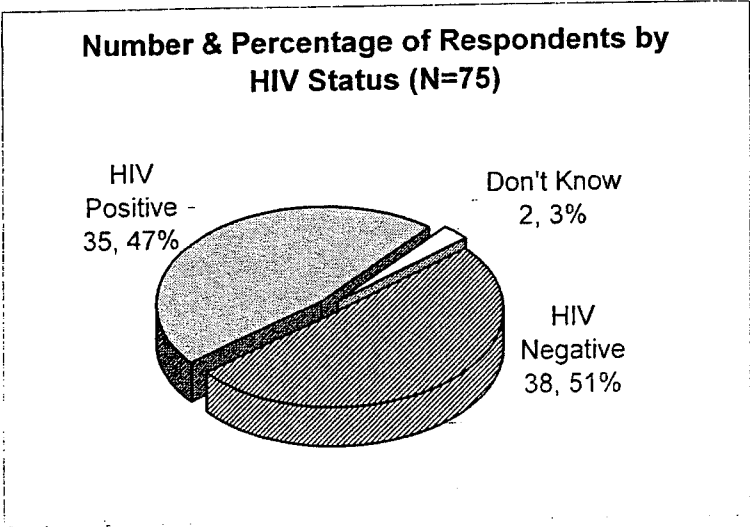
All analyses were performed on SPSS 10.05. Frequencies and percentages were calculated on all scale items and cross-tabs were computed between selected variables to explain relationships between survey items.

V. KEY FINDINGS

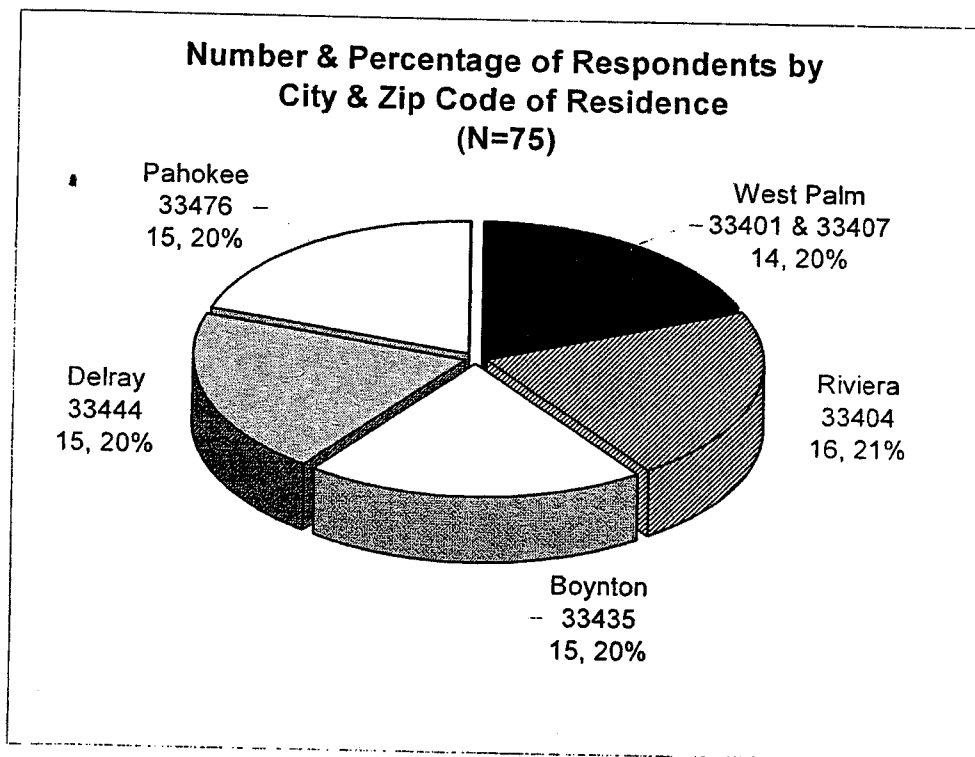


Data collectors attempted to identify and survey approximately equal numbers of infected, affected, and the general public. Based on the initial “best guess” of a person’s status, infected respondents accounted for more than a third (41%) of all respondents, while the affected and general public accounted for 31% and 28%, respectively.

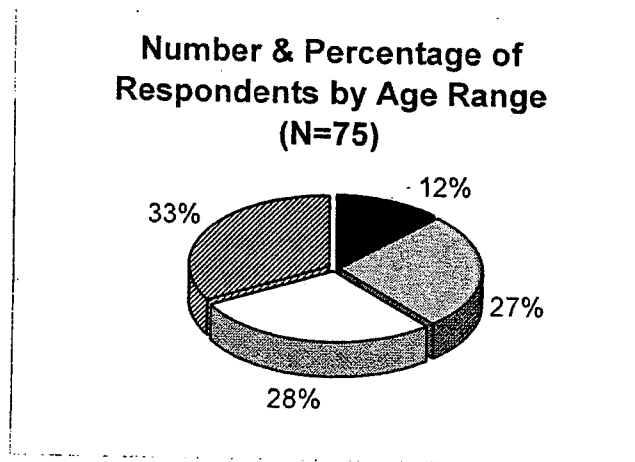
However, further analysis of answers to specific survey questions showed that 47% of all respondents were HIV positive. Notably, less than half (49%) of those who indicated they are HIV positive, were receiving HIV-related services.



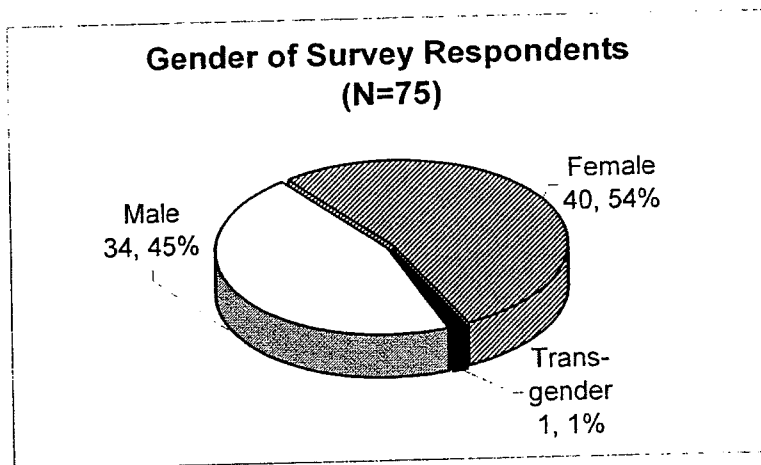
Five zip code areas with relatively high rates of recent HIV infections were targeted in this study. Two of these areas (Pahokee in the rural western area and Boynton Beach in the southern coastal area north of Delray Beach) had not been surveyed at all - at least not in recent years.



The largest age range was comprised of respondents over the age of 49. 49% were under age 40 and 51 percent were over the age of 40. Palm Beach County Health Department HIV Surveillance Data indicates that in Palm Beach County overall (all races and ethnicities), 24% of cumulative HIV cases are ages 20-29; 35% are ages 30-39; 22% are ages 40-49; and 14% are over age 49.

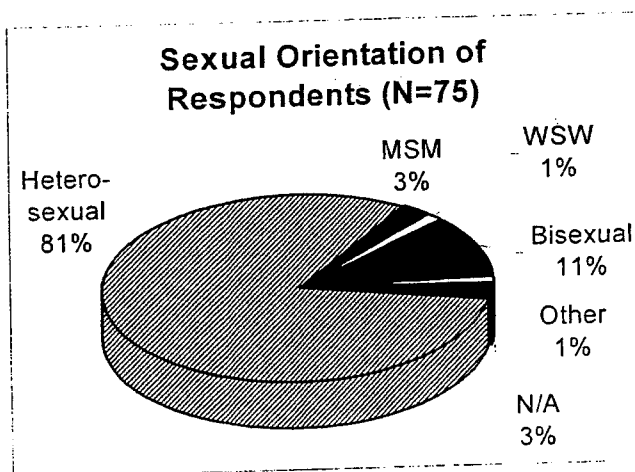


Females accounted for 54% of all respondents, while males accounted for 45%. 1% indicated they were transgendered. Although 54 % of respondents were female, none indicated they were pregnant.



In a separate survey question in which respondents were asked if they were transgendered, and if so, if they were transgendered male to female or female to male, eight (10.6%) respondents indicated they were transgendered, seven (87%) of whom indicated they were transgendered male to female. Further study is required to gain a better understanding of the knowledge, attitudes, beliefs, and behaviors of this group.

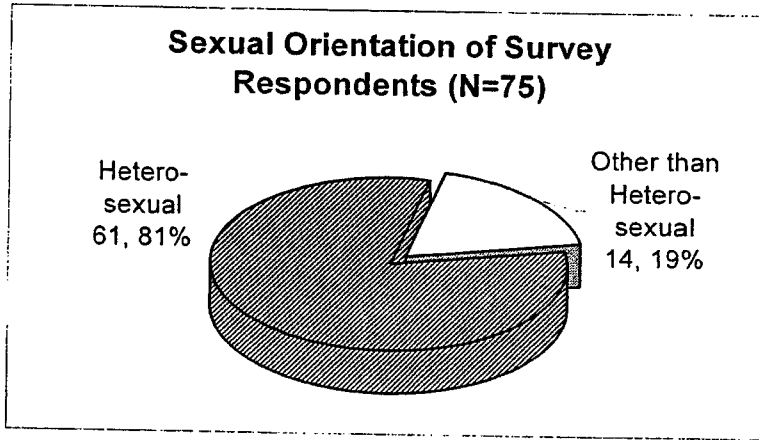
While 81.3% of respondents identified their sexual orientation as “heterosexual”, the second largest group (10.7%) identified themselves as “bisexual”, and 2.7% as “Men who have Sex with Men (MSM)”.



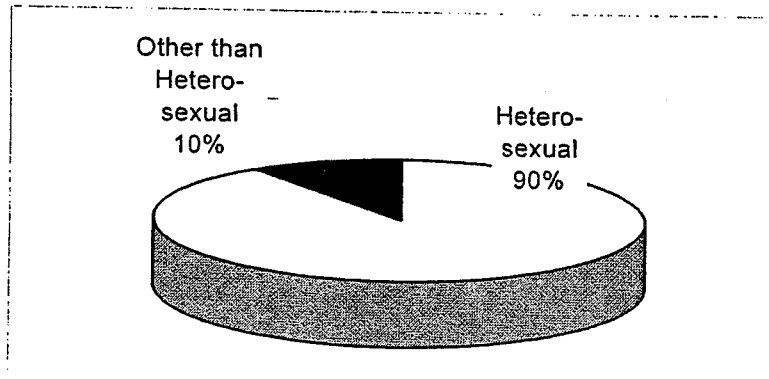
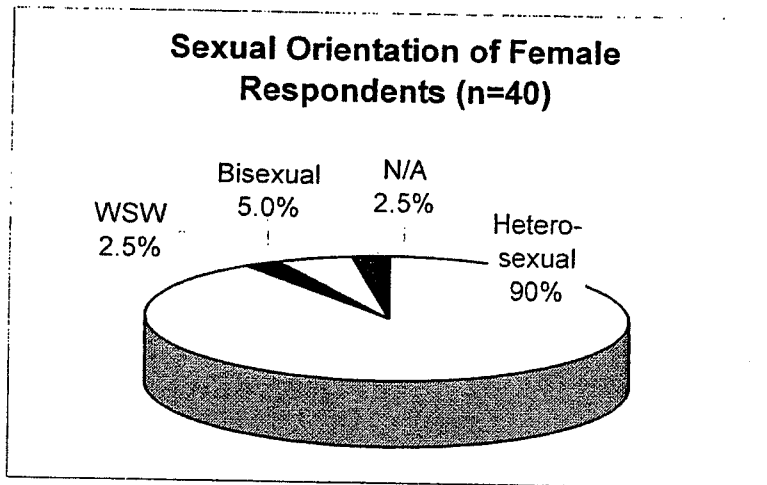
Sexual Orientation of Respondents (n=75)

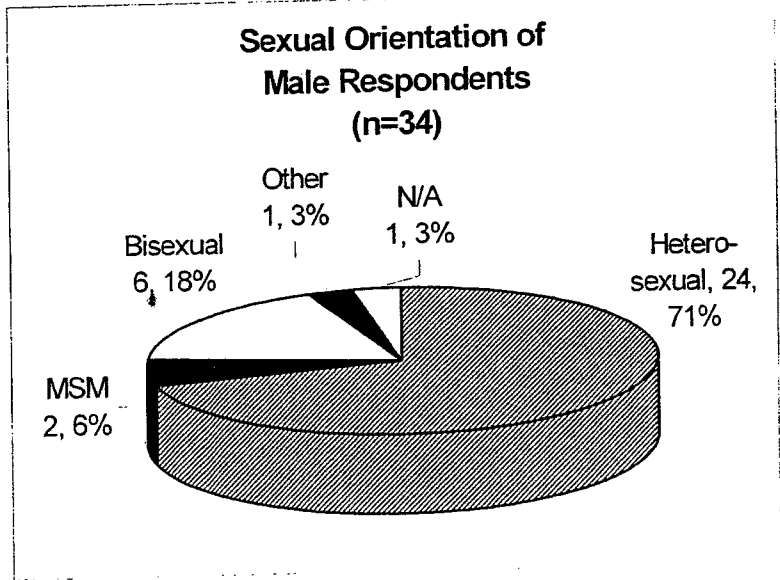
| Sexual Orientation | Number | Percent |
|--------------------|--------|---------|
| Heterosexual | 61 | 81.3% |
| MSM | 2 | 2.7% |
| WSW | 1 | 1.3% |
| Bisexual | 8 | 10.7% |
| Other | 1 | 1.3% |
| N/A | 2 | 2.7% |
| Total | 75 | 100.0% |

Overall, 19% identified their sexual orientation as other than heterosexual. Effective prevention and patient care services for this vulnerable segment of the population must be developed and implemented

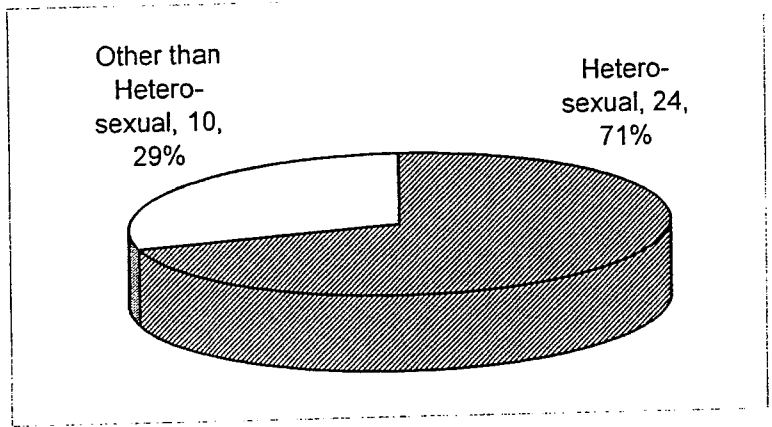


Most females (n=36, 90%) identified themselves as heterosexual, while 4 (10%) identified themselves as other than heterosexual [Women Who Have Sex with Women (WSW, n=1), bisexual, n=2, and n/a, n=1].





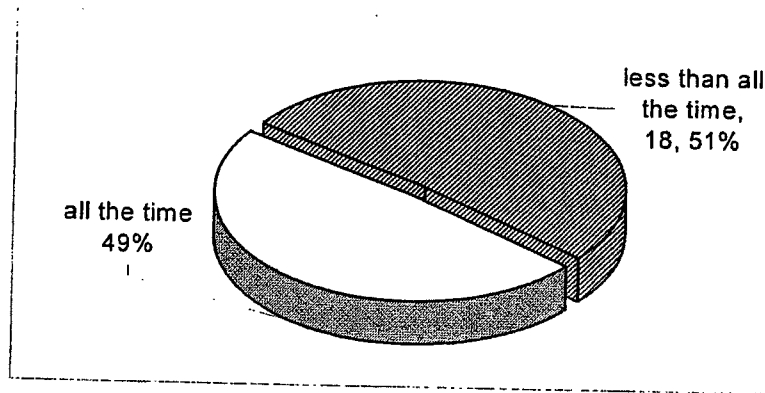
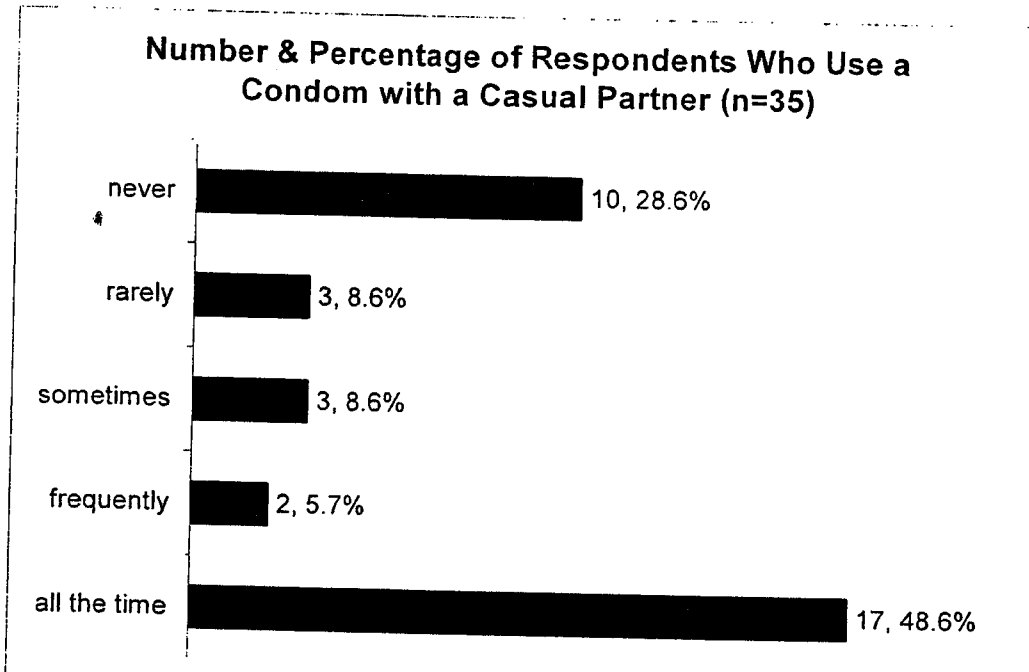
70.6% of all male respondents identified as heterosexual, 17.6% (n=6) indicated they were bisexual and 5.9% (n=2) indicated they were MSM.



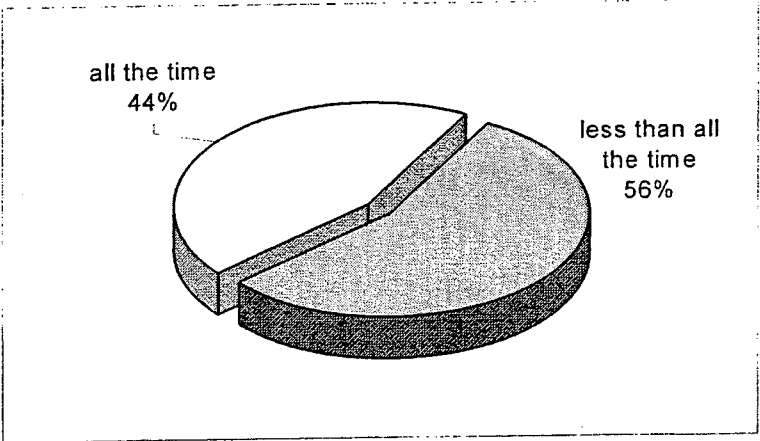
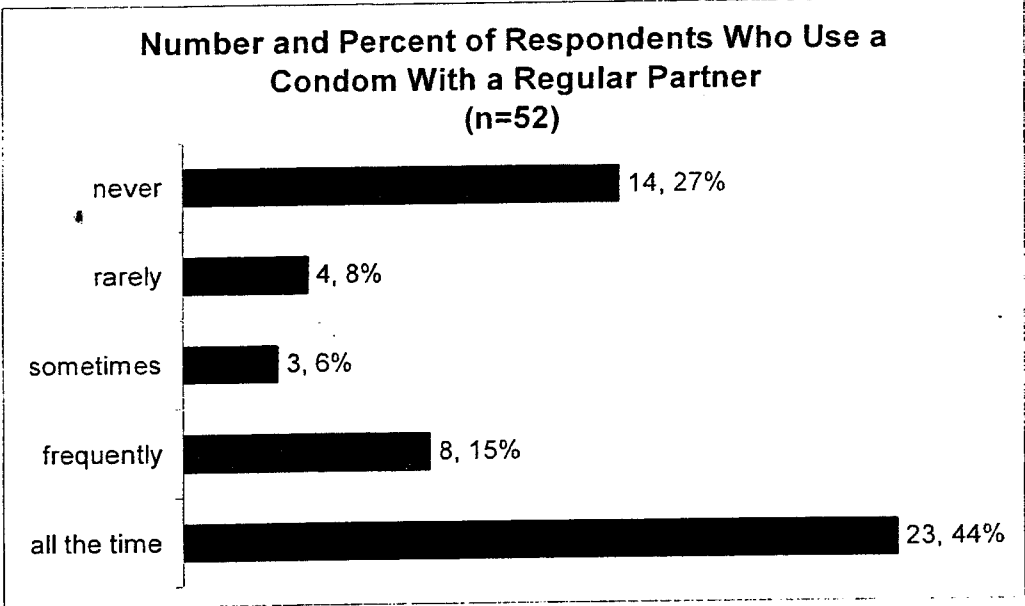
Of the eight respondents (10.7% of all respondents), who identified themselves as “bisexual”, six identified as “male” and two identified as “female”. Therefore, a total of eight males (six bisexual and two MSM) identified as other than heterosexual. This represents 23.5% of all male respondents having sex with men, most of whom (75%) also (presumably) are having sex with women. A total of 29% of the male respondents identified their sexual orientation as other than heterosexual.

Six males and two females indicated they were bisexual and HIV infected. This represents 17.6% of all male respondents and 100% of all (male, female, and transgendered) respondents who indicated they were bisexual.

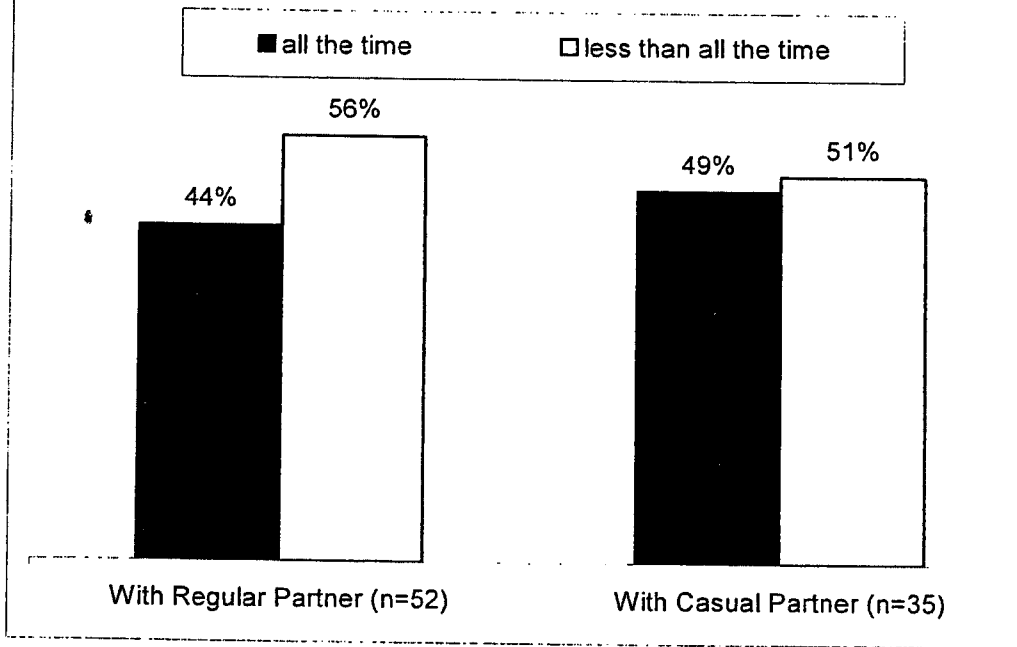
Fewer than half (48.6%) of respondents who indicated they had sex with a casual partner indicated they always use a condom when they have sex with a casual partner while nearly one third (28.6%) indicated they never use a condom.



Only 44% of respondents indicated they always use a condom when having sex with a regular partner.

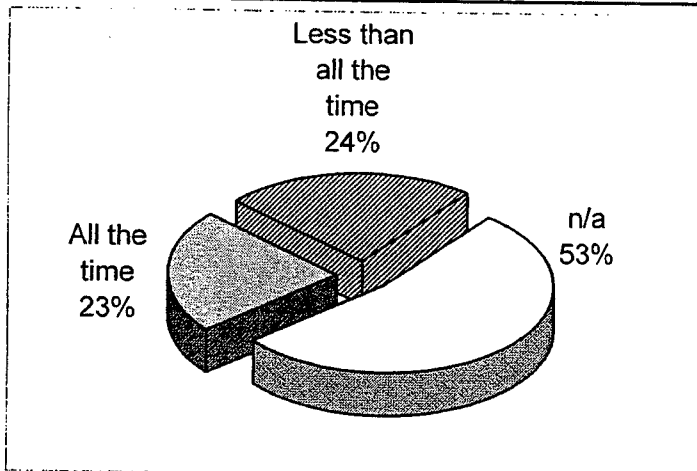


Comparison of Respondents Who Use Condoms with Regular and Casual Partners



Number & Percentage of Respondents Using A Condom with Regular & Casual Partners (N=75)

| Condom Use | Number | Percentage |
|------------------------|--------|------------|
| All the time | 17 | 22.7% |
| Less than all the time | 18 | 24.0% |
| n/a | 40 | 53.3% |
| Total | 75 | 100.0% |



Although more respondents indicated they are having sex with a regular partner (n=52) than with a casual partner (n=35), the proportion of those having unprotected sex is similar.

Further analysis revealed that 35 (46%) of respondents are having sex with regular and casual partners, and that 18 (24%) of respondents have sex with regular and casual partners and use condoms less than all the time.

The following tables summarize the frequency of condom use by HIV negative respondents and HIV positive respondents with regular and casual partners.

As shown below, HIV negative and HIV positive respondents reported nearly equal rates (less than a third) of “all the time” condom use with regular partners. HIV negative respondents had somewhat higher rates of “all the time” condom use with casual partners (26.3% versus 20.0%).

HIV positive respondents reported condom use of “frequently”, “sometimes”, or “rarely” with a regular partner at nearly three times the rate of HIV negative respondents (and, with a casual partner, nearly six times the rate of HIV negative respondents).

**Use of Condom with a Regular Partner by HIV Status
(N=75, HIV Negative=38, HIV Positive=35)**

| HIV Status | all the time | | frequently/ sometimes/ rarely | | never | | n/a | | total | |
|--------------|--------------|-------|-------------------------------------|-------|-------|-------|-----|-------|-------|------|
| | # | % | # | % | # | % | # | % | # | % |
| HIV Negative | 12 | 31.6% | 4 | 10.5% | 9 | 23.7% | 13 | 34.2% | 38 | 100% |
| HIV Positive | 11 | 31.4% | 10 | 28.6% | 4 | 11.4% | 10 | 28.6% | 35 | 100% |

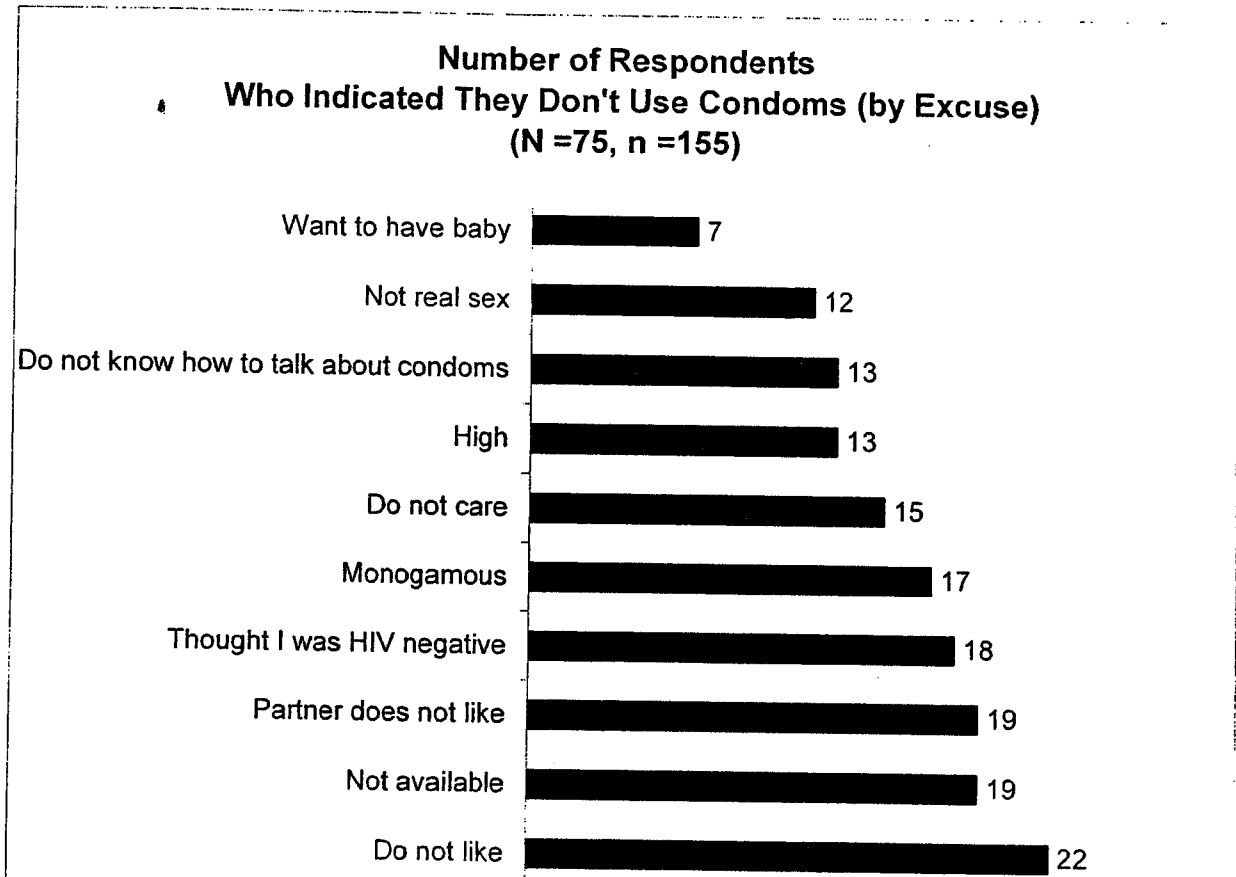
| HIV Status | all the time | | frequently/ sometimes/ rarely/never | | n/a | | total | |
|--------------|--------------|-------|-------------------------------------|-------|-----|-------|-------|------|
| | # | % | # | % | # | % | # | % |
| HIV Negative | 12 | 31.6% | 13 | 34.2% | 13 | 34.2% | 38 | 100% |
| HIV Positive | 11 | 31.4% | 14 | 40.0% | 10 | 28.6% | 35 | 100% |

**Use of Condom with a Casual Partner by HIV Status
(N=75, HIV Negative=38, HIV Positive=35)**

| HIV Status | all the time | | frequently/ sometimes/ rarely | | never | | n/a | | total | |
|--------------|--------------|-------|-------------------------------------|-------|-------|-------|-----|-------|-------|------|
| | # | % | # | % | # | % | # | % | # | % |
| HIV Negative | 10 | 26.3% | 1 | 2.6% | 7 | 18.4% | 20 | 52.6% | 38 | 100% |
| HIV Positive | 7 | 20.0% | 6 | 17.1% | 2 | 5.7% | 20 | 57.1% | 35 | 100% |

| HIV Status | all the time | | frequently/ sometimes/ rarely/never | | n/a | | total | |
|--------------|--------------|-------|-------------------------------------|-------|-----|-------|-------|------|
| | # | % | # | % | # | % | # | % |
| HIV Negative | 10 | 26.3% | 8 | 21.1% | 20 | 52.6% | 38 | 100% |
| HIV Positive | 7 | 20.0% | 8 | 22.9% | 20 | 57.1% | 35 | 100% |

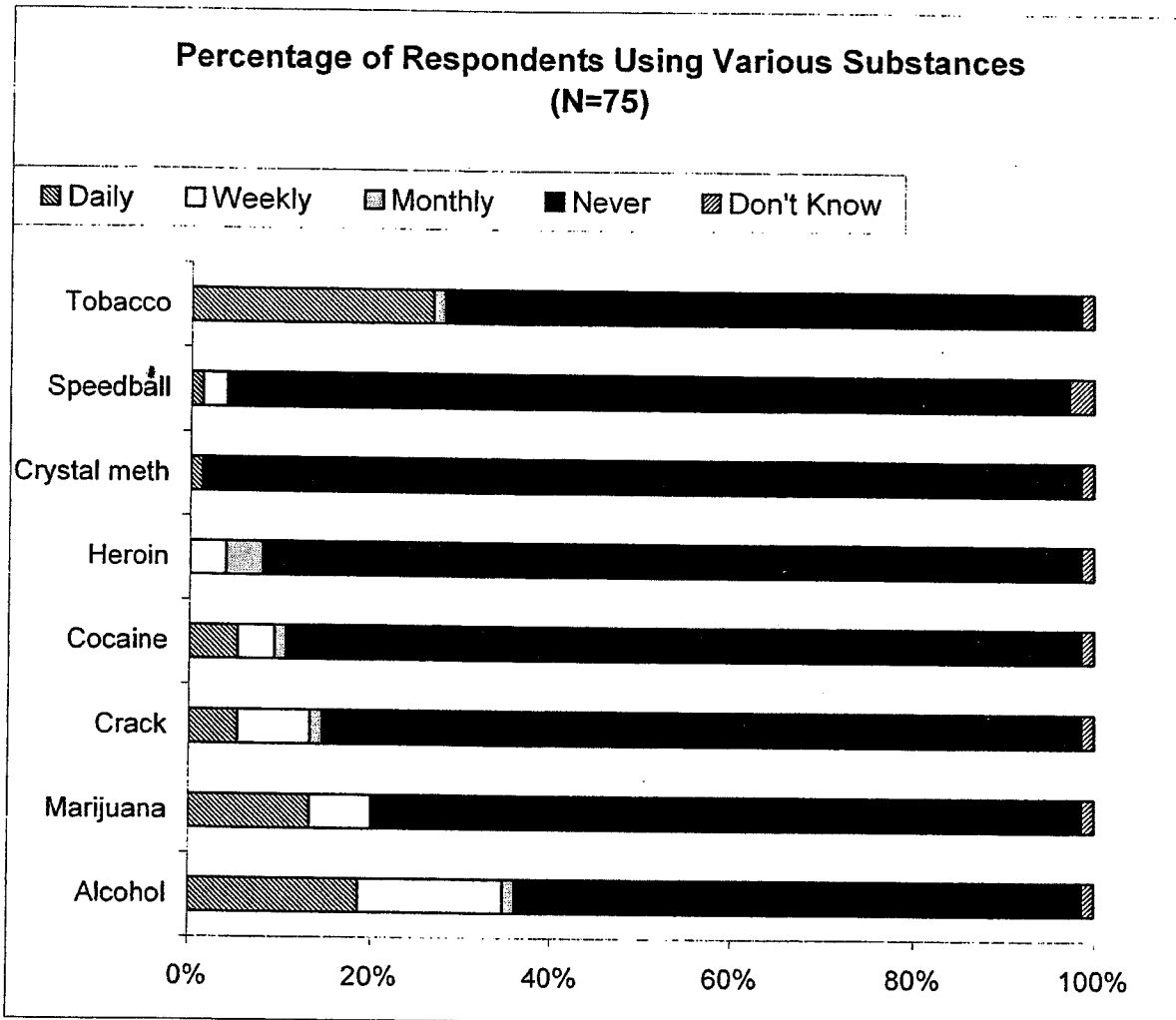
The three most frequently cited reason for not using a condom were, “do not like”, “not available”, and “partner does not like”. Thirteen (17.3%) indicated that the reason they don’t use condoms is that they are high (on drugs). Some respondents cited more than one reason.



Tobacco is the most frequently used substance, followed by alcohol and marijuana. However, daily usage of the various forms of stimulants (cocaine, crack, “crystal meth”, and speedball), is equal to the daily usage and exceeds the weekly usage of marijuana.

**Number of Respondents Using Various Substances by
Frequency of Use (N=75)**

| Substance | number of respondents by frequency of use | | | | | Total Respondents |
|--------------|---|--------|---------|-------|------------|-------------------|
| | Daily | Weekly | Monthly | Never | Don't Know | |
| Alcohol | 14 | 12 | 1 | 47 | 1 | 75 |
| Marijuana | 10 | 5 | 0 | 59 | 1 | 75 |
| Crack | 4 | 6 | 1 | 63 | 1 | 75 |
| Cocaine | 4 | 3 | 1 | 66 | 1 | 75 |
| Heroin | 0 | 3 | 3 | 68 | 1 | 75 |
| Crystal meth | 1 | 0 | 0 | 73 | 1 | 75 |
| Speedball | 1 | 2 | 0 | 70 | 2 | 75 |
| Tobacco | 20 | 0 | 1 | 53 | 1 | 75 |



Further analyses are needed to evaluate the association between substance abuse and a variety of HIV risk behaviors in this population.

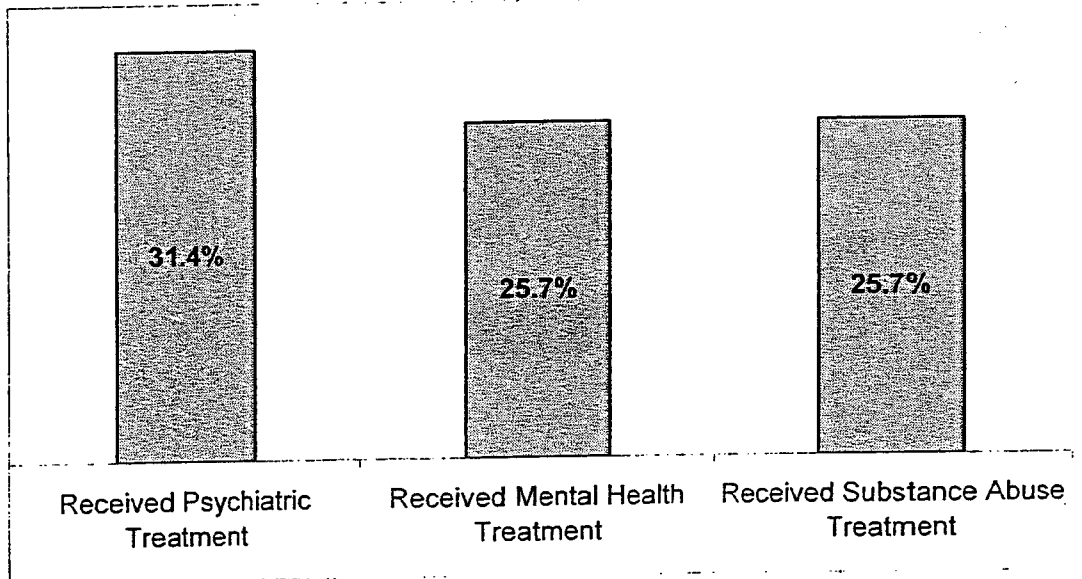
A separate question about intravenous drug use indicated the following:

- 11 respondents (15%) indicated they have injected drugs in the past.
- 4 (5%) indicated they are currently injecting drugs.
- 2 respondents indicated that they sometimes shared needles.
- 2 respondents indicated they sometimes clean needles.
- 5 said they never clean needles.
- 3 indicated they used bleach to clean needles.

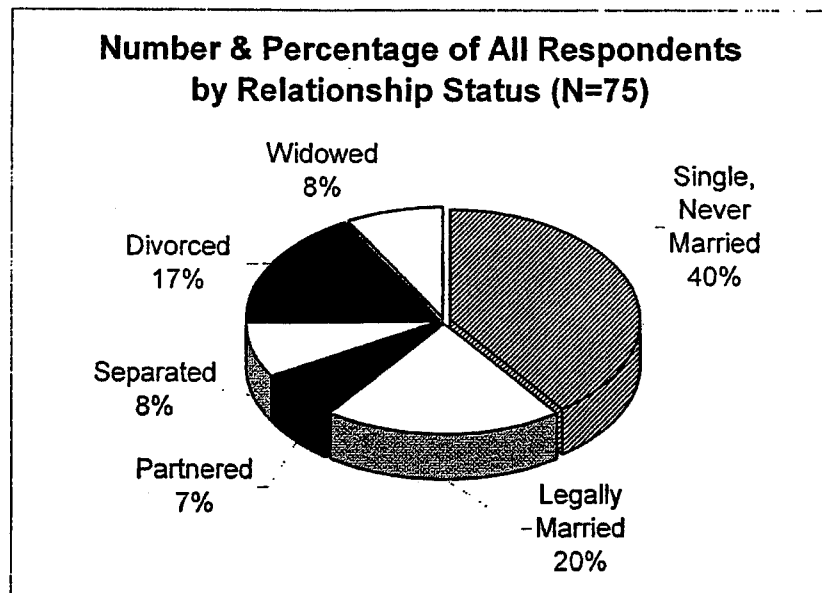
While substance abuse and mental health issues may contribute to HIV risk and impede effective HIV treatment, less than a third (n=11, 31.4%) of HIV positive respondents indicated they received psychiatric treatment since being diagnosed with HIV and only 25.7% indicated they received mental health or substance abuse treatment. Nearly twice as many respondents indicated the treatment was provided on an outpatient basis.

Summary of HIV Positive Respondents Who Received Treatment Since HIV Diagnosis, by Type of Treatment (n=35)

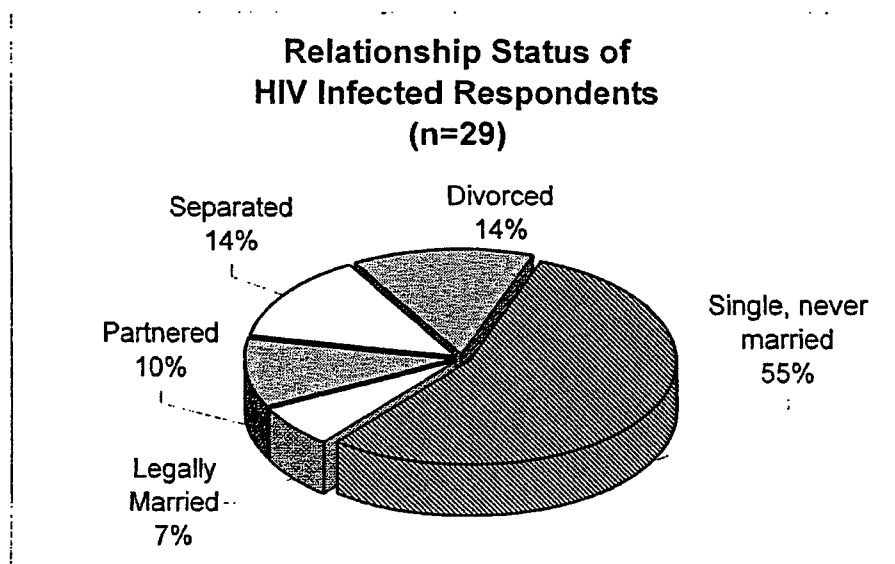
| Psychiatric | | Mental Health | | Substance Abuse | | Outpatient | | Inpatient | | Both | |
|-------------|-------|---------------|-------|-----------------|-------|------------|-------|-----------|-------|------|------|
| # | % | # | % | # | % | # | % | # | % | # | % |
| 11 | 31.4% | 9 | 25.7% | 9 | 25.7% | 9 | 25.7% | 5 | 14.3% | 1 | 2.9% |



Single, never married (40%) was the largest group in this sample, followed by legally married (20%) and divorced (17%). Further analyses would be helpful in understanding the association between relationship status, income, HIV status (including health status of individuals who are HIV positive), and HIV risk behaviors.



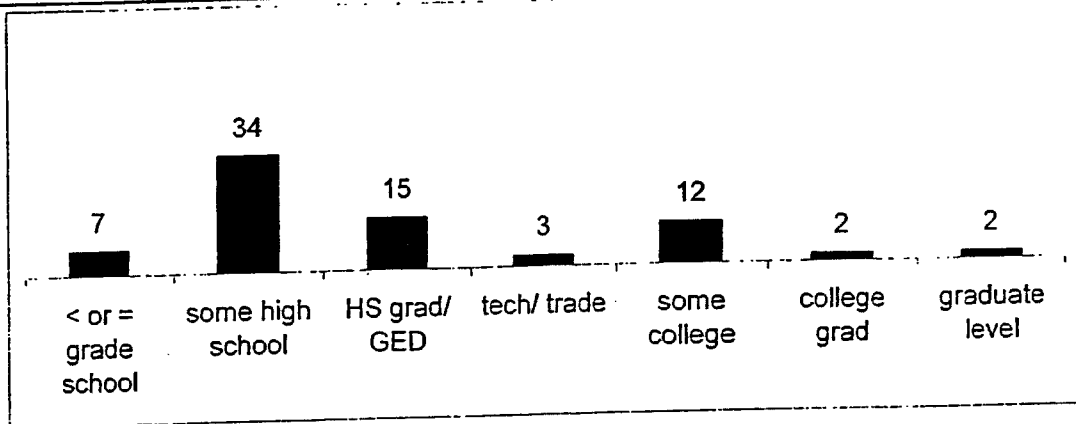
Overall, HIV infected respondents had a higher rate of being “single, never married” (55 percent) and a lower rate of being “legally married” (7 percent), than the respondents as a whole.



The highest educational level attained by respondents varied somewhat across sites. In general, the largest category across all four sites was "some high school", accounting for 45.3% (n=34) of all respondents. Seven, (9.3%) had an educational level less than or equal to grade school. A total of 41 (54.7%) of respondents had an educational level of less than high school graduate/GED. Comprehensive information about HIV prevention and patient care should be provided to this vulnerable population in a broad range of educational, literacy, and learning style formats, including arts-based presentations and alternate media sources (e.g. radio and posters).

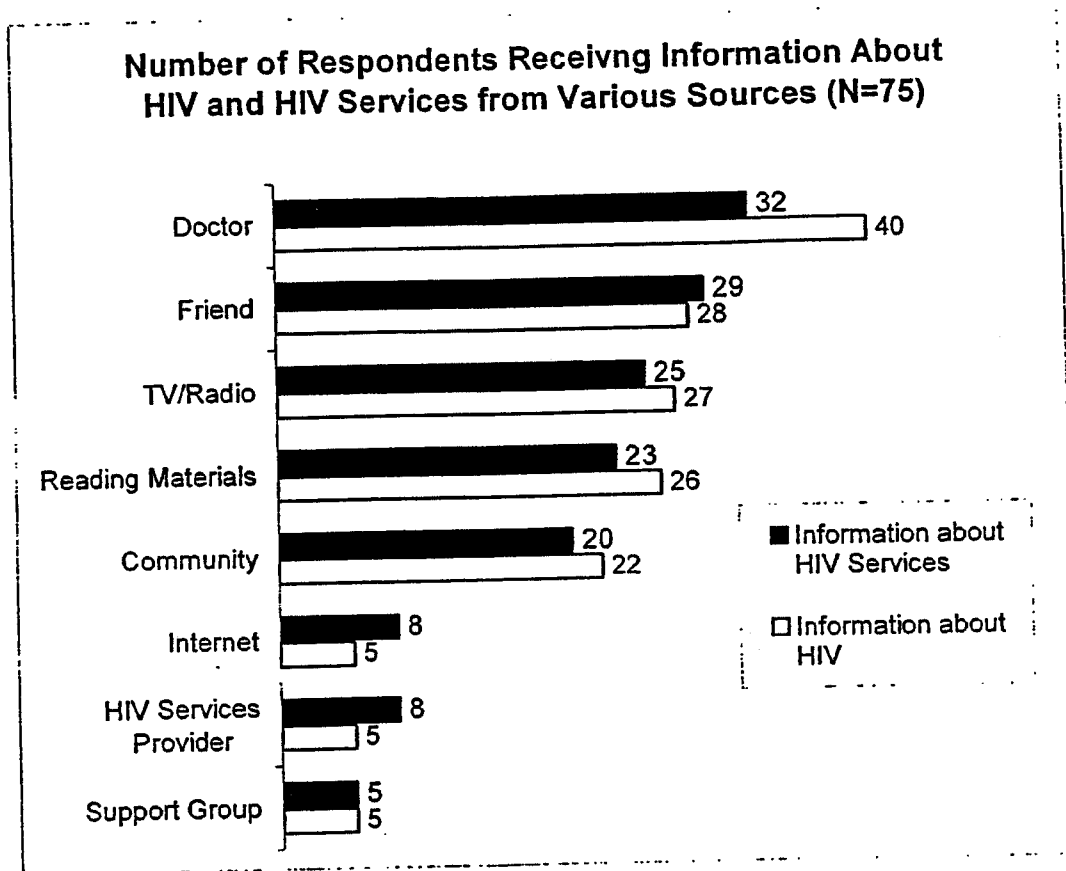
Highest Educational Level Attained by Respondents (N=75)

| Area | < or = grade school | some high school | HS grad/ GED | tech/ trade | some college | college grad | graduate level | Total |
|-----------------|---------------------------|------------------------|-----------------|----------------|-----------------|-----------------|-------------------|-------|
| Boynton Beach | 2 | 5 | 5 | 1 | 1 | | 1 | 15 |
| Delray Beach | 2 | 9 | 2 | | 1 | 1 | | 15 |
| Pahokee | 2 | 9 | 3 | | 1 | | | 15 |
| Riviera Beach | 1 | 6 | 1 | 2 | 5 | | | 15 |
| West Palm Beach | | 5 | 4 | | 4 | 1 | 1 | 15 |
| Total | 7 | 34 | 15 | 3 | 12 | 2 | 2 | 75 |



The most frequently mentioned source of information about HIV and HIV services was “doctor”, followed by “friend”, “TV/radio”, “reading materials”, and “community”. Notably, “HIV services provider” was the second least frequently mentioned source of information about HIV or HIV services.

Given the literacy and educational gap between physicians and the majority of respondents, it is important that comprehensive HIV/AIDS information services be delivered via culturally and educationally appropriate materials.

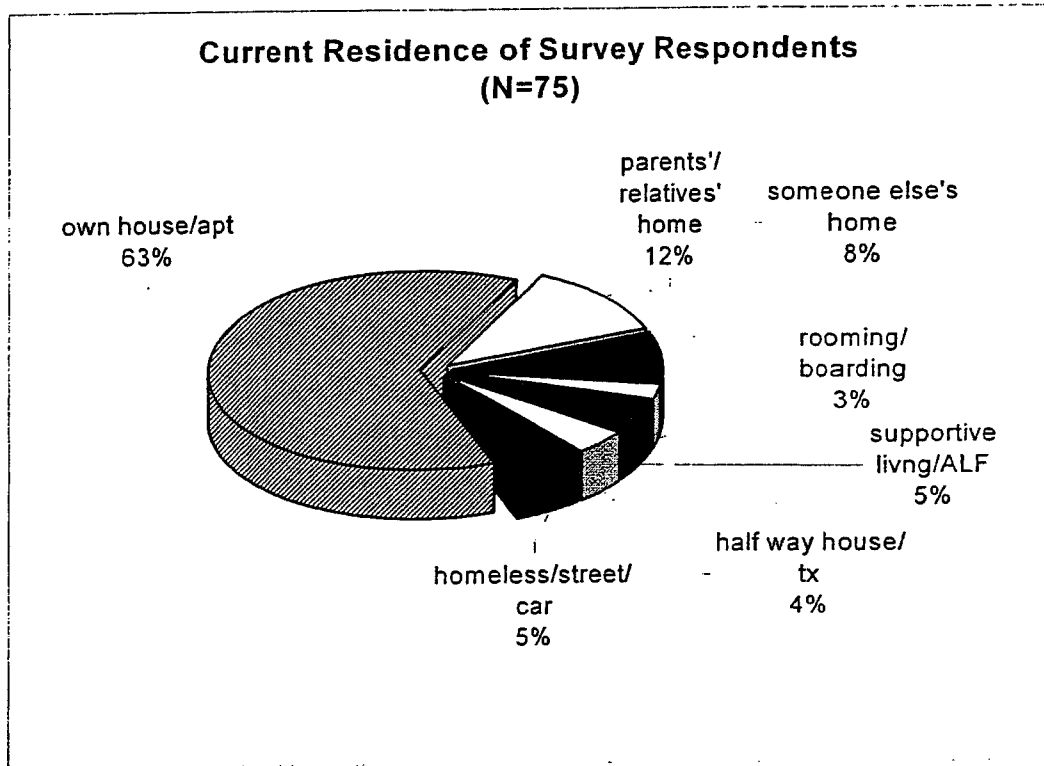


With or without HIV/AIDS, housing is a basic and universal need. However, among survey respondents, only 63 percent indicated they live in their own house or apartment. Another 12 percent live with their parents' or other relatives while 25 percent live in other housing.

Further analyses are necessary to thoroughly explore the relationship between adequate housing and HIV/AIDS prevention and treatment among Blacks in Palm Beach County.

Current Residence of Survey Respondents (N=75)

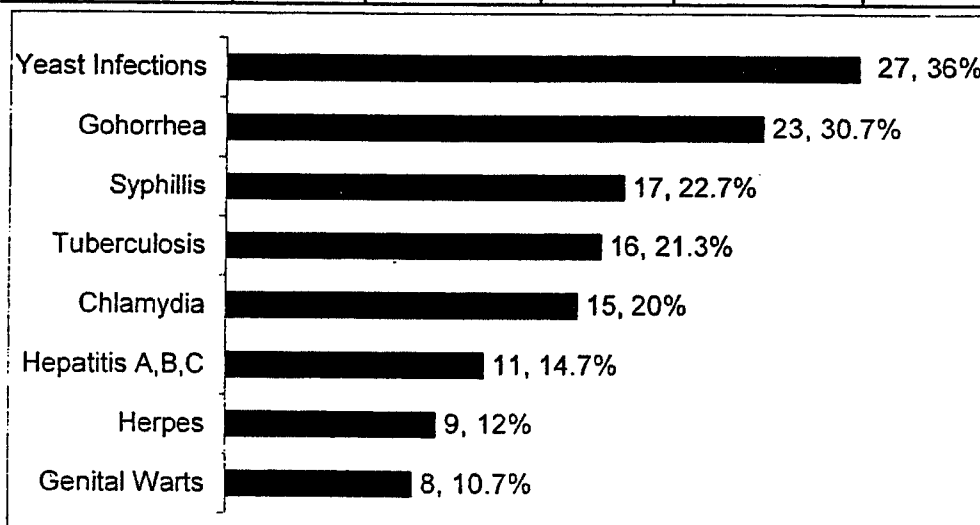
| Residence | Number | Percentage |
|--------------------------|--------|------------|
| own house/apt | 47 | 62.7% |
| parents'/relatives' home | 9 | 12.0% |
| someone else's home | 6 | 8.0% |
| rooming/boarding | 2 | 2.7% |
| supportive livng/ALF | 4 | 5.3% |
| half way house/ tx | 3 | 4.0% |
| homeless/street/car | 4 | 5.3% |
| Total | 75 | 100.0% |



Infection with any of the following diseases may increase susceptibility to HIV infection or complicate HIV/AIDS treatment. Twenty-seven (36%) of respondents indicated they had ever been diagnosed with one of the infectious diseases listed below. Some respondents indicated they had been diagnosed with more than one of these diseases. Of particular concern is the 22.7% of respondents who indicated they had been diagnosed with tuberculosis. Four (14.8%) of those diagnosed with TB were “active in treatment”, and one was “active no treatment”.

**Number & Percentage of Respondents Diagnosed
With Other Specific Infectious Diseases (N=75)**

| Other Diseases | Yes | Percent of Respondents | No | Don't Know/ Prefer Not to Answer | Total |
|------------------|-----|------------------------|----|-------------------------------------|-------|
| Genital Warts | 8 | 10.7% | 65 | 2 | 75 |
| Herpes | 9 | 12.0% | 65 | 1 | 75 |
| Hepatitis A,B,C | 11 | 14.7% | 63 | 1 | 75 |
| Chlamydia | 15 | 20.0% | 57 | 3 | 75 |
| Tuberculosis | 16 | 21.3% | 56 | 3 | 75 |
| Syphilis | 17 | 22.7% | 57 | 1 | 75 |
| Gohorrhea | 23 | 30.7% | 50 | 2 | 75 |
| Yeast Infections | 27 | 36.0% | 47 | 1 | 75 |



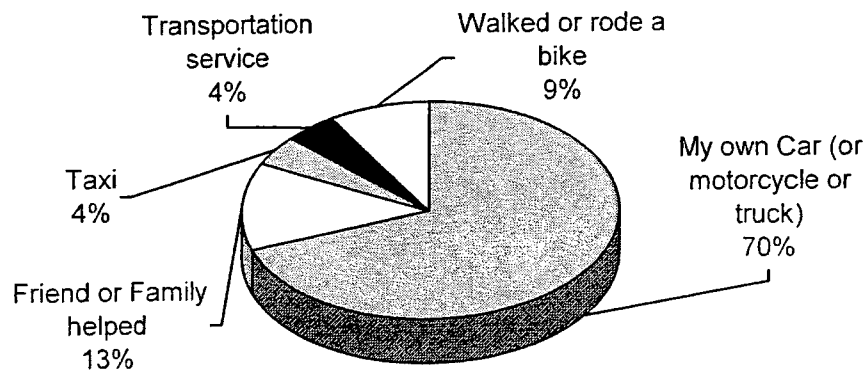
Lack of transportation is a common barrier to medical or other services appointments. When respondents were asked to identify all the means by which they traveled to their medical or other service appointments, the results showed some important differences between HIV positive and HIV negative respondents. Eleven (30 %) of the respondents who were HIV positive, indicated they used Palm Tran compared to 0 respondents who were HIV negative. 16 (70%) of respondents who were HIV negative indicated they used their own vehicle, while only 13 (35%) of respondents who were HIV positive used their own vehicle. While 13% of HIV negative respondents indicated they had help with transportation from a friend or family member, only 6% of HIV positive respondents indicated a friend or family member helped them.

Transportation Utilized to Access Services During the Past Year (N=75)

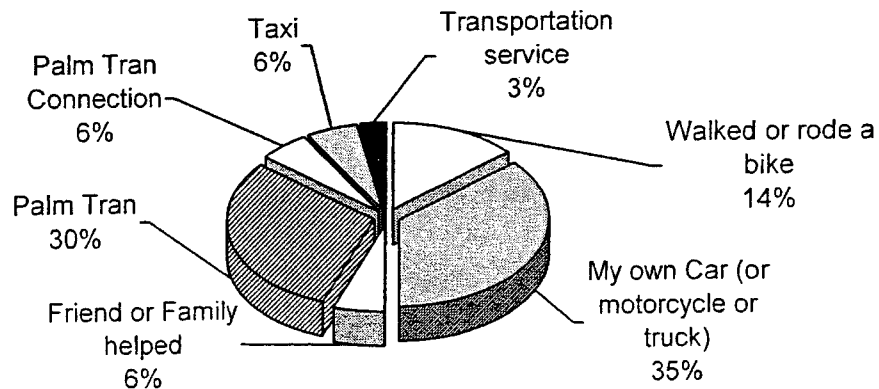
| Transportation Utilized | HIV Status of Respondent | | |
|--|--------------------------|--------------|------------|
| | HIV Negative | HIV Positive | Don't Know |
| My own Car (or motorcycle or truck) | 16 | 13 | 0 |
| Rode with a friend or family member or borrowed their car (or motorcycle or truck) | 3 | 2 | 1 |
| Palm Tran | 0 | 11 | 0 |
| Palm Tran Connection | 0 | 2 | 0 |
| Taxi | 1 | 2 | 0 |
| Transportation service | 1 | 1 | 0 |
| Walked or rode a bike | 2 | 5 | 0 |

Comparison of Transportation Used by HIV Negative and HIV Positive Respondents to Access Services During the Past Year (N=75)

Transportation Used by HIV Negative Respondents



Transportation Used by HIV Positive Respondents



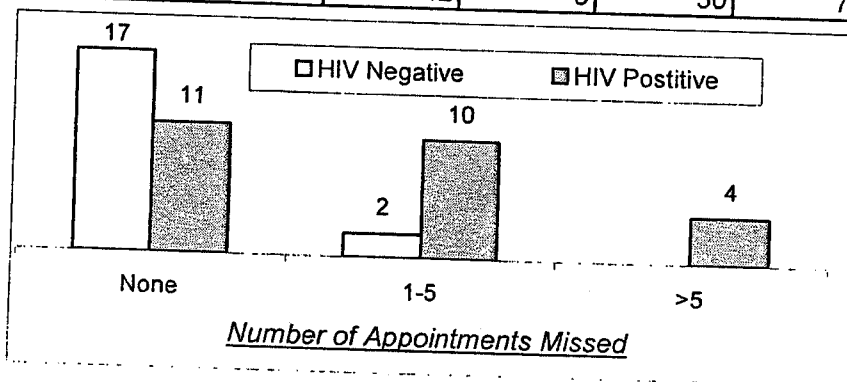
Respondents who indicated they were HIV positive missed more medical appointments than respondents who indicated they were HIV negative.

Fewer HIV positive respondents [11 (31%)] than HIV negative respondents [n=17 (44%)] indicated they missed any appointments at all.

While only 2 (5.7%) HIV negative respondents missed appointments, 14 (40%) of HIV positive respondents missed more than one.

Medical Appointments Missed During Past Year Because of Transportation Problems

| HIV Status | None | 1-5 | >5 | n/a | Total |
|--------------|------|-----|----|-----|-------|
| HIV Negative | 17 | 2 | 0 | 19 | 38 |
| HIV Positive | 11 | 10 | 4 | 10 | 35 |
| Don't Know | 0 | 0 | 1 | 1 | 2 |
| Total | 28 | 12 | 5 | 30 | 75 |



Although this report provides an overall description of some of the factors influencing HIV/AIDS prevention and treatment among Blacks in Palm Beach County, it raises more questions than it answers. The CARE Council and the CPP hope that it inspires a continued commitment to understand and remedy the conditions that impede effective HIV/AIDS prevention and patient care services for this highly vulnerable population. While more analyses are needed to understand Blacks in Palm Beach County with regard to HIV/AIDS, some of the findings of particular interest include:

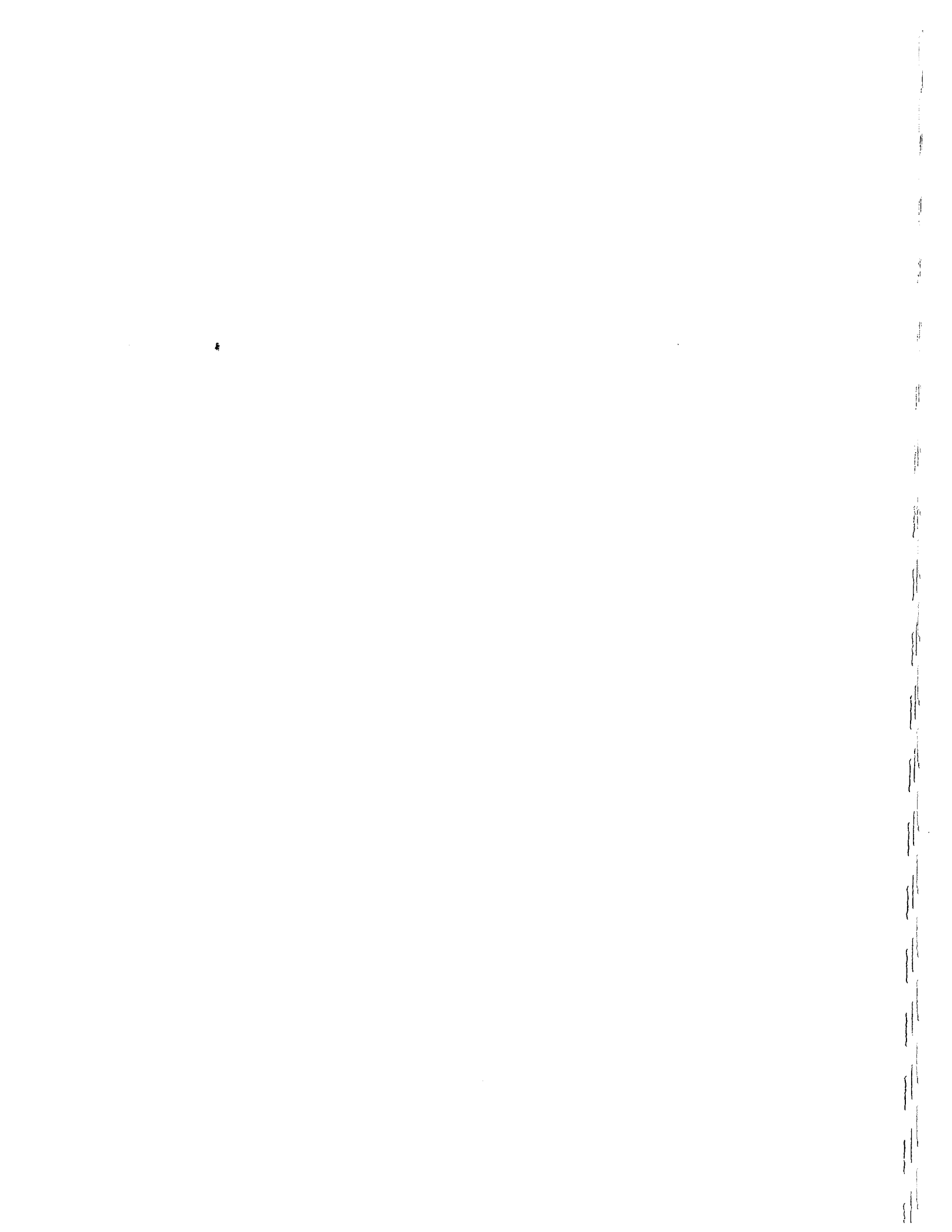
- Overall, 19% identified their sexual orientation as other than heterosexual.
- Less than half (49%) of those who indicated they were HIV positive, were receiving HIV-related services.
- Fewer than half (48.6%) of respondents indicated they always use a condom when they have sex with a casual partner.

- 35 (46%) of respondents are having sex with regular and casual partners, and that 18 (24%) of respondents have sex with regular and casual partners and use condoms less than all the time.
- Among HIV positive respondents, only 31.4% report using a condom “all the time” with a regular partner and only 20% report using a condom “all the time” with a casual partner.
- The three most frequently cited reason for not using a condom were, “do not like”, “not available”, and “partner does not like”. Some respondents cited more than one reason.
- Thirteen (17.3%) indicated that the reason they don’t use condoms is that they are high (on drugs).
- Tobacco is the most frequently used substance, followed by alcohol and marijuana. However, daily usage of the various forms of stimulants (tobacco; cocaine, crack, crystal meth, and speedball) is equal to the daily usage and exceeds the weekly usage of marijuana.
- The most frequently mentioned source of information about HIV and HIV services was “doctor”, followed by “friend”, “TV/radio”, “reading materials”, and “community”. Notably, “HIV services provider” was the second least frequently mentioned source of information about HIV or HIV services.
- 40% of HIV positive respondents missed at least one medical appointment in the past year due to transportation problems.
- All the survey respondents who indicated they used Palm Tran or Palm Tran Connection (n=13, 17.3%) were HIV positive.
- Less than a third (n=11, 31.4%) of HIV positive respondents indicated they received psychiatric treatment since being diagnosed with HIV and only 25.7% indicated they received mental health or substance abuse treatment.

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APPENDICES

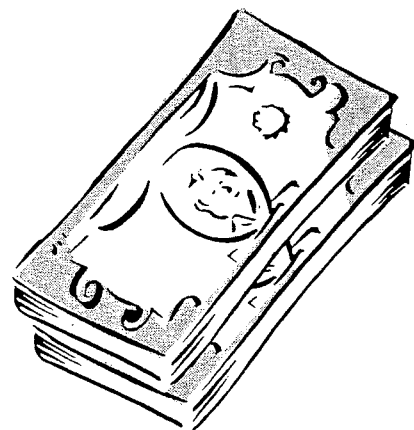


PALM BEACH COUNTY

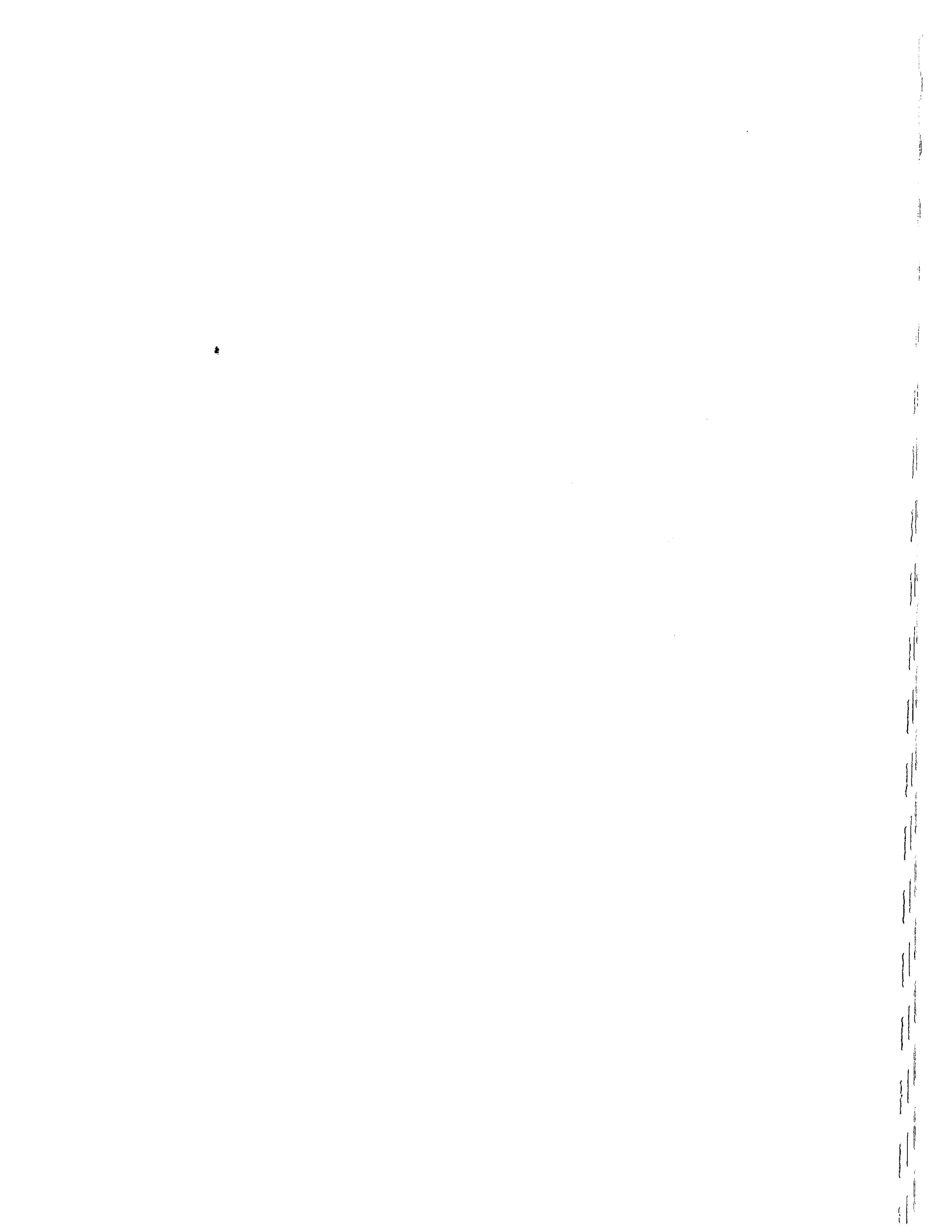


**“SPEAK OUT -
BE HEARD”**

**“SPEAK OUT -
GET PAID”**



**GUIDE FOR
DATA COLLECTORS**



CARE Council - Community Planning Partnership Special Populations Study Project

1) Introductions:

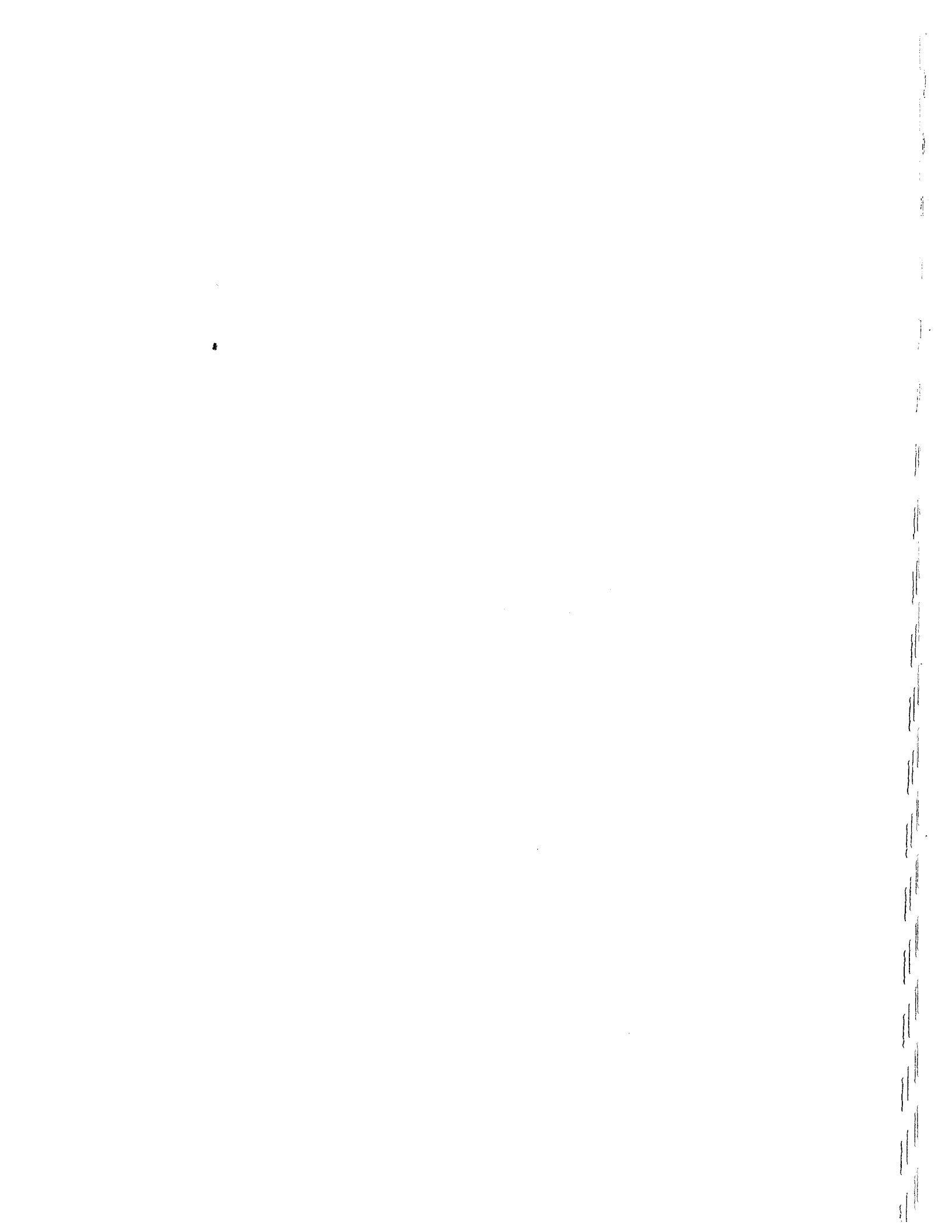
- Remind respondents to help themselves to food/beverages.
- This training session will take about 3 hours
- Lunch will be provided around noon
- Reimbursement for transportation, if needed, is available

2) Project overview:

- Special Populations Study Projects are mandated by HRSA and the CDC to ensure that Ryan White CARE Act funds and CDC Prevention funds are used to meet the needs of infected and affected PLWH/A through the provision of appropriate services.
- The CARE Council and the Community Planning Partnership will continue to work closely with the community to plan and conduct this Project.
- It will probably take approximately one hour to administer each survey.
- The survey will ask questions about HIV prevention and care in Palm Beach County.
- Respondents who complete the entire survey will receive a \$20.00 gift certificate.
- Please remind respondents that they should not complete more than one survey.

3) How data will be used:

- To prioritize services and identify service gaps.
- To develop, plan, and implement more effective prevention and treatment services.
- To assess, from the perspective of Blacks in Palm Beach County, the overall effectiveness of the HIV/AIDS prevention and care system.



Data Collection Procedures

Introduction:

There are a number of advantages in having a questionnaire administered by an interviewer rather than the respondent. Most importantly, interview surveys give higher response rates than mail or phone surveys. Second, respondents seem more reluctant to turn down interviewers. Third, data collectors can answer questions for respondents, probe for answers and clarify confusing matters, thereby obtaining relevant responses. Finally, data collectors can observe behavior as well as ask or guide questioning.

General Rules for Interviewing:

1. Try to have fun.

Relax and enjoy yourself. Get to know someone else. This is an opportunity to forget about your worries for an hour and concentrate on someone else. Take a couple of deep breaths and “meet the respondents where they are”.

2. Have a pleasant and appropriate appearance and demeanor.

Dress in a fashion similar to those you're interviewing. If unsure how you should dress, dress modestly. Your demeanor should be pleasant and communicate a genuine interest in getting to know the respondent. Relax and be friendly.

3. Read the statement of Anonymity and Informed Consent

All survey material is strictly anonymous. No names will be used in gathering or reporting the information.

The statement of informed consent at the beginning of the survey packet must be read aloud to the study participants. The completed survey document is verification that informed consent has been obtained.

4. Become thoroughly familiar with the Survey

Study the survey carefully - maybe five or six times. Practice by reading aloud. The goal is to be able to read the survey without error and without stumbling over words. Think of yourself as an actor studying lines for a play. Also, be prepared to give guidance when a respondent doesn't understand a particular question. **If a respondent is unable to answer a particular question, you should write “unanswered” by the question.**

5. Read the wording of each question exactly

Be careful with your wording even when clarifying questions or probing for answers so that your wording doesn't distort the answer. In other words, try not to “lead the witness”.

6. Record each response exactly

This is especially important for open-ended questions. Record answers as they are stated by the respondent. Please do not summarize, paraphrase or correct bad grammar.

7. Probe for responses when necessary

Sometimes respondents will respond to a question with an obviously inappropriate answer. This might simply indicate they misunderstood the question. When necessary, interviewers can explain the question in their own way. Remember to record the respondent's answer verbatim, even if it seems odd to you. Probes are more frequently required with open-ended questions. Closed-ended questions are usually self-explanatory.

8. Coordinate efforts to make sure the situation is well controlled

Whenever more than one interviewer is involved in a survey, it is essential that efforts be carefully coordinated and controlled to ensure that everyone is working from the same page.

Glossary

Open-ended questions

Questions in which the respondent is asked to provide his/her own answer. Example:
How do you feel about the delivery of services in Palm Beach County?

Closed-ended questions

Questions in which the respondent is asked to select an answer from among a list of answers provided on the survey questionnaire. Example: Pick your favorite HIV service from the following three services: massage therapy; acupuncture; food pantry.

Questionnaire

Another word for the survey instrument.

Respondent or Participant

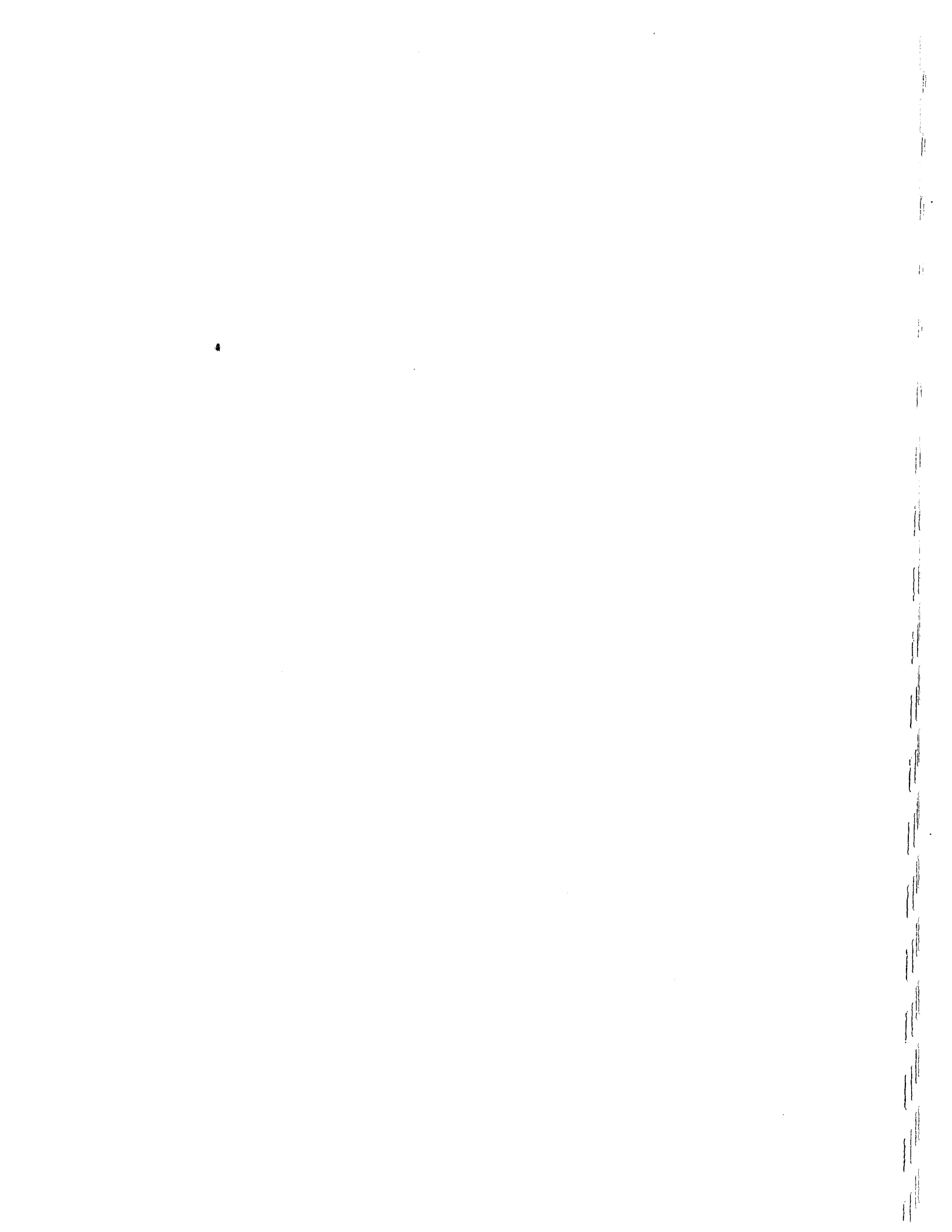
A person who answers surveys and who provides data by responding to the questionnaire.

Data collector or Interviewer

This is you - the person conducting the survey by reading questions and writing responses.

Probe

A method of interviewing to elicit responses appropriate to the question.

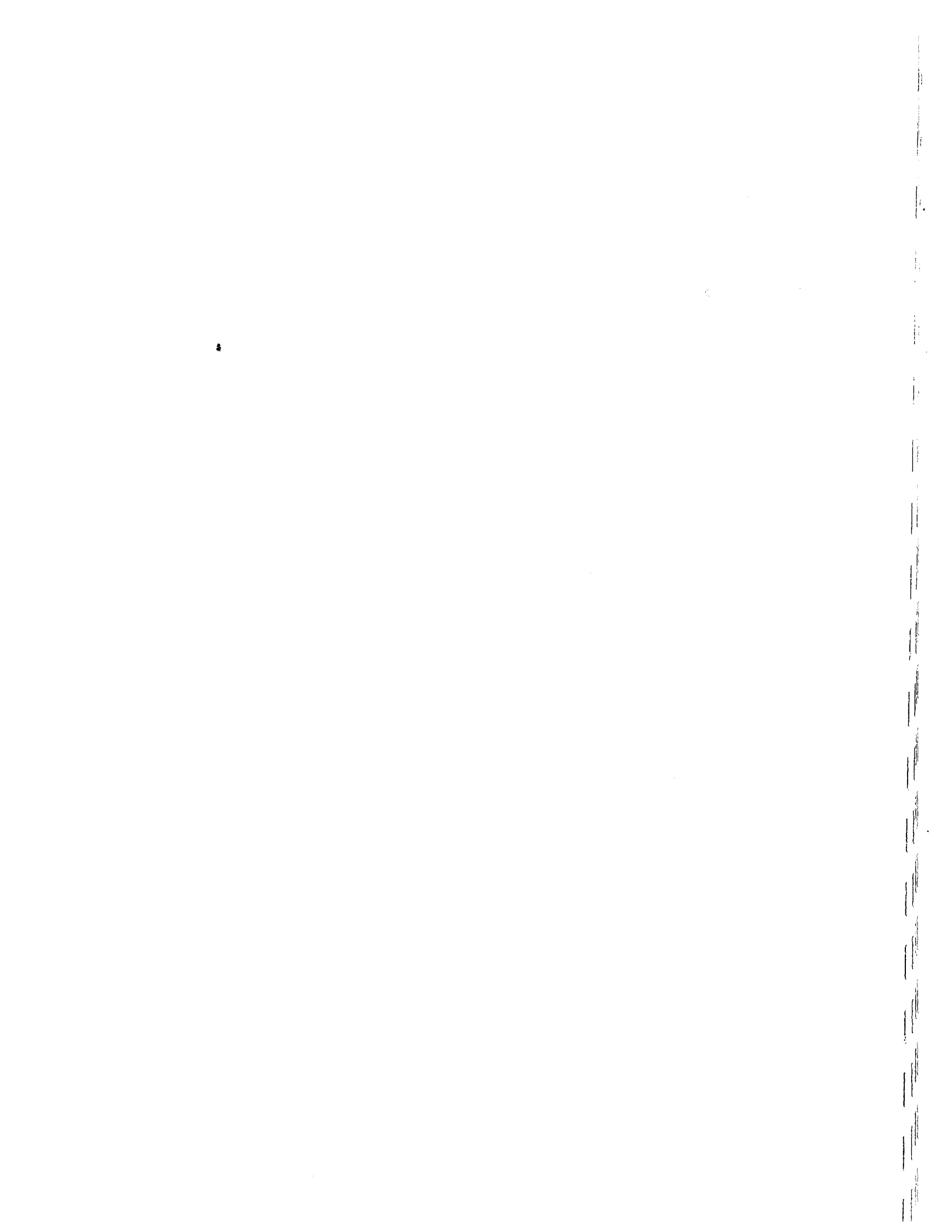


Ground Rules

How to Make Sure You Get Paid

In order to be paid, you must follow these rules for each survey.

- **Before the respondent leaves, you must validate each survey** by reviewing the entire survey for unanswered questions or inappropriate responses. If you find any, attempt to re-ask the question or probe for clarification in order to complete that item.
- You must **print your name and sign your initials** at the top of each completed survey.
- You must **print the site name** at the top of each completed survey. "Site name" means, the name of the place where you collected the data.
- After completing all the above steps, **write the number that is written on the incentive envelope at the top of the survey.**
- Then, give the envelope containing the **incentive to the respondent.**
- Present each completed survey, with all the required information described above, to the survey coordinator.



DATA COLLECTOR'S NAME _____ INITIALS _____
(PLEASE PRINT CLEARLY)

DATE: _____
NUMBER ON GIFT CERTIFICATE ENVELOPE: _____



PALM BEACH COUNTY ***SPEAK OUT – BE HEARD***

- "I understand that my completion of this survey is strictly voluntary. If I choose not to complete the survey, it will not affect the services that I receive."
- All information collected through this survey is completely **confidential** and **anonymous**. **Do not put your name on this survey.**
- The survey asks for some personal background information (to help in planning services that respond to your needs). **This personal information will never be used to identify you as an individual.**
- For each question, check or write in an answer. There are no right or wrong answers. Please take as much time as you need to answer the question based on your experiences.
- Completing this survey will take about 45 minutes of your time. When you have completed the survey, you will receive a \$20.00 gift certificate.

RB WPB BB DB P
M F T
I A GP

Please answer each of the following questions by putting a check on the line or writing the information asked for. You may need to check more than one box to answer a question.

| | Yes | No | I don't know |
|--|-------|-------|--------------|
| 1. Are you currently | | | |
| HIV negative | _____ | _____ | _____ |
| HIV positive with no symptoms | _____ | _____ | _____ |
| HIV positive with symptoms | _____ | _____ | _____ |
| Living with AIDS | _____ | _____ | _____ |
| 2. Are you currently | | | |
| HIV positive and receiving services | _____ | _____ | _____ |
| HIV positive and not receiving services | _____ | _____ | _____ |
| A caregiver of a person living with HIV/AIDS | _____ | _____ | _____ |
| 3. Are you | | | |
| _____ Male | | | |
| _____ Female | | | |
| _____ Transgender | | | |
| _____ Other: _____ | | | |
| Please Specify | | | |
| 3a. If you are transgender, are you | | | |
| _____ Male to female | | | |
| _____ Female to male | | | |
| 3b. Do you consider yourself | | | |
| _____ Heterosexual/straight | | | |
| _____ Gay man | | | |
| _____ Lesbian | | | |
| _____ Bisexual | | | |
| _____ Other: _____ | | | |
| Please Specify | | | |

If you are female, please answer questions 4 and 5. If not, please go on to question 6.

4. Are you **currently** pregnant/have you been pregnant within the past 12 months?
 Yes _____ No _____ I don't know _____

5. If you answered yes to question 4, are you currently receiving or did you receive AZT treatment during your pregnancy?
 Yes _____ No _____ I don't know _____

6. What is your date of birth? _____
Month Year

Please answer both questions 7 AND 8 no matter what your racial/ethnic background.

7. What do you consider your ethnic background?
_____ Hispanic or Latino
_____ Not Hispanic nor Latino

8. What do you consider your racial background?
_____ American Indian or Alaska Native
_____ Asian
_____ Black
_____ African-American
_____ Haitian
_____ Jamaican
_____ Caribbean Islander
_____ African
_____ Native Hawaiian or other Pacific Islander
_____ White
_____ Other: _____
Please Specify

9. Which language do you prefer to speak?
_____ English
_____ Spanish
_____ Creole
_____ Other: _____
Please Specify

10. What is the highest level of education you completed?
_____ Grade school or less
_____ Some high school
_____ High school graduate/GED
_____ Technical or Trade School
_____ Some college
_____ Completed college
_____ Graduate level
_____ Other: _____
Please Specify

11. What is the name of the city/town in which you live?
- Riviera Beach
 - West Palm Beach
 - Boynton Beach
 - Delray Beach
 - Pahokee
12. What is the zip code where you live?
- 33401 (West Palm Beach)
 - 33407 (West Palm Beach)
 - 33404 (Riviera Beach)
 - 33435 (Boynton Beach)
 - 33444 (Delray Beach)
 - (Pahokee)
 - Other: _____
Please Specify
13. What best describes your current relationship status? (Please check only one.)
- Single (Never Married)
 - Legally Married
 - Common Law
 - Partnered
 - Separated
 - Divorced
 - Widowed or partner died
 - Other: _____
Please Specify
14. Where do you currently live?
- In my own apartment/house
 - At my parent's/relative's apartment/house
 - Someone else's apartment/house
 - In a rooming or boarding house
 - In a "supportive living" facility (Assisted Living Facility)
 - In a group home or residence
 - In a half-way house, transitional housing or treatment facility (drug or psychiatric)
 - Skilled Nursing Home
 - Homeless (on the street/in car)
 - Homeless shelter
 - Living in battered women's shelter
 - Living in battered men's shelter
 - Jail or correctional facility
 - Other housing provided by the city or state
 - Residential Hospice Facility
 - Other: _____
Please Specify

14a. If you live in your own apartment/house, do you
 Not applicable, I don't live in my own apartment/house
 Own
 Rent/lease
 Other arrangement: _____
Please Specify

15. With whom do you live? **(Please check all that apply.)**
 Partner/wife/husband/lover
 Adult family member or relative
 Adult friend/roommate (non-sexual)
 Children (minor)
 I live alone
 Other: _____
Please Specify

16. Is anyone, other than yourself, currently living with HIV in your household?
 Yes
 No
 I don't know

17. Please indicate the number of children in your household by age.
 Not Applicable

| Total Number Of Children in Your Household | Ages of Children Living in Your Household | | | | |
|--|---|------------------|------------------|--------------------|--------------------|
| | Younger than 1 | 1-4 years old | 5-9 years old | 10-14 years old | 15-19 years old |
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |

18. Please indicate the number of your dependent children in your household by age.

Not Applicable

| Total Number Of Your Dependent Children in Your Household | Ages of Your Dependent Children Living in Your Household | | | | |
|---|--|------------------|------------------|--------------------|--------------------|
| | Younger than 1 | 1-4 years old | 5-9 years old | 10-14 years old | 15-19 years old |
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |

19. Do any of the children have HIV?

Yes

No

I don't know

Please answer the following question by placing a check in each box that describes your situation.

19. During the last two years, how long (total time) have you lived in one of the following places/situations?

| Type of Residence | Never | Less than a month | 1-3 months | 3 months to a year | More than a year |
|---|-------|-------------------|------------|--------------------|------------------|
| In my own apartment/house | | | | | |
| At my parent's/relative's apartment/house | | | | | |
| Someone else's apartment/house | | | | | |
| In a rooming or boarding house | | | | | |
| In a "supportive living" facility (Assisted Living Facility) | | | | | |
| In a group home or residence | | | | | |
| In a half-way house, transitional housing or treatment facility (drug or psychiatric) | | | | | |
| Skilled nursing home | | | | | |
| Homeless (on the street/in car) | | | | | |
| Homeless shelter | | | | | |
| Living in battered women's shelter | | | | | |
| Living in battered men's shelter | | | | | |
| Jail or correctional facility | | | | | |
| Other housing provided by the city or state | | | | | |
| Residential hospice facility | | | | | |
| Other: Please Specify | | | | | |

20a. During the last two years, if you have lived in any of the following places, please indicate how long you had to wait between the time you applied for the housing and the time you actually were able to move in.

| Type of Residence | Not applicable | Less than 3 months | 4-6 months | 7-12 months | 13-18 months | More than 18 months |
|---|----------------|--------------------|------------|-------------|--------------|---------------------|
| In a rooming or boarding house | | | | | | |
| In a "supportive living" facility or Assisted Living Facility | | | | | | |
| In a group home or residence | | | | | | |
| In a half-way house, transitional housing or treatment facility (drug or psychiatric) | | | | | | |
| Skilled nursing home | | | | | | |
| Homeless shelter | | | | | | |
| Battered women's shelter | | | | | | |
| Battered men's shelter | | | | | | |
| Jail or correctional facility (e.g. specialized substance abuse facility) | | | | | | |
| Other housing provided by the city or state | | | | | | |
| Residential hospice facility | | | | | | |
| Other: Please Specify _____ | | | | | | |

20b. Please indicate the total amount of your rent or mortgage payment each month. Only include rent or mortgage payments; do not include utilities or other expenses.

- _____ Less than \$100
- _____ \$101-200
- _____ \$201-300
- _____ \$301-400
- _____ \$401-500
- _____ \$501-600
- _____ More than \$600
- _____ Other: _____

_____ Please Specify

20c. If you share housing costs or get financial assistance, what is the amount that **you** pay out of pocket each month for rent or mortgage payments? Again, please only include rent or mortgage payments and not utilities or expenses.

- Not applicable, I do not share housing costs
- Less than \$100
- \$101-200
- \$201-300
- \$301-400
- \$401-500
- \$501-600
- More than \$600

20d. How often is paying for your housing a problem for you?

- Constantly Why?
- Often Why?
- Sometimes Why?
- Never

20e. Please indicate if you think it's easy to get from your house to each of the following services:

| | Not applicable | Yes | No |
|--|----------------|-----|----|
| Medical services | | | |
| Social services like case managers, etc. | | | |
| Basic services like food pantry, etc. | | | |
| Transportation | | | |
| Child care | | | |

20f. Please indicate the condition of the following parts of your housing:

| | Excellent condition | Good condition | Fair condition | Poor condition | Don't know |
|--------------------|---------------------|----------------|----------------|----------------|------------|
| Air conditioning | | | | | |
| Entry/Access Doors | | | | | |
| Interior Doors | | | | | |
| Electrical system | | | | | |
| Heating system | | | | | |
| Kitchen appliances | | | | | |
| Plumbing | | | | | |
| Safety features | | | | | |
| Windows | | | | | |

20g. If you have a disability, is there anything that should be done to make your apartment or house safer and more accessible to you?

Not applicable, I do not have a disability

No

Yes, I need the following changes:

Ramps

Lower cabinets and counters

Shower/bath handles

Other (specify) _

Wider doorways

Other (specify)

Wider hallways

Other (specify) _____

20h. Please indicate if you think you were ever turned down for a house or apartment because of any of the following reasons. **(Please check all that apply to you.)**

Not applicable, I do not believe that this has happened to me

HIV status

Race/ethnicity

Disability

Income

Your children

Other: _____

Please Specify

20i. If you think you were turned down for housing for any of these reasons, did you try to follow up with a complaint to the Fair Housing Authority or any other agency that helps in these cases?

Not applicable, I was not turned down for housing for any of these reasons

Yes

No, because I did not know where to go to follow up

No, because I did not want to follow up

No, because of some other reason: _____

Please Specify

21. What describes your **current job (work)** situation? **(Check all that apply to you.)**

Full-time job

Part-time job

Working part time on disability

Not working - on full disability

Not working - student

Not working - looking

Not working

Retired

Other: _____

Please Specify

22. Which of the following best describes your current yearly income?

- \$0 - \$9,999 (up to \$192 per week)
- \$10,000 - \$19,999 (\$193-\$385 per week)
- \$20,000 - \$29,999 (\$386-\$576 per week)
- \$30,000 - \$39,999 (\$577-\$769 per week)
- \$40,000 - \$49,999 (\$770-\$961 per week)
- greater than \$50,000 (greater than \$961 per week)

23. What kind of health insurance do you have? (Check all that apply to you.)

- None, I have no health insurance
- Insurance through work
- COBRA (insurance paid through your last employer)
- Private insurance, not through work
- Medicare

Is your Medicare coverage managed as an HMO?

- Yes
- No
- I don't know

Medicaid

Is your Medicaid coverage managed as an HMO?

- Yes
- No
- don't know

Veterans

Health Care District

Other: _____
Please Specify

23a. How satisfied are you with the health insurance program that you have?

- Not applicable, I do not have health insurance
- Very satisfied
- Somewhat satisfied
- Neutral
- Somewhat dissatisfied
- Very dissatisfied

24. If you receive HIV/AIDS drugs, what program pays for your HIV/AIDS drugs?
Please check "Yes", "No", or "I Don't Know" for each choice.

| | Yes | No | I don't know |
|---|-------|-------|--------------|
| Ryan White Medication Program or AIDS Drug Assistance Program (ADAP) | _____ | _____ | _____ |
| Private Insurance or HMO | _____ | _____ | _____ |
| Medicaid | _____ | _____ | _____ |
| Medicaid HMO | _____ | _____ | _____ |
| Other: _____ | _____ | _____ | _____ |
| Please Specify | | | |
| _____ Not Applicable | | | |

24a. Have you ever used the local AIDS drug assistance program?
 _____ Yes
 _____ No
 _____ I Don't know
 _____ Not Applicable

25. Which of the following benefits do you receive? (Please check all that apply to you.)

- _____ Unemployment Compensation
 - _____ Food Stamps
 - _____ Long term disability
 - _____ Rent supplement
 - _____ Short term disability
 - _____ Supplemental Security Income SSI
 - _____ Social Security Disability Income (SSDI)
 - _____ Veterans assistance
 - _____ Worker's compensation
 - _____ Annuity/Life insurance payments
 - _____ Retirement
 - _____ HIV/AIDS drugs
 - _____ WIC
 - _____ TANF (AFDC)
 - _____ Not eligible for benefits
 - _____ Other public assistance _____
- Please Specify
- _____ Not Applicable

26. Where do you receive your medical care? **(Please check all that apply to you.)**
- Hospital Emergency Room
 - Hospital/Hospital Clinic
 - Community Health Clinic/Center (HIV specialty clinic, provides limited focus services)
 - Private Physician's Office/Clinic
 - HMO/Managed Care Clinic
 - Public Health Clinic (provides diverse clinical services)
 - Other: _____
 - Not Applicable
27. Do you have any disabilities, other than HIV/AIDS?
- Yes What types? _____
 - No
28. If YES to any disabilities other than HIV/AIDS, how often do you need assistance related to your disability in obtaining HIV or AIDS related service?
- Never
 - Rarely (no more than once a week)
 - Some of the time (one to four times a week)
 - Often (five or more times a week)
 - Not Applicable
29. Have you been unable to get needed services because of the following circumstances or disabilities? **(Please check all that apply to you.)**
- Wheelchair bound
 - Hard of hearing
 - Legally deaf
 - Visually impaired (not correctable by eyeglasses)
 - Blind
 - Mentally impaired
 - Chemical dependency (alcohol, illicit drugs)
 - Other: _____
Please Specify
 - Not Applicable

30. How many times have you been tested for HIV infection (during the past two years) in each of the sites below? (Write "0" if you were never tested at that site)

Number of Times Tested

- Counseling & testing center
- Clinic in your community/HIV specialty clinic
- Health department
- Health fair, bar, or other place of entertainment
- Home test
- Hospital clinic
- Hospital emergency room
- Military
- Jail or correctional facility
- Private physician's office
- Other: _____

Please Specify

Not Applicable, never been tested

31. How long ago did you first test positive for HIV?

- 0-6 months
- 6 months - 1 year
- 1 year - 1 ½ years
- 1 ½ - 2 years
- 2- 2 ½ years
- 2 ½ - 3 years
- 3-4 years
- 4-5 years
- 5-6 years
- 6-7 years
- 7-8 years
- 8-9 years
- 9-10 years
- More than 10 years (Please specify number of years _____)
- Not Applicable, never been tested

32. Please indicate the month and year.

Month _____ Year _____
 Not Applicable

33. How did you find out you were HIV positive? **(Please check all that apply)**

- When you were tested for HIV
- When you donated blood
- When you went to the hospital or emergency room for something else
- As part of a physical examination
- For women - as part of care while pregnant
- From a partner
- In jail or prison
- In a drug treatment program or facility
- Other: _____
Please Specify
- Not Applicable

33a. When you found out you were HIV positive, were you referred for any of the following services? **(Please check all that apply.)**

- Not applicable, I was not referred for services
- Medical care related to being HIV positive
- Medical care for a condition other than HIV
- Substance use counseling/treatment
- Mental health services (other than substance use)
- Case management services
- Other: _____
Please Specify
- Not Applicable

33b. How soon after finding out you were HIV positive did you get medical care for your HIV?

- Not applicable, I have not gotten medical care for HIV
- Within 3 months
- Within 6 months
- Within 1 year
- Longer than 1 year
- Other: _____
Please Specify
- Not Applicable

33c. If you did not seek medical care within one (1) year of finding out you were HIV positive, please indicate why. **(Please check all that apply.)**

- Not applicable, I got medical care within one year
- No one told me that I needed to get medical care for HIV
- My doctor or nurse told me that I did not need medical care at that time
- I did not think that I needed medical care then because I wasn't sick
- I did not think that medical care would do me any good
- I did not find a doctor or nurse who I wanted to treat me
- I did not know where to go for medical care
- I did not want to receive medical care
- I used alternative treatments
- I couldn't afford medical care at that time
- I was out doing drugs
- I was in jail or prison and did not receive care
- Other: Please Specify _____
- Not Applicable

33d. How recently have you received medical care related to your HIV?

- I have never had medical care related to HIV
- Within the last 3 months
- 4-6 months ago
- 7-12 months ago
- More than 1 year ago
- Other: _____
Please Specify
- Not Applicable

33e. If it has been more than 6 months since you received medical care related to HIV from a doctor or nurse, please indicate why. **(Please check all that apply.)**

- Not applicable, I got medical care within the past 6 months
- My doctor or nurse told me that I do not need medical care right now
- I do not think that I need medical care now because I am not sick
- I do not think that medical care would do me any good
- I have not found a doctor or nurse who I want to treat me
- I do not know where to go for medical care
- I do not want to receive medical care
- I use alternative treatments
- I can't afford medical care now
- Other: _____
Please Specify
- Not Applicable

34. Have you been told by the doctor, nurse, or other health care team member that you have AIDS?

- Yes
- No
- Prefer not to answer
- Not Applicable

35. If yes, when were you told that you had AIDS?

- Year
- Don't Remember
- Prefer not to answer
- Not Applicable

You're more than half way through!



36. Please indicate your lowest, highest and current viral load?
Place a check in the box for your lowest, a check for your highest, and also a check for your current.

| Viral Count | Lowest | Highest | Current |
|--------------------------------|--------|---------|---------|
| Undetectable | | | |
| Detectable but less than 1,000 | | | |
| 1,001 - 5,000 | | | |
| 5,001 - 10,000 | | | |
| 10,001 - 50,000 | | | |
| 50,001 - 100,000 | | | |
| 100,001 - 500,000 | | | |
| 500,001 - 1 million | | | |
| > 1 million | | | |
| Don't Know | | | |
| Not Applicable | | | |

37. In the past year, how have you gotten to most of your medical or other service appointments? **(Please check all that apply)**

- My own car (or motorcycle or truck)
- Rode with a friend or family member or borrowed their car (or motorcycle or truck)
- Palm Tran
- Palm Tran Connection
- Taxi
- *Transportation service
- Walked or rode a bike
- Other: _____

_____ Please Specify

Not Applicable

37a. In the past year, how many medical appointments have you missed because of transportation problems?

- None
- 1 - 5
- More than 5
- Not Applicable

37b. In the past year, how many other service appointments have you missed because of transportation problems?

- None
- 1 - 5
- More than 5
- Not Applicable

37c. In the past year, if you have used a transportation service, how much ahead of time did the service require you to make a reservation?

- Not applicable, I did not use a transportation service
- Less than 1 week
- 2 weeks
- 3 weeks
- 4 weeks
- More than 4 weeks

37d. In the past year, if you have used a transportation service to get to medical or other service appointments, please indicate your reasons. **(Please check all that apply.)**

- Not applicable, I did not use a transportation service
- I do not own a car (or other vehicle) or I do not know how to drive
- I share a car, but cannot use it for going to appointments
- I cannot afford to have my car fixed
- I cannot afford to drive to my appointments
- I am too sick to drive
- I do not know anyone who could give me a ride to the appointments
- I do not know how to get around in the area where my providers are located
- I have a disability
- Other: _____

Please Specify

37e. In the past year, if you have used a transportation service to get to HIV-related medical or other HIV service appointments, please rate the service on each of the following:

Not applicable

| Type of Transportation Service (Please Specify) | Always | Often | Sometimes | Rarely | Never |
|---|--------|-------|-----------|--------|-------|
| Easy to reserve a ride | | | | | |
| Arrives on time | | | | | |
| Have to wait a long time for a ride back home from my appointment | | | | | |
| Easy to get in and out of vehicles | | | | | |
| Vehicles have seatbelts | | | | | |
| Drivers are polite | | | | | |
| Drivers know where to go | | | | | |
| Drivers drive safely | | | | | |
| I am satisfied with the transportation service that I use | | | | | |

38. How do you think you were infected by HIV? (Check all that you think may apply.)

- Having sex with a man
- Having sex with a woman
- Sharing needles
- Trading sex for drugs/money
- Blood products/Transfusion
- Other: _____
- Don't know
- I prefer not to answer
- Not Applicable

39. Since you were infected with HIV, have you been treated/are you receiving mental health counseling (including psychiatric or emotional) for a psychiatric or emotional problem?

- Yes
- No
- Not Applicable

39a. Since you were infected with HIV, have you received any of the following:

| | Yes | No | I don't know |
|--|-------|-------|--------------|
| ◆ Individual therapy with a psychiatrist? | _____ | _____ | _____ |
| ◆ Medication prescribed by a psychiatrist? | _____ | _____ | _____ |
| ◆ <i>Individual</i> therapy with a psychologist, social worker, licensed professional counselor, nurse clinician, or licensed chemical dependency counselor? | _____ | _____ | _____ |
| ◆ <i>Group</i> therapy with a psychologist, social worker, licensed professional counselor, nurse clinician, or licensed chemical dependency counselor? | _____ | _____ | _____ |
| <input type="checkbox"/> Not Applicable | | | |

39b. If you received treatment, was it

- Outpatient (by a doctor or counselor)
- Inpatient (in a hospital at least overnight)
- Not Applicable

39c. Do you use alcohol or other drugs (other than drugs [as] prescribed by a physician)?

- Yes
- No

39d. Since you were infected with HIV, have you received any treatment for alcohol or drug use?

- Yes
- No
- Not Applicable

40. Have you ever been diagnosed with any of the diseases listed below?

| | Yes | No | I don't know | I prefer not to answer |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Syphilis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes (genital) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gonorrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chlamydia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital warts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis (A, B, or C) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Yeast infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

41. Have you ever been diagnosed with Tuberculosis (TB)?

- No
- Never been tested
- Had positive skin test, but never got active TB
- Yes, have inactive TB
- Have Active TB, in treatment
- Have Active TB, not in treatment
- Don't know
- Prefer not to answer

42. Are you currently taking any medicines for your HIV infection?

- Yes
- No
- Not Applicable

42a. If you are NOT currently taking any medicines for your HIV infection, why not?

- Not applicable, I take HIV medications
- They have never been prescribed for me
- My health care provider told me to stop taking them
- I decided to stop taking them
- Due to problems with health insurance coverage
- I decided to stop taking them
- Other (Please specify) _____
- Not applicable, I have never been diagnosed with HIV.

42b. Are you currently having side effects related to your HIV medicines?

- Yes
- No
- Don't Know
- Not Applicable

43. If you are taking prescribed medication for HIV, are you taking any of the following?
Place a check in **Yes**, **No**, or **I don't know** for each of the following medications.

| | Yes | No | I don't know |
|--|--------------------------|--------------------------|--------------------------|
| Antiretrovirals and/or protease inhibitors that work against the virus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antibiotics (such as Bactrim) that fight off infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antifungal (such as Diflucan) that are for body rashes or thrush | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Steroids which help you with your appetite or build weight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Antidepressants for depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (Prescription, Non-Prescription, Herbal, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Not Applicable | | | |

44. If you are taking prescribed medication for HIV, do you take three or more medications to fight HIV? (i.e., are you on a three or more drug cocktail?)

- Yes
- No
- Don't know
- Prefer not to answer
- Not Applicable

45. How often do you skip a dose of your medication?
- Never
 - Rarely (no more than once a week)
 - Some of the time (one to four times a week)
 - Often (five or more times a week)
 - Not Applicable

46. If you do not take your HIV medication as directed, which of the following are the reasons for not taking your medication? (Check all that may apply.)
- Side effects
 - Difficult schedule
 - Medication didn't work
 - Could not afford it
 - Just did not want to take them
 - Forgot to take them
 - Other: _____
Please Specify
 - Not Applicable

- 47a. Have your doctors, nurses, or other health care providers talked to you about participating in clinical trials for HIV/AIDS medicines?
- Yes
 - No
 - Don't know
 - Not Applicable

48. During the past six months, how often have you used any of the following substances?

| Substances | How Often Used? | | | | |
|-------------------------------------|-----------------|-------|--------|---------|------------------------|
| | Not at all | Daily | Weekly | Monthly | I Prefer Not to Answer |
| Alcohol | | | | | |
| Marijuana or hash | | | | | |
| Crack | | | | | |
| Cocaine | | | | | |
| Heroin | | | | | |
| Crystal Meth or Methamphetamines | | | | | |
| Speedball | | | | | |
| Tobacco | | | | | |
| Other drug: _____ Please Specify | | | | | |
| Other drug: _____ Please Specify | | | | | |

49. Have you ever injected any of the above substances?
 Yes
 No
 I prefer not to answer
- 49a. Do you CURRENTLY inject substances that are not prescribed to you by a health care provider?
 Yes
 No
 I prefer not to answer
- 49b. If you are currently injecting substances, how often do you share needles or works?
 Not applicable, I am not currently injecting
 All the time
 Usually, but not always
 Sometimes
 Never
 Not Applicable
- 49c. If you share needles or works, how often do you clean the needles or works with bleach?
 Not applicable, I do not share needles or works
 All the time
 Usually, but not always
 Sometimes
 Never
 Not Applicable
- 49d. If you share needles or works, would you be willing to use bleach if it were available?
 Yes
 No
 Not Applicable

49e. Please indicate how often in the past six months years you have had oral, vaginal, or anal sex with the following people. (Please check all that apply.)

| Partners | Frequently (once a month or more) | Infrequently (less than once a month) | Almost never (a few times a year or less) | Never |
|--------------------------------------|--------------------------------------|--|--|-------|
| A man who is a regular partner | | | | |
| A man who is not a regular partner | | | | |
| A woman who is a regular partner | | | | |
| A woman who is not a regular partner | | | | |

49f. If you have had sex with a **regular partner**, how often do you and your partner use a condom or other HIV protection when having sex?

- Not applicable, I have not had sex with a regular partner in the last 2 years
- All the time or almost every time
- Frequently-more than half the time
- Sometimes-about half the time
- Rarely-less than half the time
- Never
- Not Applicable

49g. If you have had sex with **someone other than a regular partner**, how often do you and your partner use a condom or other HIV protection when having sex?

- Not applicable, I have not had sex with a casual partner in the last 2 years
- All the time or almost every time
- Frequently-more than half the time
- Sometimes-about half the time
- Rarely-less than half the time
- Never
- Not Applicable

51. Where do you get information about HIV? **(Please check all that apply.)**

- Don't know
- My doctor or other health care provider
- Friends or family
- Support group
- Community outreach
- Books, magazines, newspapers or other reading materials
- TV or radio
- Internet
- HIV service providers: _____
Please Specify

Other: _____
Please Specify

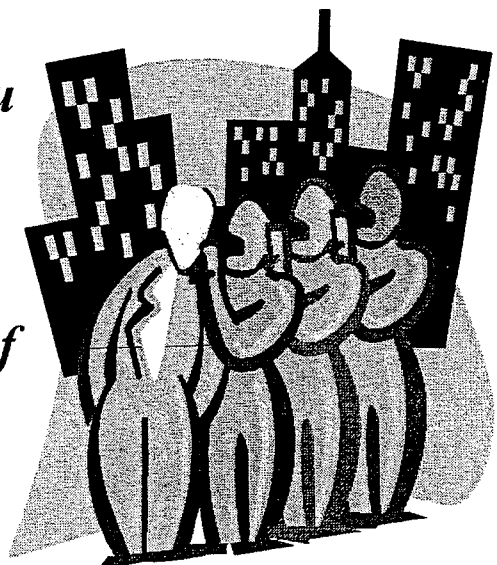
I've never received information about HIV

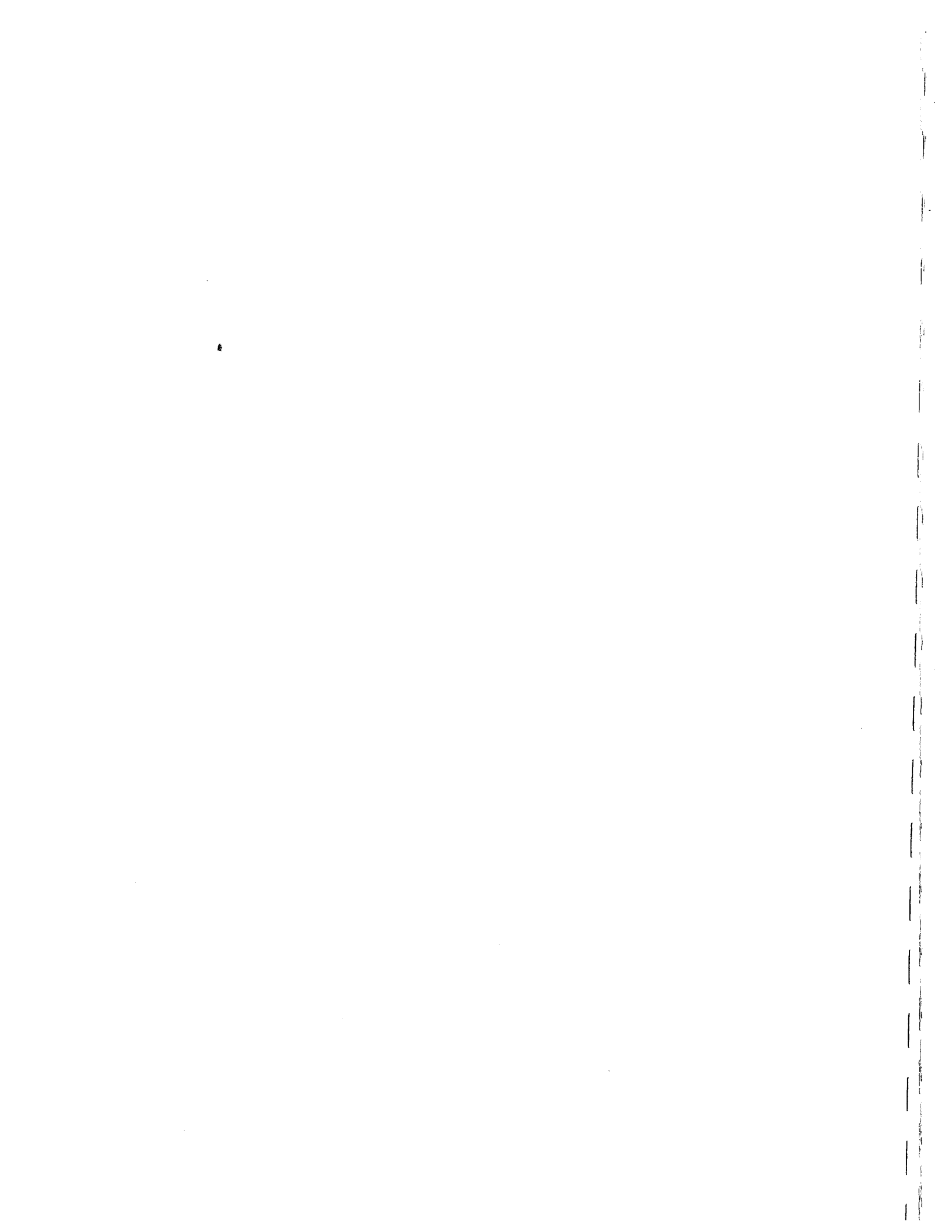
51a. Where do you get information about **services for people with HIV?** **(Please check all that apply.)**

- Don't know
- My doctor or other health care provider
- Friends or family
- Support group
- Community outreach
- Books, magazines, newspapers or other reading materials
- TV or radio
- Internet
- HIV service providers: _____
Please Specify

I've never received information about **services for people with HIV.**

Thank you for the time that you have taken to complete this survey. Your answers will provide valuable information for the planning and delivery of services to our community.





**TABLE 1: AIDS INCIDENCE, AIDS PREVALENCE AND HIV PREVALENCE
BY DEMOGRAPHIC GROUP AND EXPOSURE CATEGORY
STATE/ELIGIBLE METROPOLITAN AREA (EMA) WEST PALM BEACH, FL**

| IDA DEPARTMENT OF HEALTH, Demographic Group/ Exposure Category | AIDS INCIDENCE: 07/01/98 TO 6/30/00 | | | AIDS PREVALENCE AS OF 6/30/00 | | | HIV PREVALENCE AS OF 06/30/00 | | |
|--|--|------------|---|----------------------------------|------------|--|----------------------------------|------------|--|
| | # | % of Total | AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified*. | # | % of Total | AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.* | # | % of Total | HIV Prevalence is defined as the estimated number of people living with HIV, (non-AIDS), as of the date specified.* (Reported by live HIV cases) |
| | | | | | | | | | |
| Ethnicity | | | | | | | | | |
| White, not Hispanic | 195 | 20 | | 858 | 27 | | 273 | 22 | |
| Black, not Hispanic | 720 | 73 | | 2104 | 65 | | 863 | 70 | |
| Hispanic | 75 | 8 | | 258 | 8 | | 86 | 7 | |
| Native American/Pacific Islander | 1 | 0 | | 4 | 0 | | 4 | 0 | |
| Alaska Native | 0 | 0 | | 2 | 0 | | 0 | 0 | |
| Other | 0 | 0 | | 0 | 0 | | 351 | 29 | |
| Specified | 991 | 100 | | 3226 | 100 | | 1226 | 100 | |
| Gender | | | | | | | | | |
| Male | 649 | 66 | | 2097 | 67 | | 644 | 53 | |
| Female | 328 | 34 | | 1046 | 33 | | 574 | 47 | |
| Total | 977 | 100 | | 3143 | 100 | | 1218 | 100 | |
| Age at Diagnosis (Years) | | | | | | | | | |
| 0-14 years | 14 | 0 | | 83 | 3 | | 8 | 0 | |
| 15-24 years | 15 | 2 | | 44 | 1 | | 67 | 5 | |
| 25-34 years | 642 | 65 | | 2250 | 69.5 | | 867 | 70 | |
| 35-44 years | 320 | 33.5 | | 850 | 26.5 | | 284 | 25 | |
| 45-64 years | 991 | 100 | | 3226 | 100 | | 1226 | 100 | |
| Exposure Category | | | | | | | | | |
| Men who have sex with men | 177 | 18 | | 808 | 26 | | 169 | 14 | |
| Injection drug users | 81 | 8 | | 358 | 11 | | 72 | 6 | |
| Men who have sex with men and inject | 8 | 1 | | 68 | 2 | | 19 | 2 | |
| Other | 0 | 0 | | 4 | 0 | | 5 | 0 | |
| Hemophilia/coagulation disorder | 471 | 48 | | 1312 | 42 | | 600 | 49 | |
| Other | 1 | 0 | | 10 | 0 | | 2 | 0 | |

| AIDS INCIDENCE: 07/01/98 TO 6/30/00 | AIDS PREVALENCE AS OF 6/30/00 | | HIV PREVALENCE AS OF 06/30/00 | |
|---|----------------------------------|-----|----------------------------------|-----|
| | | | | |
| blood components, or tissue ask not reported or identified | 239 | 24 | 583 | 19 |
| total | 977 | 100 | 3143 | 100 |
| Mediatric AIDS Exposure Categories | | | | |
| thrombophilia/coagulation disorder | 0 | 0 | 0 | 0 |
| other with/at risk for HIV infection | 14 | 100 | 80 | 96 |
| receipt of blood transfusion, blood components or tissue | 0 | 0 | 0 | 0 |
| ask not reported or identified | 0 | 0 | 3 | 4 |
| total | 14 | 100 | 83 | 100 |
| | | | | 7 |
| | | | | 8 |
| | | | | 13 |
| | | | | 100 |

Complete: Does your State have HIV reporting? (Check one.)
 Yes No

Cumulative HIV cases for Palm Beach County by mode, race and sex
Through March 2002

By-> Sex of patient=(1)Male

Mode of exposure (row) vs. Patient Race/Ethnicity (column)
frequency

| | (1)White | (2)Black | (3)Hispani c | (4)Asian | (9)Unknown | total |
|----------------------|----------|----------|-----------------|----------|------------|-------|
| (01)Homo-Bi Male | 172 | 93 | 30 | 3 | 3 | 301 |
| (02)IV drug user | 17 | 25 | 7 | 0 | 0 | 49 |
| (03)Homo & IDU | 12 | 11 | 10 | 0 | 0 | 33 |
| (04)Adult Hemophl | 1 | 0 | 0 | 0 | 0 | 1 |
| (05)Hetsx Contact | 23 | 309 | 22 | 2 | 0 | 356 |
| (06)Transfus,Trpl | 2 | 0 | 0 | 0 | 0 | 2 |
| (09)Risk not specifi | 82 | 195 | 32 | 0 | 1 | 310 |
| (12)M w HIV HIV-Risk | 0 | 2 | 0 | 0 | 0 | 2 |
| total | 309 | 635 | 101 | 5 | 4 | 1054 |

By-> Sex of patient=(2)Female

Mode of exposure (row) vs. Patient Race/Ethnicity (column)
frequency

| | (1)White | (2)Black | (3)Hispani c | (4)Asian | (9)Unknown | total |
|----------------------|----------|----------|-----------------|----------|------------|-------|
| (02)IV drug user | 29 | 32 | 3 | 0 | 0 | 64 |
| (04)Adult Hemophl | 1 | 5 | 0 | 0 | 0 | 6 |
| (05)Hetsx Contact | 68 | 454 | 26 | 0 | 1 | 549 |
| (06)Transfus,Trpl | 0 | 1 | 0 | 0 | 0 | 1 |
| (09)Risk not specifi | 44 | 199 | 15 | 1 | 2 | 261 |
| (12)M w HIV HIV-Risk | 0 | 7 | 0 | 0 | 0 | 7 |
| (18)Confirmed Oth | 0 | 1 | 0 | 0 | 0 | 1 |
| (19)Ped Oth/Und | 0 | 1 | 0 | 0 | 0 | 1 |
| total | 142 | 700 | 44 | 1 | 3 | 890 |

Cumulative AIDS cases for Palm Beach County by mode, race and sex
Through March 2002

By-> Sex of patient=(1)Male

Mode of exposure (row) vs. Patient Race/Ethnicity (column)
frequency

| | (1)White | (2)Black | (3)Hispani c | (4)Asian | (5)Indian | total |
|----------------------|----------|----------|-----------------|----------|-----------|-------|
| (01)Homo-Bi Male | 1564 | 635 | 196 | 3 | 3 | 2401 |
| (02)IV drug user | 171 | 487 | 69 | 0 | 0 | 727 |
| (03)Homo & IDU | 126 | 108 | 17 | 0 | 0 | 251 |
| (04)Adult Hemophl | 13 | 3 | 2 | 0 | 0 | 18 |
| (05)Hetsx Contact | 76 | 1235 | 87 | 1 | 1 | 1400 |
| (06)Transfus,Trpl | 25 | 13 | 2 | 0 | 0 | 40 |
| (08)Confirmed Oth | 1 | 0 | 0 | 0 | 0 | 1 |
| (09)Risk not specifi | 146 | 682 | 56 | 0 | 0 | 884 |
| (12)M w HIV HIV-Risk | 4 | 109 | 8 | 0 | 0 | 121 |
| (18)Confirmed Oth | 1 | 1 | 0 | 0 | 0 | 2 |
| (19)Ped Oth/Und | 0 | 2 | 0 | 0 | 0 | 2 |
| total | 2127 | 3275 | 437 | 4 | 4 | 5847 |

By-> Sex of patient=(2)Female

Mode of exposure (row) vs. Patient Race/Ethnicity (column)
frequency

| | (1)White | (2)Black | (3)Hispani c | (4)Asian | total |
|----------------------|----------|----------|-----------------|----------|-------|
| (02)IV drug user | 138 | 351 | 27 | 0 | 516 |
| (04)Adult Hemophl | 2 | 2 | 0 | 0 | 4 |
| (05)Hetsx Contact | 138 | 1201 | 67 | 2 | 1408 |
| (06)Transfus,Trpl | 17 | 16 | 3 | 0 | 36 |
| (08)Confirmed Oth | 0 | 2 | 0 | 0 | 2 |
| (09)Risk not specifi | 52 | 365 | 14 | 0 | 431 |
| (12)M w HIV HIV-Risk | 4 | 96 | 7 | 0 | 107 |
| (13)P Trnsfus,Trpl | 0 | 1 | 0 | 0 | 1 |
| (19)Ped Oth/Und | 0 | 1 | 1 | 0 | 2 |
| total | 351 | 2035 | 119 | 2 | 2507 |

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Acquired Immunodeficiency Syndrome (AIDS)
 AIDS CASES FOR TOTAL PALM BEACH COUNTY
 Surveillance Report - 04/08/2002

| Disease Category | Adult/Adolescent * | | Pediatric * | | Total | |
|-----------------------|--------------------|--------------|-------------|--------------|-------------|--------------|
| | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) |
| PCP | 1903 (23) | 1434 (75) | 89 (38) | 48 (54) | 1992 (24) | 1482 (74) |
| Other Disease w/o PCP | 3825 (47) | 2221 (58) | 146 (62) | 73 (50) | 3971 (47) | 2294 (58) |
| KS Alone | 93 (1) | 66 (71) | 0 (0) | 0 (.) | 93 (1) | 66 (71) |
| No Diseases Listed | 2335 (29) | 521 (22) | 0 (0) | 0 (.) | 2335 (28) | 521 (22) |
| Total | 8156 (100) | 4242 (52) | 235 (100) | 121 (51) | 8391 (100) | 4363 (52) |

| Age * | Cases (%) | 3. Race/Ethnicity | Adult/Adolescent * | | Pediatric * | | Total | |
|---------|-------------|--------------------------|--------------------|--------------|-------------|--------------|-------------|--------------|
| | | | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) |
| Under 5 | 197 (2) | White, Not Hispanic | 2472 (30) | | 9 (4) | | 2481 (30) | |
| 5-12 | 38 (0) | Black, Not Hispanic | 5132 (63) | | 210 (89) | | 5342 (64) | |
| 13-19 | 81 (1) | Hispanic | 541 (7) | | 16 (7) | | 557 (7) | |
| 20-29 | 1426 (17) | Asian/Pacific Is. | 7 (0) | | 0 (0) | | 7 (0) | |
| 30-39 | 3274 (39) | Am. Indian/Alaska Native | 4 (0) | | 0 (0) | | 4 (0) | |
| 40-49 | 2031 (24) | Unknown | 0 (0) | | 0 (0) | | 0 (0) | |
| Over 49 | 1344 (16) | Total | 8156 (100) | | 235 (100) | | 8391 (100) | |
| Unknown | 0 (0) | | | | | | | |
| Total | 8391 (100) | | | | | | | |

| Exposure Category | Adult/Adolescent Transmission Modes | | Total (%) |
|--|-------------------------------------|---------------|-------------|
| | Males (%) | Females (%) | |
| Men who have sex with men | 2405 (42) | 0 (0) | 2405 (29) |
| Injecting drug use | 727 (13) | 516 (21) | 1243 (15) |
| Men who have sex with men and inject drugs | 251 (4) | 0 (0) | 251 (3) |
| Hemophilia/coagulation disorder | 18 (0) | 3 (0) | 21 (0) |
| Heterosexual contact | 1420 (25) | 1419 (59) | 2839 (35) |
| Receipt of blood, components, or tissue | 40 (1) | 36 (1) | 76 (1) |
| Risk not reported/Other | 889 (15) | 432 (18) | 1321 (16) |
| Total | 5750 (100) | 2406 (100) | 8156 (100) |

| | Pediatric Transmission Modes | | Total (%) |
|---|------------------------------|---------------|-------------|
| | Males (%) | Females (%) | |
| Hemophilia/coagulation disorder | 0 (0) | 0 (0) | 0 (0) |
| Mother with/at risk for HIV infection | 121 (97) | 107 (97) | 228 (97) |
| Receipt of blood, components, or tissue | 0 (0) | 1 (1) | 1 (0) |
| Risk not reported/Other | 4 (3) | 2 (2) | 6 (3) |
| Total | 125 (100) | 110 (100) | 235 (100) |

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

Acquired Immunodeficiency Syndrome (AIDS)
 AIDS CASES FOR COASTAL PALM BEACH COUNTY
 Surveillance Report - 04/08/2002

| Disease Category | Adult/Adolescent * | | Pediatric * | | Total | |
|-----------------------|--------------------|--------------|-------------|--------------|-------------|--------------|
| | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) |
| Perinatal | 1576 (24) | 1158 (73) | 71 (38) | 38 (54) | 1647 (24) | 1196 (73) |
| Other Disease w/o PCP | 2941 (44) | 1652 (56) | 114 (62) | 54 (47) | 3055 (45) | 1706 (56) |
| Alone | 87 (1) | 61 (70) | 0 (0) | 0 (.) | 87 (1) | 61 (70) |
| Diseases Listed | 2069 (31) | 445 (22) | 0 (0) | 0 (.) | 2069 (30) | 445 (22) |
| Total | 6673 (100) | 3316 (50) | 185 (100) | 92 (50) | 6858 (100) | 3408 (50) |

| Age * | Cases (%) | 3. Race/Ethnicity | Adult/Adolescent * | Pediatric * | Total |
|---------|-------------|--------------------------|--------------------|-------------|-------------|
| | | | Cases (%) | Cases (%) | Cases (%) |
| Under 5 | 154 (2) | White, Not Hispanic | 2437 (37) | 9 (5) | 2446 (36) |
| 5-12 | 31 (0) | Black, Not Hispanic | 3731 (56) | 160 (86) | 3891 (57) |
| 13-19 | 64 (1) | Hispanic | 494 (7) | 16 (9) | 510 (7) |
| 20-29 | 1118 (16) | Asian/Pacific Is. | 7 (0) | 0 (0) | 7 (0) |
| 30-39 | 2785 (41) | Am. Indian/Alaska Native | 4 (0) | 0 (0) | 4 (0) |
| 40-49 | 1677 (24) | Unknown | 0 (0) | 0 (0) | 0 (0) |
| Over 49 | 1029 (15) | Total | 6673 (100) | 185 (100) | 6858 (100) |
| Unknown | 0 (0) | | | | |
| Total | 6858 (100) | | | | |

| Exposure Category | Adult/Adolescent Transmission Modes | | Total (%) |
|--|-------------------------------------|---------------|-------------|
| | Males (%) | Females (%) | |
| Men who have sex with men | 2253 (47) | 0 (0) | 2253 (34) |
| Injecting drug use | 601 (13) | 413 (22) | 1014 (15) |
| Men who have sex with men and inject drugs | 209 (4) | 0 (0) | 209 (3) |
| Hemophilia/coagulation disorder | 17 (0) | 3 (0) | 20 (0) |
| Heterosexual contact | 940 (20) | 1069 (57) | 2009 (30) |
| Receipt of blood, components, or tissue | 37 (1) | 33 (2) | 70 (1) |
| Risk not reported/Other | 739 (15) | 359 (19) | 1098 (16) |
| Total | 4796 (100) | 1877 (100) | 6673 (100) |

| | Pediatric Transmission Modes | | Total (%) |
|---|------------------------------|---------------|-------------|
| | Males (%) | Females (%) | |
| Hemophilia/coagulation disorder | 0 (0) | 0 (0) | 0 (0) |
| Mother with/at risk for HIV infection | 95 (96) | 83 (97) | 178 (96) |
| Receipt of blood, components, or tissue | 0 (0) | 1 (1) | 1 (1) |
| Risk not reported/Other | 4 (4) | 2 (2) | 6 (3) |
| Total | 99 (100) | 86 (100) | 185 (100) |

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

Acquired Immunodeficiency Syndrome (AIDS)
 AIDS CASES FOR WESTERN PALM BEACH COUNTY
 Surveillance Report - 04/08/2002

| Disease Category | Adult/Adolescent * | | Pediatric * | | Total | |
|-----------------------|--------------------|-------------------|-----------------|------------------|-------------------|-------------------|
| | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) |
| PCP | 327 (22) | 276 (84) | 18 (36) | 10 (56) | 345 (23) | 286 (83) |
| Other Disease w/o PCP | 884 (60) | 569 (64) | 32 (64) | 19 (59) | 916 (60) | 588 (64) |
| KS Alone | 6 (0) | 5 (83) | 0 (0) | 0 (.) | 6 (0) | 5 (83) |
| No Diseases Listed | 266 (18) | 76 (29) | 0 (0) | 0 (.) | 266 (17) | 76 (29) |
| Total | 1483 (100) | 926 (62) | 50 (100) | 29 (58) | 1533 (100) | 955 (62) |

| Age * | Cases (%) | 3. Race/Ethnicity | Adult/Adolescent * | | Pediatric * | | Total | |
|--------------|-------------------|--------------------------|--------------------|-----------------|-----------------|-------------------|-------------------|--------------|
| | | | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) |
| Under 5 | 43 (3) | White, Not Hispanic | 35 (2) | 0 (0) | 0 (0) | 35 (2) | 0 (0) | |
| 5-12 | 7 (0) | Black, Not Hispanic | 1401 (94) | 50 (100) | 50 (100) | 1451 (95) | 47 (3) | |
| 13-19 | 17 (1) | Hispanic | 47 (3) | 0 (0) | 0 (0) | 47 (3) | 0 (0) | |
| 20-29 | 308 (20) | Asian/Pacific Is. | 0 (0) | 0 (0) | 0 (0) | 0 (0) | 0 (0) | |
| 30-39 | 489 (32) | Am. Indian/Alaska Native | 0 (0) | 0 (0) | 0 (0) | 0 (0) | 0 (0) | |
| 40-49 | 354 (23) | Unknown | 0 (0) | 0 (0) | 0 (0) | 0 (0) | 0 (0) | |
| Over 49 | 315 (21) | Total | 1483 (100) | 50 (100) | 50 (100) | 1533 (100) | 955 (62) | |
| Unknown | 0 (0) | | | | | | | |
| Total | 1533 (100) | | | | | | | |

| Exposure Category | Adult/Adolescent Transmission Modes | | Total (%) |
|--|-------------------------------------|------------------|-------------------|
| | Males (%) | Females (%) | |
| Men who have sex with men | 152 (16) | 0 (0) | 152 (10) |
| Injecting drug use | 126 (13) | 103 (19) | 229 (15) |
| Men who have sex with men and inject drugs | 42 (4) | 0 (0) | 42 (3) |
| Hemophilia/coagulation disorder | 1 (0) | 0 (0) | 1 (0) |
| Heterosexual contact | 480 (50) | 350 (66) | 830 (56) |
| Receipt of blood, components, or tissue | 3 (0) | 3 (1) | 6 (0) |
| Risk not reported/Other | 150 (16) | 73 (14) | 223 (15) |
| Total | 954 (100) | 529 (100) | 1483 (100) |

| | Pediatric Transmission Modes | | Total (%) |
|---|------------------------------|-----------------|-----------------|
| | Males (%) | Females (%) | |
| Hemophilia/coagulation disorder | 0 (0) | 0 (0) | 0 (0) |
| Mother with/at risk for HIV infection | 26 (100) | 24 (100) | 50 (100) |
| Receipt of blood, components, or tissue | 0 (0) | 0 (0) | 0 (0) |
| Risk not reported/Other | 0 (0) | 0 (0) | 0 (0) |
| Total | 26 (100) | 24 (100) | 50 (100) |

... at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

Acquired Immunodeficiency Syndrome (AIDS)
 HIV CASES FOR TOTAL PALM BEACH COUNTY
 Surveillance Report - 04/08/2002

| Disease Category | Adult/Adolescent * | | Pediatric * | | Total | |
|-----------------------|--------------------|----------------|-----------------|---------------|-------------------|----------------|
| | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) |
| CP | 0 (0) | 0 (.) | 0 (0) | 0 (.) | 0 (0) | 0 (.) |
| Other Disease w/o PCP | 0 (0) | 0 (.) | 0 (0) | 0 (.) | 0 (0) | 0 (.) |
| S Alone | 0 (0) | 0 (.) | 0 (0) | 0 (.) | 0 (0) | 0 (.) |
| Other Diseases Listed | 1930 (100) | 52 (3) | 11 (100) | 1 (9) | 1941 (100) | 53 (3) |
| Total | 1930 (100) | 52 (3) | 11 (100) | 1 (9) | 1941 (100) | 53 (3) |

| Age * | Cases (%) | 3. Race/Ethnicity | Adult/Adolescent * | Pediatric * | Total |
|--------------|-------------------|--------------------------|--------------------|-----------------|-------------------|
| | | | Cases (%) | Cases (%) | Cases (%) |
| Under 5 | 6 (0) | White, Not Hispanic | 455 (24) | 0 (0) | 455 (23) |
| 5-12 | 5 (0) | Black, Not Hispanic | 1316 (68) | 11 (100) | 1327 (68) |
| 13-19 | 84 (4) | Hispanic | 145 (8) | 0 (0) | 145 (7) |
| 20-29 | 466 (24) | Asian/Pacific Is. | 6 (0) | 0 (0) | 6 (0) |
| 30-39 | 675 (35) | Am. Indian/Alaska Native | 0 (0) | 0 (0) | 0 (0) |
| 40-49 | 435 (22) | Unknown | 8 (0) | 0 (0) | 8 (0) |
| Over 49 | 270 (14) | | | | |
| Unknown | 0 (0) | Total | 1930 (100) | 11 (100) | 1941 (100) |
| Total | 1941 (100) | | | | |

| Exposure Category | Adult/Adolescent Transmission Modes | | Total (%) |
|--|-------------------------------------|------------------|-------------------|
| | Males (%) | Females (%) | |
| Men who have sex with men | 303 (29) | 0 (0) | 303 (16) |
| Injecting drug use | 48 (5) | 64 (7) | 112 (6) |
| Men who have sex with men and inject drugs | 33 (3) | 0 (0) | 33 (2) |
| Hemophilia/coagulation disorder | 1 (0) | 6 (1) | 7 (0) |
| Heterosexual contact | 347 (33) | 546 (62) | 893 (46) |
| Receipt of blood, components, or tissue | 2 (0) | 1 (0) | 3 (0) |
| Risk not reported/Other | 311 (30) | 268 (30) | 579 (30) |
| Total | 1045 (100) | 885 (100) | 1930 (100) |

| | Pediatric Transmission Modes | | Total (%) |
|---|------------------------------|----------------|-----------------|
| | Males (%) | Females (%) | |
| Hemophilia/coagulation disorder | 0 (0) | 0 (0) | 0 (0) |
| Mother with/at risk for HIV infection | 2 (100) | 7 (78) | 9 (82) |
| Receipt of blood, components, or tissue | 0 (0) | 0 (0) | 0 (0) |
| Risk not reported/Other | 0 (0) | 2 (22) | 2 (18) |
| Total | 2 (100) | 9 (100) | 11 (100) |

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

Acquired Immunodeficiency Syndrome (AIDS)
 HIV CASES FOR COASTAL PALM BEACH COUNTY
 Surveillance Report - 04/08/2002

| Disease Category | Adult/Adolescent * | | Pediatric * | | Total | |
|-----------------------|--------------------|-----------------|-----------------|-----------------|-------------------|-----------------|
| | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) |
| PCP | 0 (0) | 0 (.) | 0 (0) | 0 (.) | 0 (0) | 0 (.) |
| Other Disease w/o PCP | 0 (0) | 0 (.) | 0 (0) | 0 (.) | 0 (0) | 0 (.) |
| KS Alone | 0 (0) | 0 (.) | 0 (0) | 0 (.) | 0 (0) | 0 (.) |
| No Diseases Listed | 1747 (100) | 43 (2) | 10 (100) | 1 (10) | 1757 (100) | 44 (3) |
| Total | 1747 (100) | 43 (2) | 10 (100) | 1 (10) | 1757 (100) | 44 (3) |

| Age * | Cases (%) | 3. Race/Ethnicity | Adult/Adolescent * | | Pediatric * | | Total | |
|--------------|-------------------|--------------------------|--------------------|--------------|-----------------|--------------|-------------------|--------------|
| | | | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) |
| Under 5 | 5 (0) | White, Not Hispanic | 446 (26) | | 0 (0) | | 446 (25) | |
| 5-12 | 5 (0) | Black, Not Hispanic | 1149 (66) | | 10 (100) | | 1159 (66) | |
| 13-19 | 76 (4) | Hispanic | 138 (8) | | 0 (0) | | 138 (8) | |
| 20-29 | 421 (24) | Asian/Pacific Is. | 6 (0) | | 0 (0) | | 6 (0) | |
| 30-39 | 621 (35) | Am. Indian/Alaska Native | 0 (0) | | 0 (0) | | 0 (0) | |
| 40-49 | 399 (23) | Unknown | 8 (0) | | 0 (0) | | 8 (0) | |
| Over 49 | 230 (13) | Total | 1747 (100) | | 10 (100) | | 1757 (100) | |
| Unknown | 0 (0) | | | | | | | |
| Total | 1757 (100) | | | | | | | |

| Exposure Category | Adult/Adolescent Transmission Modes | | Total (%) |
|--|-------------------------------------|------------------|-------------------|
| | Males (%) | Females (%) | |
| Men who have sex with men | 294 (31) | 0 (0) | 294 (17) |
| Injecting drug use | 45 (5) | 60 (8) | 105 (6) |
| Men who have sex with men and inject drugs | 31 (3) | 0 (0) | 31 (2) |
| Hemophilia/coagulation disorder | 1 (0) | 6 (1) | 7 (0) |
| Heterosexual contact | 297 (31) | 487 (61) | 784 (45) |
| Receipt of blood, components, or tissue | 2 (0) | 1 (0) | 3 (0) |
| Risk not reported/Other | 284 (30) | 239 (30) | 523 (30) |
| Total | 954 (100) | 793 (100) | 1747 (100) |

| | Pediatric Transmission Modes | | Total (%) |
|---|------------------------------|----------------|-----------------|
| | Males (%) | Females (%) | |
| Hemophilia/coagulation disorder | 0 (0) | 0 (0) | 0 (0) |
| Mother with/at risk for HIV infection | 2 (100) | 6 (75) | 8 (80) |
| Receipt of blood, components, or tissue | 0 (0) | 0 (0) | 0 (0) |
| Risk not reported/Other | 0 (0) | 2 (25) | 2 (20) |
| Total | 2 (100) | 8 (100) | 10 (100) |

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

Acquired Immunodeficiency Syndrome (AIDS)
HIV CASES FOR WESTERN PALM BEACH COUNTY
Surveillance Report - 04/08/2002

| Disease Category | Adult/Adolescent * | | Pediatric * | | Total | |
|-----------------------|--------------------|---------------|----------------|---------------|------------------|---------------|
| | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) | Cases (%) | Deaths (%) |
| PCP | 0 (0) | 0 (.) | 0 (0) | 0 (.) | 0 (0) | 0 (.) |
| Other Disease w/o PCP | 0 (0) | 0 (.) | 0 (0) | 0 (.) | 0 (0) | 0 (.) |
| Alone | 0 (0) | 0 (.) | 0 (0) | 0 (.) | 0 (0) | 0 (.) |
| Other Diseases Listed | 183 (100) | 9 (5) | 1 (100) | 0 (0) | 184 (100) | 9 (5) |
| Total | 183 (100) | 9 (5) | 1 (100) | 0 (0) | 184 (100) | 9 (5) |

| Age * | Cases (%) | 3. Race/Ethnicity | Adult/Adolescent * | Pediatric * | Total |
|--------------|------------------|--------------------------|--------------------|----------------|------------------|
| | | | Cases (%) | Cases (%) | Cases (%) |
| Under 5 | 1 (1) | White, Not Hispanic | 9 (5) | 0 (0) | 9 (5) |
| 5-12 | 0 (0) | Black, Not Hispanic | 167 (91) | 1 (100) | 168 (91) |
| 13-19 | 8 (4) | Hispanic | 7 (4) | 0 (0) | 7 (4) |
| 20-29 | 45 (24) | Asian/Pacific Is. | 0 (0) | 0 (0) | 0 (0) |
| 30-39 | 54 (29) | Am. Indian/Alaska Native | 0 (0) | 0 (0) | 0 (0) |
| 40-49 | 36 (20) | Unknown | 0 (0) | 0 (0) | 0 (0) |
| Over 49 | 40 (22) | | | | |
| Unknown | 0 (0) | Total | 183 (100) | 1 (100) | 184 (100) |
| Total | 184 (100) | | | | |

| Exposure Category | Adult/Adolescent Transmission Modes | | Total (%) |
|--|-------------------------------------|-----------------|------------------|
| | Males (%) | Females (%) | |
| Men who have sex with men | 9 (10) | 0 (0) | 9 (5) |
| Injecting drug use | 3 (3) | 4 (4) | 7 (4) |
| Men who have sex with men and inject drugs | 2 (2) | 0 (0) | 2 (1) |
| Hemophilia/coagulation disorder | 0 (0) | 0 (0) | 0 (0) |
| Heterosexual contact | 50 (55) | 59 (64) | 109 (60) |
| Receipt of blood, components, or tissue | 0 (0) | 0 (0) | 0 (0) |
| Risk not reported/Other | 27 (30) | 29 (32) | 56 (31) |
| Total | 91 (100) | 92 (100) | 183 (100) |

| | Pediatric Transmission Modes | | Total (%) |
|---|------------------------------|----------------|----------------|
| | Males (%) | Females (%) | |
| Hemophilia/coagulation disorder | 0 (.) | 0 (0) | 0 (0) |
| Mother with/at risk for HIV infection | 0 (.) | 1 (100) | 1 (100) |
| Receipt of blood, components, or tissue | 0 (.) | 0 (0) | 0 (0) |
| Risk not reported/Other | 0 (.) | 0 (0) | 0 (0) |
| Total | 0 (100) | 1 (100) | 1 (100) |

* Classification at time of AIDS dx if patient met the AIDS case definition (otherwise age at first HIV report).

MSM EVOLVE STUDY



Palm Beach County
Homosexual SurveySurvey

During the month of June 2002 the EVOLVE program had Palm Beach County's MSM community take a survey which asked six questions regarding their sexual behavior and awareness regarding STD's and STD testing. We also asked about unprotected anal sex and we have been surveying this response every six months for the past two years.

Survey responses were obtained the following ways: through the internet (survey was posted on the Compass homepage); through social/support groups that meet at Compass; and through bars across Palm Beach County. We surveyed a total of 197 MSM. 72% of the surveys were obtained through table outreach at the bars. 23% of the surveys were obtained through the internet and 5% of the responses were obtained from social/support groups that meet at Compass. 23% of respondents via the internet is much greater response than we have previously received (12/01 was 11.3%). This higher percent of internet respondents can be attributed to a few factors. First, we did several hours of online outreach during the month of June. Secondly, the gay online community continues to grow rapidly, and therefore, there are a growing number of gays online that access the Compass website and our survey which was posted there.

Surveys were also evaluated in terms of Age and Race/Ethnicity. In the past the largest participation in the surveys came from the 30-49 age category (12/01 was 61%) whereas the 20-29 age category (12/01 was 23%) was much lower. The June 2002 survey reflects a very different age break down. 43% of respondents were from the 20-29 age category whereas only 40% of respondents were from the 30-49 category. This points to a growing number of younger gay males in Palm Beach County. Race/Ethnicity category is also seeing a shift. While 81% of the survey respondents identified as Caucasian/White, 19% identified as non-white (Hispanic, Black, Asian Pacific/Islander). This is an increase of 8% in non-white respondents since 12/01 and to translate that into numbers that is 20 more persons surveyed. The Hispanic MSM population continues to outnumber the Black MSM population surveyed 2 to 1. The increased number of nonwhite respondents can be attributed to our program making a conscious effort to focus on gay ethnic men's issues and ways to reach them more effectively.

The survey questions for this period had two main focuses: first, to find out where men were meeting partners for sex and second, to know if men were getting tested for STD's and which STD's were being diagnosed to the MSM population.

The first question asked "Within the past year, have you met a partner for sex on the internet?" The response was as follows: 66% Never, 9% Once, 15% 2-5 times, 4% 5-10 times, and 6% 10 or more times. First, this says that over one-third (34%) of survey respondents are using the internet and meeting people for sex. Secondly it also shows that those that have met a partner for sex on the internet are having several sex partners. 73% are having at least 2-5 sex partners off of the internet.

The second question asked "Within the past year, have you met a partner for sex in a bar?" The response was as follows: 46% Never, 21% Once, 24% 2-5 times, 5% 5-10 times, and 4% 10 or more times. First, this says that over half of survey respondents (54%) have gone to the bars and met a sex partner there, and again more than half (61%) of those have had at least 2-5 sex partners. The bar and the internet are almost equally frequented scenes when it comes to

finding a sex partner. The bars and the internet were our focus because in past surveys these two venues came up the most in regards to where men meet men for sex.

The next two questions focused on STD testing and diagnosis of certain STD's. The question asked, "Within the past year, have you been tested for a Sexually Transmitted Disease (excluding HIV)?" The response was 61% Yes and 39% No. This question did not elicit an accurate response. We do not believe that 61% of MSM get regular STD testing. It is most likely that the men who answered yes have gotten an HIV test in the past year. It is also likely that they do not know what a Sexually Transmitted Disease is besides HIV. We did specifically say "excluding HIV" but we feel that the question was not understood by the target population. We also base this assumption on pretest HIV counseling that we do with clients. We specifically ask clients whether they have undergone STD testing. We have an almost 100% response of "No" when that question is asked during a pretest HIV counseling session. It is not possible that 61% of those surveyed have received any kind of STD testing other than an HIV test in the past year.

The next question asked, "Within the past year have you been diagnosed with a Sexually Transmitted Disease (excluding HIV)?" Our response to this question was 94% No and 6% Yes. Referring back to the inaccurate response of the last question, if 61% of MSM had been tested for STD's a higher rate of STD diagnosis would more likely have been apparent. It is also possible that questions about Sexually Transmitted Diseases are more personal and embarrassing to survey respondents. There is a stigma associated with STD's which means an accurate response for these questions may not be possible solely on the fact that people don't want to share about their STD's, especially if it is an STD that has been treated and taken care of. When asked which STD's they had been diagnosed with crabs, gonorrhea, and syphilis were the responses with only a total of 10 persons actually sharing which STD's they had been diagnosed with. The most interesting point is that 50% of the persons who shared what STD they had been diagnosed with were internet respondents while only 23% of total survey respondents were from the internet. This says that people are more likely to share STD information in a confidential arena such as the internet than at a bar or group setting.

Our final question asked, "Within the past 6 months, have you had unprotected anal sex?" The response was 63% No and 37% Yes. Our program has been asking this question consistently every 6 months for the last two years. 37% is a 6% increase from the last time we asked this question in 12-01. There are several possible explanations for this increase. First is that we surveyed more nonwhite populations; 58% of Blacks have had unprotected anal sex; 35% of Whites have unprotected anal sex; 33% of Hispanics have had unprotected anal sex. Another possible explanation is that younger guys are having more unprotected anal sex than older guys and this survey population was younger than survey populations in the past. 42% of respondents 29 and under are having unprotected sex whereas only 31% of respondents over 30 answered yes to having unprotected anal sex.

The final set of data we looked at was comparing unprotected anal sex to the origin of the survey. 59% of survey respondents who answered the survey online answered yes to having unprotected anal sex in the last 6 months. Only 30% of bar respondents answered yes. Possible explanations are, as was mentioned before; people are more honest in a confidential setting such as the internet as opposed to at the bar. Second possible explanation is that internet respondents are heavy internet users and internet users may not be exposed to HIV prevention messages such as condom jars and safe sex packets that bar patrons see on a regular basis. These statistics show the growing need for online outreach to prevent the expanding gay population on the internet from practicing risky behavior.

Survey questions for the June 2002 survey

Age _____

Race/Ethnicity _____

Palm Beach County Resident - Yes No

1 - Within the past year, have you met a partner for sex on the internet?

Never Once 2-5 Times 5-10 Times 10 or More Times

2 - Within the past year, have you met a partner for sex in a bar?

Never Once 2-5 Times 5-10 Times 10 or More Times

3 - Within the past year, have you been tested for a Sexually Transmitted Disease?
(Excluding HIV)

Yes No

4 - Within the past year, have you been diagnosed with a Sexually Transmitted Disease?
(Excluding HIV)

Yes No

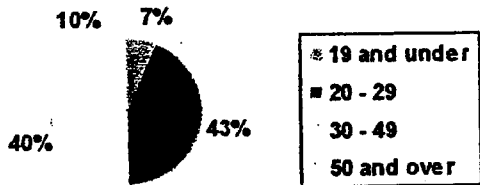
5 - Which one(s)? Gonorrhea Chlamydia Syphilis Herpes Genital Warts Hepatitis B

Other _____

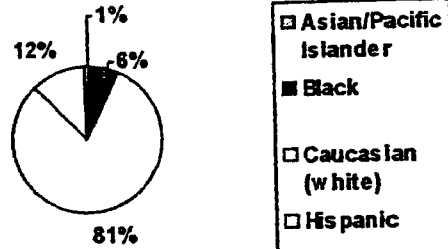
6 - Within the past 6 months, have you had unprotected anal sex?

Yes No

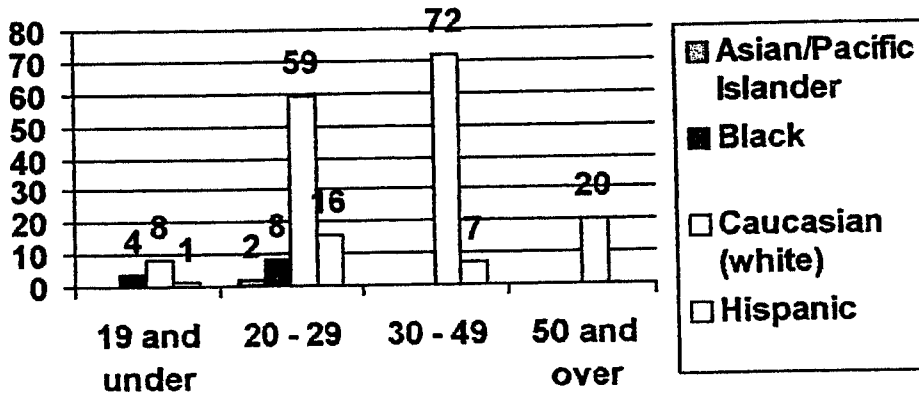
Age of Respondents



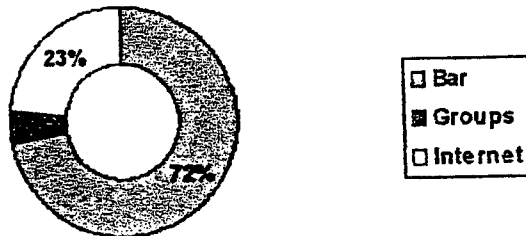
Race/Ethnicity of Respondents



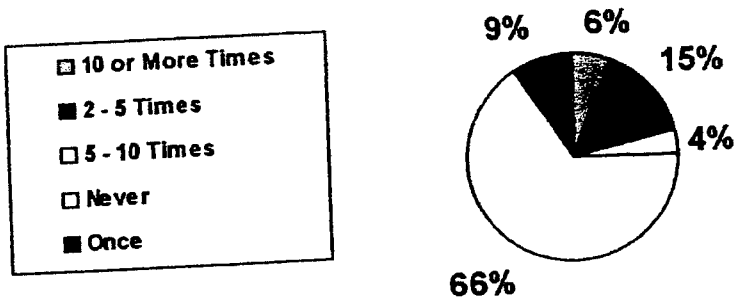
of Respondents by Age/Race



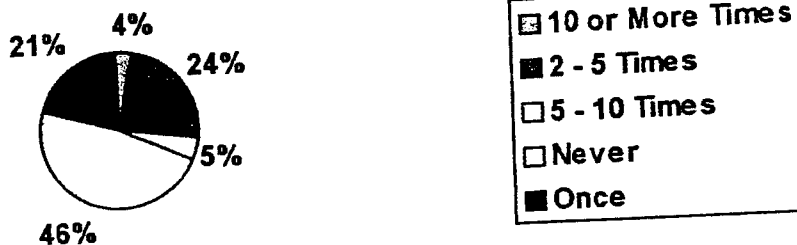
Origin of Survey



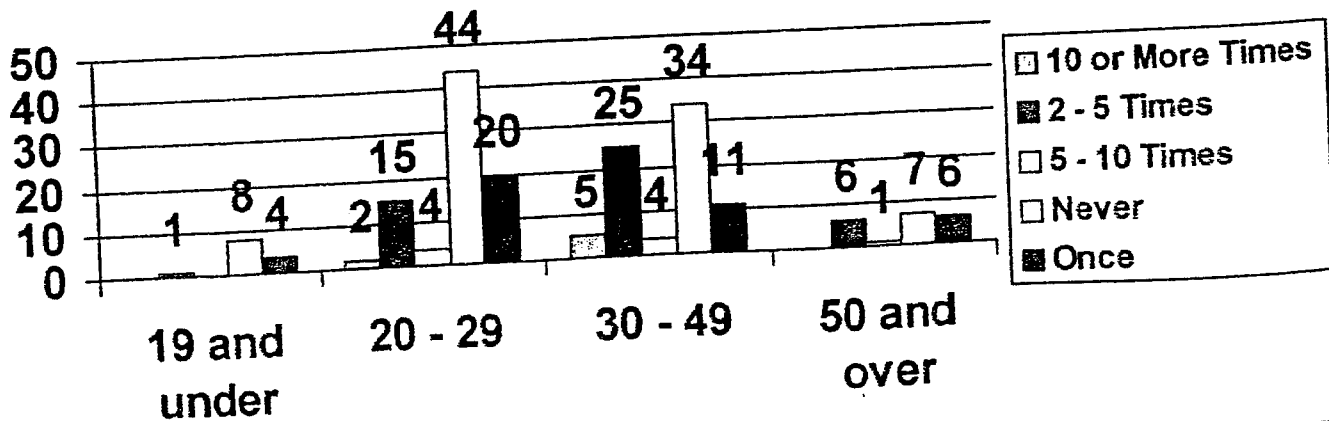
Within the past year, have you met a partner for sex on internet?



Within the past year, have you met a partner for sex in a bar?



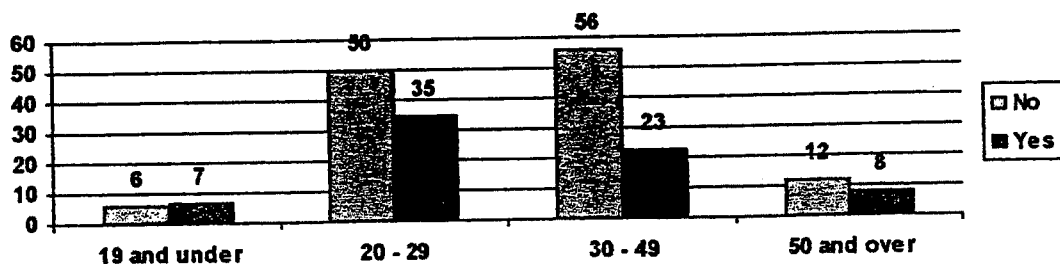
Age of respondents that met partners in bar for sex



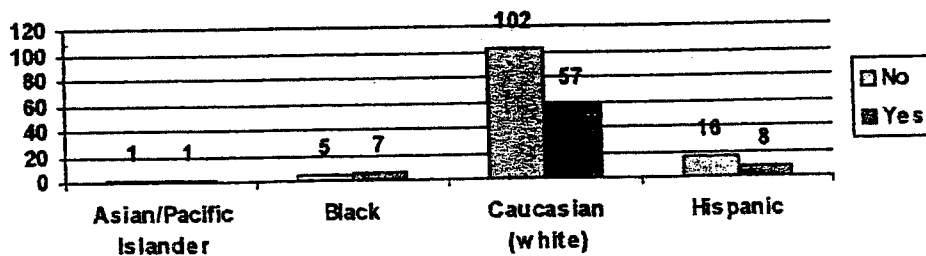
Within the past 6 months, have you had unprotected anal sex?



Unprotected Anal Sex Compared to Respondent's Age



Unprotected Sex compared to Race



Within the past year have you been tested for a Sexually Transmitted Disease (excluding HIV)?



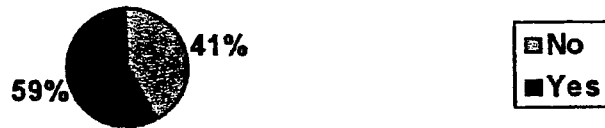
No
 Yes

Within the past year have you been diagnosed with a Sexually Transmitted Disease (excluding HIV)?



No
 Yes

Internet Responses: In the past 6 months have you had unprotected anal sex?



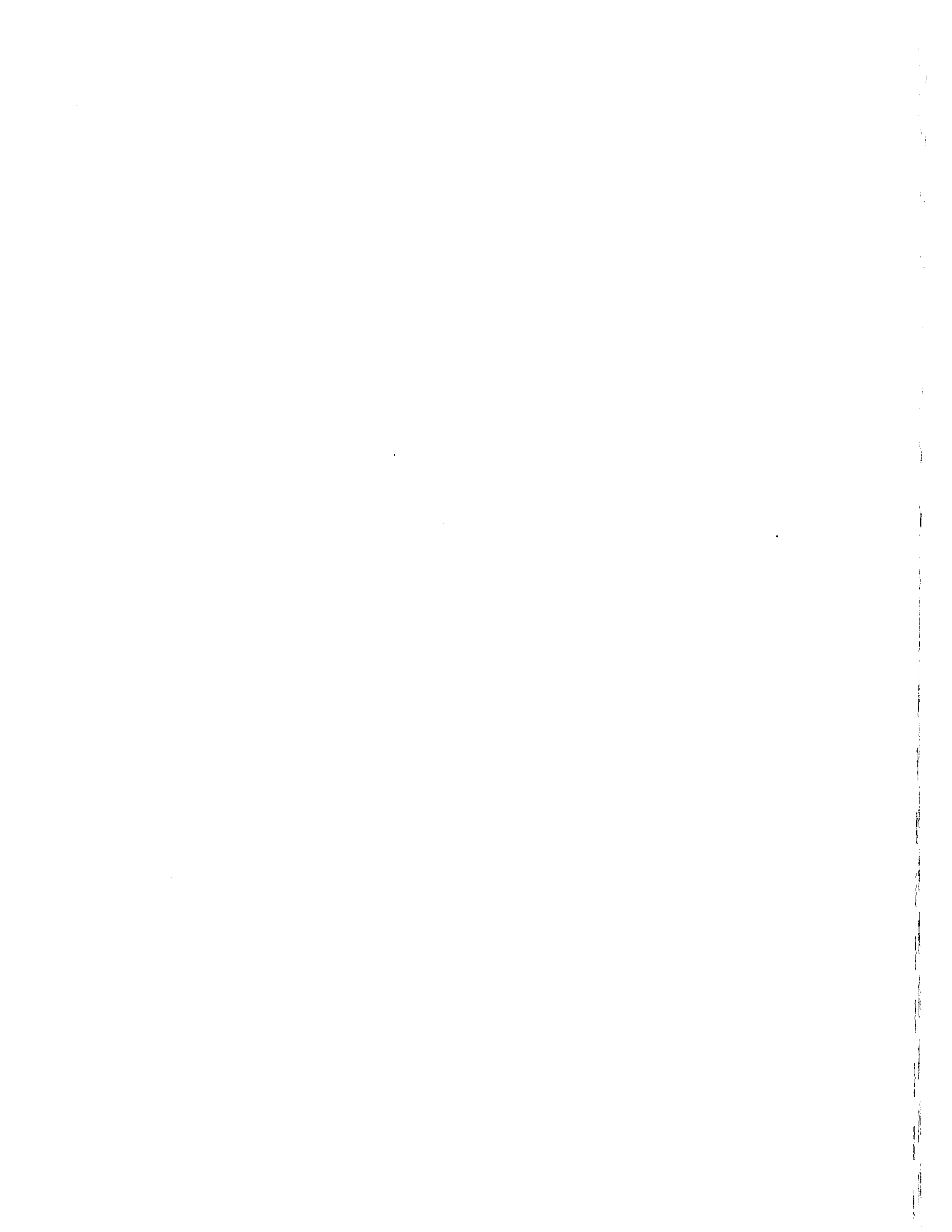
Bar Responses: In the past 6 months have you had unprotected anal sex?



APPENDICES



CONSUMER SURVEY



CONSUMER SURVEY

OF

NEED



(I) MEDICAL AND RELATED SERVICES

| Service | Need and Use | Do Not Need | Need/ Can't Get | Can Get/ Won't Use | Comments |
|---|--------------|-------------|-----------------|--------------------|----------|
| Dental Care | | | | | |
| Hospital Care/Inpatient | | | | | |
| Outpatient Primary Medical Care (Doctor, Nurse, etc.) | | | | | |
| Laboratory Testing | | | | | |
| Clinical Trial Outreach | | | | | |
| HIV Prevention | | | | | |
| Medical Referrals | | | | | |
| Vitamins/Health Foods | | | | | |
| Florida State AIDS Prescription Drug Program (ADAP) | | | | | |
| Help Paying for Insurance | | | | | |
| Hospice Care | | | | | |
| Nursing Facility | | | | | |
| Physical Therapy | | | | | |
| Massage Therapy | | | | | |
| Acupuncture | | | | | |
| Alternative Non-Western Therapies (Herbal Medicine, Chinese Medicine, etc.) | | | | | |
| Are you currently receiving alternative therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, do you consider this to be your primary form of medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

(2) IN-HOME SERVICES

| Service | Need and Use | Do Not Need | Need/ Can't Get | Can Get/ Won't Use | Comments |
|--|--------------|-------------|-----------------|--------------------|----------|
| Buddy/Companion (Help with Shopping, Cooking, Cleaning, etc.) | | | | | |
| Home Health Care; Nursing (shots, infusion, etc.) | | | | | |
| Home Health Aide (bathing, blood pressure, etc.) | | | | | |
| Home Delivered Meals | | | | | |

(3) INFORMATION AND HELP GETTING SERVICES

| Service | Need and Use | Do Not Need | Need/ Can't Get | Can Get/ Won't Use | Comments |
|--|--------------|-------------|-----------------|--------------------|----------|
| Medical Information about HIV/AIDS, Treatments, etc. | | | | | |
| Telephone Referrals to Medical or Dental Care | | | | | |
| Interpreter Services (i.e., Spanish, Haitian, sign language, etc.) | | | | | |
| Case Management (Having a Professional help you get Services) | | | | | |
| Peer Advocacy Services | | | | | |

(4) CASE MANAGEMENT SERVICES

| Service | Need and Use | Do Not Need | Need/ Can't Get | Can Get/ Won't Use | Comments |
|--|--------------|-------------|-----------------|--------------------|----------|
| Help Getting Support Services | | | | | |
| Help Getting/ Maintaining Private Insurance | | | | | |
| Benefits Information (Medicaid/Medicare insurance, etc.) | | | | | |
| Help Filling out Government Forms (Medicaid, GAU, etc.) | | | | | |

(5) COUNSELING, TREATMENT AND SUPPORT

| Service | Need and Use | Do Not Need | Need/ Can't Get | Can Get/ Won't Use | Comments |
|--|--------------|-------------|-----------------|--------------------|----------|
| Professional Mental Health Counseling/ Therapy | | | | | |
| Support Groups | | | | | |
| One-to-One Peer Emotional Support | | | | | |
| Drug or Alcohol Counseling or Treatment | | | | | |
| Spiritual/Religious Counseling | | | | | |

(6) HOUSING AND FINANCIAL HELP

| Service | Need and Use | Do Not Need | Need/ Can't Get | Can Get/ Won't Use | Comments |
|--|--------------|-------------|-----------------|--------------------|--|
| Help Finding Affordable Housing | | | | | |
| Help Paying for Groceries | | | | | |
| Help Paying Utility Bills | | | | | |
| Help Paying Rent | | | | | |
| Are you receiving housing (apartment, group home, etc.)? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you receiving help paying rent for which you qualified because you have HIV? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

(7) SUPPORT SERVICES

| Service | Need and Use | Do Not Need | Need/ Can't Get | Can Get/ Won't Use | Comments |
|--|--------------|-------------|-----------------|--------------------|----------|
| Food Bank (Receiving Groceries) | | | | | |
| Child Care | | | | | |
| Transportation/Rides | | | | | |
| Adult Day Health Program | | | | | |
| Legal Assistance | | | | | |
| Returning to Work (supplemental money) | | | | | |
| Help Finding a New Job or Learning Job Skills | | | | | |
| Permanency Planning (planning for future placement of children) | | | | | |
| Are there any other services (besides the ones mentioned above) which you use or need? | | | | | |
| | | | | | |

(8) WHAT SERVICES ARE MOST IMPORTANT TO YOU?

Now we want to find out which services you consider to be **MOST IMPORTANT** for you. **YOU MAY CHECK UP TO SEVEN (7) OF THE SERVICES LISTED BELOW.** Please be specific to only your need. Do not consider your agency.

| | |
|--|--|
| Medical Care (Outpatient) | Legal Services |
| Inpatient Hospital Care | Vocational Rehabilitation |
| Laboratory Testing | HIV Prevention |
| Drug/Medicine | Home Health Services (Nursing, etc.) |
| Clinical Trial Outreach/Coordination | Health Aid (Bathing, Blood Pressure) |
| Dental Care Services/Dentures | Buddy/Companion Services (Cooking, cleaning) |
| Nurse Care Coordination | Counseling (Support Services, Drop-in, etc.) |
| Health Insurance Continuation | Massage Therapy |
| Hospice | Acupuncture |
| Vitamins and Health Foods | Day and Respite Care |
| Substance Abuse Outpatient Counseling | Direct Emergency Assistance |
| Residential Substance Abuse Treatment | Child Care |
| Case Management | Help Paying for Groceries |
| Housing Assistance/Help find a place to live | Help Paying Rent/Mortgage |
| Food Services | Help Paying Utility Bills |
| Transportation Assistance | One-to-One Emotional Support |
| Mental Health Services | Medical Info. about HIV, Treatment, etc. |
| Telephone Referrals/Counseling | Interpreter Services/Translation |
| Home Delivered Meals | Permanency Planning |
| Alternative Medicine | Spiritual/Religious Counseling |
| Physical Therapy | Help filling out Government Forms |

(9) TELL US ABOUT YOURSELF

(Remember, your answers are strictly **ANONYMOUS**)

| | |
|--|--|
| What is your sex? | |
| <input type="checkbox"/> Male | <input type="checkbox"/> Transgendered (Male to Female) |
| <input type="checkbox"/> Female | <input type="checkbox"/> Transgendered (Female to Male) |
| <input type="checkbox"/> Other _____ | |
| How would you describe yourself? (Check one) | |
| <input type="checkbox"/> African American/Black (Not Hispanic) | <input type="checkbox"/> Caucasian/White (Not Hispanic) |
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Carribean Islander |
| <input type="checkbox"/> American Indian/Native American | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Haitian | |
| What is your zip code? _____ | |
| What is your age (in years)? _____ | |
| What is your annual household income (before taxes)? | |
| <input type="checkbox"/> 0 - \$8,000 | <input type="checkbox"/> \$24,001 - \$32,000 |
| <input type="checkbox"/> \$8,001 - \$16,000 | <input type="checkbox"/> \$32,001 - \$40,000 |
| <input type="checkbox"/> \$16,001 - \$24,000 | <input type="checkbox"/> Over \$40,000 |
| | <input type="checkbox"/> Other _____ |
| How do you identify yourself (check one) | |
| <input type="checkbox"/> Straight/Heterosexual | <input type="checkbox"/> Bisexual |
| <input type="checkbox"/> Gay/Lesbian | <input type="checkbox"/> Other _____ |
| How do you believe you became infected with HIV (check all that apply) | |
| <input type="checkbox"/> Male to Male Sexual Contact | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Sex with a Man | <input type="checkbox"/> Blood Products |
| <input type="checkbox"/> Sex with a Woman | <input type="checkbox"/> Mother with HIV/AIDS |
| <input type="checkbox"/> Sex with an Injection Drug User | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sharing Drug Needles | |
| The following two (2) questions are of a sensitive nature. You do not have to answer any questions. | |
| Did you get infected by rape? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did you get infected by your partner? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

What is your HIV status? (check all that apply)

- HIV positive, without symptoms
- HIV positive, with symptoms
- AIDS Diagnosed (based on low T-cell count, below 200 or less than 14%)
- AIDS diagnosed (based on opportunistic infections)

Some common opportunistic infections (OIs) are:

- PCP: pneumonia, a lung infection;
- MAC: a bacterial infection related to TB in the blood;
- KS (Kaposi's Saroma): type of cancer affecting skin and organs;
- Displasia and other gynecological conditions in women: pre-cancerous sores or cancer on cervix or uterus;
- CMV: a herpes-type virus that in most cases causes blindness but can affect other areas of the body;
- TB: Tuberculosis, a bacterial infection of the lungs.

Tell us about your HIV status

When did you first test positive for HIV?

Year

When did you first receive medical care for your HIV infection?

When did you first receive other services for HIV?

What is your T-cell count now? (check one)

- Don't Know
- Under 200 or less than 14%
- Between 200 - 500
- Over 500

What is your Viral Load now? (check one)

- Don't Know
- Undetectable or Below 200
- Between 200 - 1,000
- Between 1,001 - 10,000
- Between 10,001 - 100,000
- Over 100,000

Are you now taking any of the following medications for your HIV infection? (check all that apply)

- Antiviral Medications (AZT, ddI, d4T, ddC, nevirapirne, delavirdine, etc.)
- Protease Inhibitors (invidinavir (rixivan), saquinavir, nitonavir, nelfinavir, etc.)
- Drugs to Treat or Prevent Opportunistic Infections

In the past 12 months, have you (check all that apply):

- Been in Jail or Prison
- Been Homeless (no permanent place to live)
- Used Needles to Inject Street Drugs
- Used other Street Drugs

Have you ever been diagnosed with a mental illness?

- Yes
- No
- Don't Know

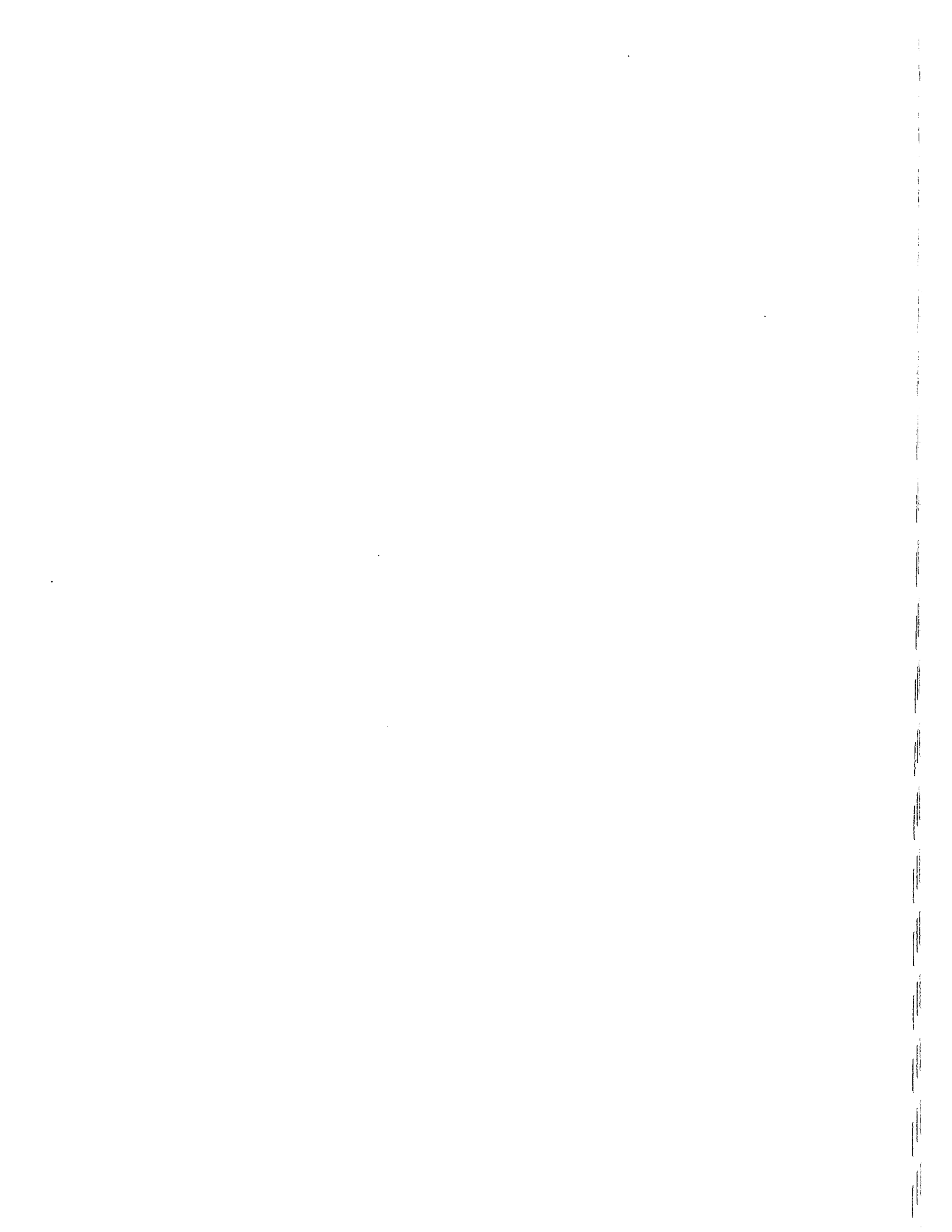
Thank you again for filling out this survey. We greatly appreciate it. Your anonymous responses will help the Planning Council make important funding decisions.

Please tell your friends about this survey. We'd like to hear from as many people as possible. They can pick up the survey where you got yours.

Returning

There are some choices for you. You can:

- Put in enclosed pre-postage envelope and drop it in the mail by **March 1, 2000;**
- Give to your case management agency;
- Bring to the CARE Council office
4152 West Blue Heron Blvd. Suite 228, Riviera Beach



PROVIDER SURVEY



2003 HIV/AIDS CARE SERVICES NEEDS ASSESSMENT PROVIDER INTERVIEW

POPULATION: _____

NAME: _____

TITLE/POSITION: _____

AGENCY: _____

PHONE: _____

What kinds of HIV/AIDS related care services do you/your agency provide?

HEALTH INDICATORS: Tell us about how your clients are doing in regards to each of the following health indicators. Are there any changes or trends you've observed in these areas in the past year?

1) HIV health status:

2) Access to/compliance with HIV medications:

3) Mental health status:

4) Substance use status:

**PART 2:
WHAT SERVICES ARE MOST IMPORTANT
FOR YOUR CLIENTS?**

Here is a list of services available to persons living with HIV/AIDS in West Palm Beach. In thinking about the entire client population on your active caseload, which of these services do you consider to be the most important for them?

You may check up to **SEVEN (7)** of the services listed below.

| | |
|--|--|
| Acupuncture | Hospice |
| Alternative Medicine | Housing Assistance/Help find a place to live |
| Buddy/Companion Services (Cooking, cleaning) | Inpatient Hospital Care |
| Case Management | Interpreter Services/Translation |
| Child Care | Laboratory Testing |
| Clinical Trial Outreach/Coordination | Legal Services |
| Counseling (Support Services, Drop-in etc) | Massage Therapy |
| Day and Respite Care | Medical Care (Outpatient) |
| Dental Care Services/Dentures | Medical Info. about HIV, Treatment, etc. |
| Direct Emergency Assistance | Mental Health Services |
| Drug/Medicine | Nurse Care Coordination |
| Food Services | One-to-One Emotional Support |
| Health Insurance Continuation | Permanency Planning |
| Health Aid (Bathing, Blood Pressure) | Physical Therapy |
| Help filling out Government Forms | Residential Substance Abuse Treatment |
| Paying for Groceries | Spiritual/Religious Counseling |
| Paying Rent/Mortgage | Substance Abuse Outpatient Counseling |
| Paying Utility Bills | Telephone Referrals/Counseling |
| HIV Prevention | Transportation Assistance |
| Home Delivered Meals | Vitamins and Health Foods |
| Home Health Services (Nursing, etc.) | Vocational Rehabilitation |

**PART 3:
WHAT SERVICES DO YOUR CLIENTS NEED,
BUT CAN'T GET?**

Now we'd like you to identify the services which a substantial number of your clients need, but are having trouble accessing. In the box labeled "Other," you may include services which your clients need, but you feel don't exist in the current care system.

You may check as many boxes as you wish.

| | | | |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | Acupuncture | <input type="checkbox"/> | Hospice |
| <input type="checkbox"/> | Alternative Medicine | <input type="checkbox"/> | Housing Assistance/Help find a place to live |
| <input type="checkbox"/> | Buddy/Companion Services (Cooking, cleaning) | <input type="checkbox"/> | Inpatient Hospital Care |
| <input type="checkbox"/> | Case Management | <input type="checkbox"/> | Interpreter Services/Translation |
| <input type="checkbox"/> | Child Care | <input type="checkbox"/> | Laboratory Testing |
| <input type="checkbox"/> | Clinical Trial Outreach/Coordination | <input type="checkbox"/> | Legal Services |
| <input type="checkbox"/> | Counseling (Support Services, Drop-in etc) | <input type="checkbox"/> | Massage Therapy |
| <input type="checkbox"/> | Day and Respite Care | <input type="checkbox"/> | Medical Care (Outpatient) |
| <input type="checkbox"/> | Dental Care Services/Dentures | <input type="checkbox"/> | Medical Info. about HIV, Treatment, etc. |
| <input type="checkbox"/> | Direct Emergency Assistance | <input type="checkbox"/> | Mental Health Services |
| <input type="checkbox"/> | Drug/Medicine | <input type="checkbox"/> | Nurse Care Coordination |
| <input type="checkbox"/> | Food Services | <input type="checkbox"/> | One-to-One Emotional Support |
| <input type="checkbox"/> | Health Insurance Continuation | <input type="checkbox"/> | Permanency Planning |
| <input type="checkbox"/> | Health Aid (Bathing, Blood Pressure) | <input type="checkbox"/> | Physical Therapy |
| <input type="checkbox"/> | Help filling out Government Forms | <input type="checkbox"/> | Residential Substance Abuse Treatment |
| <input type="checkbox"/> | Paying for Groceries | <input type="checkbox"/> | Spiritual/Religious Counseling |
| <input type="checkbox"/> | Paying Rent/Mortgage | <input type="checkbox"/> | Substance Abuse Outpatient Counseling |
| <input type="checkbox"/> | Paying Utility Bills | <input type="checkbox"/> | Telephone Referrals/Counseling |
| <input type="checkbox"/> | HIV Prevention | <input type="checkbox"/> | Transportation Assistance |
| <input type="checkbox"/> | Home Delivered Meals | <input type="checkbox"/> | Vitamins and Health Foods |
| <input type="checkbox"/> | Home Health Services (Nursing, etc.) | <input type="checkbox"/> | Vocational Rehabilitation |

PART 4:
ARE THERE ANY OTHER COMMENTS
THAT YOU WOULD LIKE TO SHARE WITH US?

Thank you for filling out this survey. We greatly appreciate it. Your responses will help the Planning Council make important funding decisions.

Please tape your survey closed and drop it in the mail by March 31, 2003

GUIDE FOR DATA COLLECTORS



“SPEAK OUT - BE HEARD”

Guide for Data Collectors

SPEAK OUT & GET PAID

There are a number of advantages in having a questionnaire administered by an interviewer rather than the respondent. Most importantly, interview surveys give higher response rates than mail or phone surveys. Second, respondents seem more reluctant to turn down interviewers. Third, data collectors can answer questions for respondents, probe for answers and clarify confusing matters, thereby obtaining relevant responses. Finally, data collectors can observe behavior as well as ask or guide questioning.

General Rules for Interviewing:

1) Appearance and Demeanor

Dress in a fashion similar to those you're interviewing. If in question, dress modestly. Demeanor should be pleasant and communicate a genuine interest in getting to know respondent. Relax and be friendly.

2) Familiarity with Questionnaire

Study the questionnaire carefully, maybe five or six times. Pick it up and read it. Practice by reading it out loud. The goal is to be able to read the survey without error; without stumbling over words. Think of an actor studying lines for a play. Also, be prepared to give guidance when a subject or respondent doesn't understand. Leave a question unanswered if it poses too much difficulty.

3) Follow Question Wording Exactly

Be careful with your wording even when clarifying questions or probing for answers. Your wording can alter how people answer.

4) Record Responses Exactly

This is especially important for open-ended questions. Record answers as they are given to you. Please do not summarize, paraphrase or correct bad grammar.

5) Probing for Responses

Sometimes respondents will respond to a question with an inappropriate answer. When necessary, interviewers can explain the question in their own way, using their own judgement. Remember to record the respondents answer, even if it seems odd to you. Probes are more frequently required with open-ended questions. Closed-ended questions are usually self-explanatory.

6) Coordination and Control

Whenever more than one interviewer is involved in a survey, it is essential that efforts be carefully controlled to insure that everyone is working from the same page.

Some specifications are:

- 1) Interviewers be trained in a group;
- 2) Interviewers be briefed on purpose of data-collection and overall study;
- 3) Questionnaire be reviewed question by question...aloud;
- 4) Trial or practice sessions need to be conducted;
- 5) Specifications or instructions handed out. Turn to the questionnaire; review each question aloud.

This survey should take 30 minutes

Read all of page 3 aloud.

Please, emphasize that if respondents have already taken the survey, that they STOP and Not take it again.

If questions, call 844-4430.

Page 4

Read aloud.

Options for taking survey underscore importance of sending back survey by March 1, 2000.

Be clear about when the survey can be taken at various sites.

Page 5

Read aloud.

Go over sample.

Page 6

This is where the survey actually begins. Read each category separately. If your person needs assistance, read category aloud and then read the possible responses aloud. Ask if they have any comments. Really try to encourage respondents to fill out the "comments" area. Don't forget the bottom of page 6. There are two yes/no questions.

Page 7

The same as page 6. Read categories aloud. Read possible responses aloud. Again, probe for comments.

Page 8

Same as page 7.

Page 9

Same as page 8. Don't forget yes/no after Housing. Also, don't forget open-ended question after Support.

Page 10

Instruct respondents to **ONLY** pick 7 of the services which they consider to be most important. If respondents request, read the list aloud.

Page 11

These are more sensitive questions. Respondents might need some privacy. If they appear awkward or uncomfortable, suggest they go where there are fewer people. Read the questions aloud to everyone or separately. USE your judgement. Please be aware of your people at this juncture. Especially be sensitive to the two questions at the bottom of page.

Page 12

Same directions as page 11.

Page 13

Same as directions as pages 11 & 12. Encourage respondents to fill out the large box set aside for comments.

Glossary

Open-ended questions

The respondent is asked to provide his/her own answer to the question.

Closed-ended questions

The respondent is asked to select an answer from among a list of answers provided on the survey questionnaire.

Questionnaire

Another word for the survey instrument.

Respondent

A person who answers survey and who provides data by responding to the questionnaire.

Data collector or interviewer

This is you; the person conducting the research project by either reading and writing questions and responses or the person there to answer questions and probe for responses.

Probe

A way of interviewing that aims at soliciting responses appropriate to the question.

- I. Reimbursement available for the following expenses:
 - a. Milage @ .29 a mile;
 - b. Training;
 - c. Facilitation.

- II. Transportation may be provided for those unable to get to sites on their own.

- III. Remember, while filling out the survey now, you can make up answers. This is a trial run!!

- IV. Confidentiality:
Refer to State Confidentiality forms, sign it please!! Please turn it in during training.

Cheat Sheet

If someone asks you why you're doing this survey, please answer with the following response:

"We are trying to find you what HIV/AIDS services you need, what you get, and what you need and can't get. Your answers will help guide HIV/AIDS service delivery in Palm Beach County."



GLOSSARY



GLOSSARY

AAR (Annual Administrative Report): The AAR is a provider-based report generating aggregate client, provider and service data for each State and EMA. Information is reported on all clients who receive at least one service during the reporting period.

ADAP (AIDS Drug Assistance Program): A state-administered program authorized under Title II of the CARE Act that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

AETC (AIDS Education and Training Center): Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETC's are authorized under Part F of the CARE Act and administered by the HRSA, HIV/AIDS Bureau's Division of Training and Technical Assistance (DTTA).

Aggregate Data: Combined data, composed of multiple elements, often from multiple sources; for example, combining demographic data about clients from all primary care providers in a service area generates aggregate data about client characteristics.

AIDS (Acquired Immunodeficiency Syndrome): A disease caused by the human immunodeficiency virus.

Average: A way of describing the typical value or measuring the "central tendency" among a group of numbers, such as average age or average income. Technically, the average is the **mean** (numerical average), but two other measures, the **median** (middle) and **mode** (most), are often called averages (see each in the *Glossary*).

CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act): The Federal legislation created to address the health care and service needs of people living with HIV/AIDS (PLWH) disease and their families in the United States and its territories. The CARE Act was enacted in 1990 (PUB. L 101-381) and reauthorized in 1996 as the Ryan White CARE Act Amendments of 1996.

CDC (Centers for Disease Control and Prevention): The DHHS agency that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process, among other programs. The CDC is responsible for monitoring and reporting infectious diseases, administers AIDS surveillance grants and publishes epidemiologic reports such as the *HIV/AIDS Surveillance Report*.

Closed-Ended Questions: Questions in an interview or survey format that provide a limited set of predefined alternative responses; for example, a survey might ask PLWH respondents if they are receiving case management services, and if they say yes, ask "About how often have you been in contact with your case manager for services during the past six months, either in person or by telephone?" and provide the following response options: Once a week or more, 2-3 times a month, about once a month, 3-5 times, 1-2 times, not at all.

Co-morbidity: A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.

Coding: The process of “translating” data from one format to another, usually so the information can be entered into a computer to be tabulated and analyzed; often, coding involves assigning numbers to all the possible responses to a question, such as Yes = 1, No = 2, Not Sure = 3, No Response = 0.

Comprehensive Planning: The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PLWH.

Consortium/HIV CARE Consortium: A regional or statewide planning entity established by many State grantees under Title II of the CARE Act to plan and sometimes administer Title II services. An association of health care and support service providers that develops and delivers services for PLWH under Title II of the CARE Act.

Continuum of Care: An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWH.

Cultural Competence: The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

Data Analysis: Careful, rigorous study of data; usually involves studying various elements of information and their relationships.

Eligible Metropolitan Area (EMA): The geographic area eligible to receive Title I CARE Act funds. The boundaries of the eligible metropolitan area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the Centers for Disease Control and Prevention (CDC). Some EMA's include just one city and others are composed of several cities and/or counties. Some EMA's extend over more than one State.

Epidemic: A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person for from a contaminated source such as food or water.

Epidemiologic Profile: A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.

Epidemiology: The branch of medical science that studies the incidence, distribution, and control of disease in a population.

Exposure Category: In describing HIV/AIDS cases, same as **transmission categories**; how an individual may have been exposed to HIV, such as injecting drug use, male-to-male sexual contact, and heterosexual contact.

Focus Group: A method of information collection involving a carefully planned discussion among a small group led by a trained moderator.

Frequency Distribution: A tally of the number of times each score or response occurs in a group of scores or responses; for example, if 20 women with HIV provided information about how they were infected with the virus, the frequency distribution might be 8 = injection drug use, 5 = heterosexual contact with an injection drug user, 3 = other heterosexual contact, 1 = blood transfusion, and 3 = don't know.

Generalizability: The extent to which findings or conclusions from a sample can be assumed to be true of the entire population from which the sample was drawn; findings can be generalized only when the sampling procedure and the data meet certain methodological standards.

Grantee: The recipient of CARE Act funds responsible for administering the funds.

HIV Disease: Any signs, symptoms, or other adverse health affects due to the human immunodeficiency virus.

HIV/AIDS Bureau (HAB): The bureau within the Health Resources and Services Administration (HRSA) of the DHHS that is responsible for administering the Ryan White CARE Act. Within HAB, the Division of Service Systems administers Title I, Title II, and the AIDS Drug Assistance Program; the Division of Community Based Programs administers Title II, Title IV, and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Centers Program. The Bureau's Office of Science and Epidemiology administers the Special Projects of National Significance (SPNS) Program.

HIV/AIDS Dental Reimbursement Program: The program within HRSA's HIV/AIDS Bureau's Division of Community Based Programs that assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV positive patients.

HOPWA (Housing Opportunities for People With AIDS): A program administered by the U.S. Department of Housing and Urban Development (HUD) which provides funding to support housing for PLWH and their families.

HRSA (Health Resources and Services Administration): The DHHS agency that is responsible for administering the CARE Act.

IDU (Injecting Drug User)

Incidence: The number of new cases of a disease or condition that occurs in a specified population during a specified time period.

Incidence Rate: The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 population. AIDS rates are often expressed in this way.

Key Informant Interview: A non-survey information collection method involving in-depth interviews with a small number of individuals carefully selected because of their experiences and/or knowledge related to the topic of interest. An interview guide or checklist is used to guide the discussion. Also called a key person interview.

Mean: Arithmetic average, calculated by adding up all the values or the responses to a particular question and dividing by the number of cases; for example, to determine the mean age of 12 children in a pediatric AIDS program, add up their individual ages and divide by 12.

Median: A type of "average" or measure of central tendency that calculates the central value, the one that falls in the middle of all the values when they are listed in order from highest to lowest; for example, if the annual incomes of seven families were \$37,231, \$35,554, \$30,896, \$27,432, \$24,334, \$19,766, and \$18,564, the median would be \$27,432. To determine the median of an even number of values, average the two central values (that is, add them together and divide by two).

Mode: A type of "average" or measure of central tendency that identifies the most frequently occurring value; for example, suppose a prevention project included 13 youth of the following ages: 16, 16, 15, 14, 14, 14, 14, 13, 13, 12, 12, 11, 10; the mode would be 14, which occurs four times.

Needs Assessment: A process of collecting information about the needs of persons living with HIV (PLWH) (both those receiving care and those not in care), identifying current resources (CARE Act and other) available to meet those needs, and determining what gaps in care exist.

Open-Ended Questions: Questions in an interview or survey format that allow those responding to answer as in a narrative and unrestricted context in contrast to close-ended questions that require selection from a limited set of predefined alternative responses.

Opportunistic Infection (O.I.): An infection or cancer that occurs in persons with weak immune systems due to AIDS, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy.

Part F: The part of the CARE Act that includes the AETC Program, the SPNS Program, and the HIV/AIDS Dental Reimbursement Program.

Percent: Literally, per hundred; a proportion of the whole, where the whole is 100. Percent is calculated by dividing the part of interest by the whole, and then multiplying by 100; for example, if you want to know what percent of recently reported AIDS cases are women, take the number of women AIDS cases (the part of interest), divide by the number of total AIDS cases (the whole), and multiply by 100; if your community has a total of 70 recently reported AIDS cases and 14 are women, divide 14 by 70 ($=.2$) and multiply by 100, and you get 20%.

Percentage Point: One one-hundredth; term used to describe numerical differences between two percents without comparing relative size; for example, if 16% of AIDS cases are Hispanic and 32% are African American, the difference is 16 percentage points (32 minus 16).

PLWH (*Person[s] Living with HIV Disease*)

Planning Council: A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to establish a plan for the delivery of HIV care services in the EMA and establish priorities for the use of Title I CARE Act funds.

Planning Process: Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.

Population Count: Data describing an entire population that were obtained from that entire population without sampling; the U.S. Census conducted every ten years is a population count since it attempts to obtain information from everyone living in the United States.

Prevalence: The total number of persons living with a specific disease or condition in a defined population at a given time (compared to the incidence, which refers to the number of new cases).

Prevalence Rate: The proportion of a population living at a given time with a condition or disease. (In contrast the incidence rate refers to new cases.)

Prevention Services: Interventions, strategies, programs, and structures designed to change behavior that may lead to HIV infection or other disease. Examples of HIV prevention services include street outreach, educational sessions, condom distribution, and mentoring and counseling programs.

Priority Setting: The process used by a planning council or consortium to establish numerical priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.

Probability: The likelihood that a particular event or relationship will occur.

Probability Value: The probability that a statistical result— an observed difference or relationship— would have occurred by chance alone, rather than reflecting a real difference or relationship; statistical results are often considered to be significant if the probability or **p value** is less than .05, which means that there is less than a 5% chance— 5 out of 100— that the result would have occurred by chance alone.

Profile of Provider Capability/Capability: A description of the extent to which the various services offered by a network of providers in the service area are available, accessible, and appropriate for PLWH, including particular populations.

Proportion: A number smaller than the total, which is calculated by dividing the number of subjects having a certain characteristic by the total number of subjects; for example, if 35 new AIDS cases have been reported in the Community in the past year and 7 of them are women, the proportion of female AIDS cases is 7 divided by 35 or $1/5$ (.2).

Public Health Surveillance: The ongoing, systematic collection, analysis, and interpretation of data essential to the planning, implementation, and evaluation of public health practice; closely integrated with the timely dissemination of these data to those responsible for prevention and control.

Ratio: A combination of two numbers that shows their relative size; the ratio of one number to another is simply the first number divided by the other, with the relation between the two numbers expressed as a fraction (X/Y) or decimal (X.Y/I), or simply the two numbers separated by a colon (X:Y); for example, the ratio of minority to white pediatric AIDS cases in a community with 75 total cases, 45 among Hispanic and Black children and 30 among White children, would be 45/30, 3/2 (3:2), or 1.5:1.

Raw Data: Data in their original form, as collected, that have not been coded or analyzed; for example, if a woman participating in an HIV nutrition workshop is tested to determine her knowledge of nutrition needs and gets a score of 11, that is her raw score; if the score represented 11 correct answers out of 20, then the score could be converted to 11 divided by 20 times 100 or 55%, which is no longer a raw score.

Reliability: The consistency of a measure or question in obtaining very similar or identical results when used repeatedly; for example, if you repeated a blood test three times on the same blood sample, it would be reliable if it generated the same results each time.

Representative: Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

Risk Factor or Risk Behavior: Behavior or other factor that places a person at risk for disease; for HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work.

SAMHSA (*Substance Abuse and Mental Health Services Administration*): The DHHS agency that administers programs in alcohol abuse, substance abuse, and mental health.

Sample: A group of subjects selected from a total population or universe with the expectation that studying the group will provide important information about the total population.

Self-Administered Survey: A survey that is mailed or given to an individual to be completed independently by the individual and then returned, rather than having an interviewer ask the questions and record the answers.

Serology: The study of blood serum and its component parts; blood serum is the fluid that separates from clotted or blood plasma that is allowed to stand. HIV testing is conducted using blood serum from the person being tested.

Seroprevalence: The number of persons in a defined population who test HIV positive based on HIV testing of blood specimens. Seroprevalence is often presented as a percent of the total specimens tested or as a rate (per 100,000 persons tested.)

Seroprevalence Reports: Reports that provide information about the percent or rate of people in specific testing groups and populations who have tested positive for HIV.

Statistical Significance: A measure of whether an observed difference or relationship is larger or smaller than would be expected to occur by chance alone; statistical results are often considered to be significant if there is less than a 5% chance— 5 out of 100— that they would have occurred by chance alone.

Statistics: Information presented in numerical terms (quantitative data); often refers to numerical summaries of data obtained through surveys or analysis.

Surveillance Reports: A report providing information on the number of reported cases of a disease such as AIDS, nationally and for specific subpopulations.

Survey: Data collection method in which a number of individuals (often a probability sample) are asked the same set of questions, which are usually largely multiple choice or short-answer, and their responses are tabulated, analyzed, and compared to provide quantitative data about the population surveyed.

Survey Research: Research in which a sample of subjects is drawn from a population and then interviewed or otherwise studied to gain information about the total population from which the sample was drawn.

Tabulation of Data: Ordering and counting of data to determine the frequency of responses, usually the first step in data analysis; often involves entering data into a computer for manipulation through some form of data analysis program.

Target Populations: A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.

Title I: The part of the CARE Act that provides emergency assistance to localities (EMA's) disproportionately affected by the HIV epidemic.

Title II: The part of the CARE Act that enables States and territories to improve the quality, availability, and organization of health care and support services to individuals with HIV and their families.

Title III: The part of the CARE Act that support outpatient primary medical care and early intervention services to people living with HIV disease through grants to public and private non-profit organizations.

Title IV: The part of the CARE Act that supports coordinated services and access to research for children, youth, and women with HIV disease and their families.

Transmission Category: A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include injection drug use, men who have sex with men, heterosexual contact, perinatal transmission, etc.

Trend: Movement in a particular direction in the value o variables over time.

Trend Charts: Line charts which show changes or movement in the values of a particular variable over time; usually, values are recorded periodically as points on a graph, and then connected to show how the values are changing; often used to provide comparisons, such as separate lines showing reported AIDS cases among different population groups over time.

Universe: The total population from which a sample is drawn.

Unmet Need: Service needs of those individuals not currently in care as well as those in care whose needs are only partially met or not being met. Needs might be unmet because available services are either inappropriate for or inaccessible to the target population.

Validity: The extent to which a survey question or other measurement instrument actually measures what it is supposed to measure; for example, a question which asks men who have sex with men whether they are using condoms is valid if it accurately measures the actual extent to which they are using condoms; it is not valid if the men are not giving honest answers, and the question is really measuring the extent to which they realize that they should be using condoms.

Value: Individual response or score; for example, if people responding to a survey are asked to state their age, each age is a value.

Variable: A characteristic for finding that can change or vary among different people or in the same person over time; for example, race/ethnicity varies among individuals, and income varies for the same individual over time.

**Service Categories
Collapsed into
Ryan White
Funding Categories**



HIV/AIDS CARE Services Needs Assessment
Collapsing Services on the Consumer Survey into Ryan White Funding Categories

| Ryan White Funding Category | Includes the following services... |
|---------------------------------------|--|
| Alternative, non-Western Category | Acupuncture, massage therapy |
| Ambulatory/Outpatient Medical Care | Lab tests, clinical trials outreach, Primary Medical Care |
| Case Management | Case management benefits, help filling out government forms, help getting support services |
| Child Care | Child Care |
| Client Advocacy | Peer advocacy, legal permanency planning, medical information, interpretation/translation, telephone referrals, HIV prevention |
| Counseling | Support groups, spiritual/religious, I-to-I emotional/peer support |
| Day or Respite Care | Adult Day Health Program |
| Dental Care | Dental Care |
| Direct Emergency Financial Assistance | Help paying rent, help paying utility bills, help paying for groceries |
| Drug Prescription Program | ADAP |
| Food/Meals | Home delivered meals, vitamins/health foods, food bank/pantry |
| Home Health Care | Home health nurse, home health aid, nursing facility, buddy/companion |
| Hospice Care | Hospice |
| Housing Assistance | Help finding low income housing |
| Insurance Programs | Insurance, maintaining private insurance |
| Mental Health Therapy | Professional mental health counseling |
| Rehabilitation Care | Physical therapy |
| Substance Abuse Treatment/Counseling | Substance Abuse Treatment (outpatient & residential) |
| Transportation | Transportation/rides |
| Returning To Work/Training* | Returning to work training |
| New Job Skills* | learning new job skills |
| Inpatient Hospitalization | Inpatient hospitalization |

* Not a Ryan White fundable service



ANNUAL ADMINISTRATIVE REPORT



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| PROVIDER | #1 | #2 | #3 | #4 | #5 | #6 | #7 | #8 | #9 | #10 | #11 | #12 | #13 | Total |
|---|-----|------|-----|----|------|----|-----|-----|-----|-----|-----|-----|-----|-------|
| GENDER | | | | | | | | | | | | | | |
| Male | 59 | 1035 | 67 | 6 | 1281 | 7 | 189 | 0 | 513 | 2 | 63 | 34 | 0 | 3256 |
| Female | 53 | 1435 | 72 | 9 | 936 | 19 | 123 | 0 | 447 | 0 | 20 | 19 | 21 | 3154 |
| Transgender | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Unknown/unreported | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 821 | 0 | 2 | 0 | 0 | 0 | 825 |
| RACE | | | | | | | | | | | | | | |
| Black | 90 | 1420 | 120 | 0 | 1555 | 21 | 191 | 0 | 524 | 2 | 61 | 15 | 7 | 4006 |
| White | 10 | 773 | 3 | 0 | 829 | 5 | 98 | 0 | 382 | 0 | 22 | 33 | 13 | 1958 |
| Asian | 0 | 6 | 0 | 0 | 4 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 12 |
| American Indian/Alaska Native | 0 | 4 | 0 | 0 | 1 | 0 | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 9 |
| Native Hawaiian or Pacific Islander | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| More than one race | 1 | 5 | 8 | 17 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 31 |
| Unknown/unreported | 0 | 276 | 8 | 0 | 28 | 0 | 22 | 821 | 50 | 0 | 0 | 5 | 1 | 1211 |
| HISPANIC OR LATINO/A ETHNICITY | | | | | | | | | | | | | | |
| Hispanic or Latino/a | 11 | 233 | | 17 | 178 | 1 | 22 | | 113 | 0 | 5 | 5 | 1 | 586 |
| Non-Hispanic or Non-Latino/a | 101 | 2001 | | 0 | 2039 | 25 | 292 | | 797 | 2 | 78 | 48 | 20 | 5403 |
| Unknown/unreported | 0 | 250 | | 0 | 0 | 0 | 0 | 821 | 50 | 0 | 0 | 0 | 0 | 1121 |
| AGE | | | | | | | | | | | | | | |
| Less than 2 years | 0 | 28 | 0 | 0 | 15 | 0 | 1 | 0 | 13 | 0 | 0 | 0 | 0 | 58 |
| 2-12 years | 2 | 40 | 0 | 2 | 68 | 2 | 1 | 0 | 172 | 2 | 0 | 0 | 0 | 289 |
| 13-24 years | 2 | 94 | 8 | 1 | 99 | 3 | 17 | 0 | 83 | 0 | 7 | 3 | 2 | 319 |
| 25-44 years | 82 | 1254 | 85 | 9 | 1234 | 18 | 189 | 0 | 440 | 0 | 52 | 31 | 16 | 3410 |
| 45-64 years | 20 | 1058 | 46 | 3 | 741 | 3 | 98 | 0 | 237 | 0 | 24 | 18 | 3 | 2251 |
| 65 years or older | 6 | 3 | 0 | 2 | 60 | 0 | 8 | 0 | 15 | 0 | 0 | 1 | 0 | 95 |
| Unknown/unreported | 0 | 6 | 0 | 0 | 0 | 0 | 0 | 821 | 0 | 0 | 0 | 0 | 0 | 827 |
| HOUSEHOLD INCOME (at the end of reporting period) | | | | | | | | | | | | | | |
| Equal to or below the Federal poverty line | 112 | 1362 | 92 | 8 | 499 | 26 | 274 | | 447 | 2 | 83 | 34 | 15 | 2954 |
| 101-200% of Federal poverty line | 0 | 145 | 44 | 1 | 224 | 0 | 27 | | 142 | 0 | 0 | 19 | 5 | 607 |
| 201-300% of Federal poverty line | 0 | 76 | 2 | 2 | 46 | 0 | 13 | | 46 | 0 | 0 | 0 | 1 | 186 |
| >300% of Federal poverty line | 0 | 46 | 1 | 0 | 319 | 0 | 8 | | 8 | 0 | 0 | 0 | 0 | 374 |
| Unknown/unreported | 0 | 855 | 0 | 6 | 1129 | 0 | 0 | 821 | 377 | 0 | 0 | 0 | 0 | 3128 |
| HOUSING/LIVING ARRANGEMENTS (at the end of reporting period) | | | | | | | | | | | | | | |
| Permanently housed | 112 | 1804 | 76 | 17 | 0 | 0 | 0 | | 0 | 0 | 20 | 0 | 11 | 2040 |
| Non-permanently housed | 0 | 30 | 27 | 0 | 0 | 0 | 0 | | 0 | 2 | 46 | 0 | 5 | 110 |
| Institution | 0 | 44 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 1 | 0 | 4 | 49 |
| Other | 0 | 15 | 36 | 0 | 0 | 0 | 0 | | 0 | 0 | 5 | 0 | 0 | 56 |
| Unknown/unreported | 0 | 591 | 0 | 0 | 2217 | 26 | 314 | 821 | 960 | 0 | 11 | 83 | 1 | 4991 |
| MEDICAL INSURANCE (at the end of reporting period) | | | | | | | | | | | | | | |
| Private | 0 | 109 | 8 | 0 | 104 | 0 | 22 | | 0 | 0 | 1 | 0 | 0 | 244 |
| Medicare | 6 | 135 | 3 | 0 | 69 | 0 | 26 | | 0 | 0 | 8 | 0 | 0 | 247 |
| Medicaid | 65 | 489 | 20 | 0 | 682 | 0 | 62 | | 0 | 2 | 14 | 0 | 10 | 343 |
| Other Public | 41 | 269 | 36 | 44 | 627 | 0 | 44 | | 0 | 0 | 42 | 0 | 6 | 1065 |
| No insurance | 0 | 377 | 72 | 17 | 735 | 0 | 18 | | 0 | 0 | 0 | 0 | 5 | 1224 |
| Other | 0 | 447 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 5 | 0 | 0 | 452 |

2002 CADR REPORT

| PROVIDER | #1 | #2 | #3 | #4 | #5 | #6 | #7 | #8 | #9 | #10 | #11 | #12 | #13 | Total |
|--|-----|------|----|----|------|----|-----|-----|-----|-----|-----|-----|-----|-------|
| HIV positive, not AIDS | 19 | 1002 | 82 | 10 | 384 | 26 | 206 | 0 | 0 | 0 | 29 | 0 | 16 | 1774 |
| HIV positive, AIDS status unknown | 0 | 453 | 42 | 0 | 0 | 0 | 0 | 960 | 0 | 0 | 38 | 53 | 0 | 1546 |
| CDC-defined AIDS | 93 | 1029 | 15 | 1 | 1833 | 0 | 108 | 0 | 0 | 2 | 16 | 0 | 5 | 3102 |
| HIV negative (affected clients only) | 0 | 0 | 0 | 6 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |
| Unknown/unreported | 0 | 2484 | 0 | 0 | 0 | 0 | 0 | 821 | 0 | 0 | 0 | 0 | 0 | 3305 |
| CLIENTS' VITAL/ENROLLMENT STATUS (at the end of reporting period) | | | | | | | | | | | | | | |
| Active, client new to program | 0 | 590 | 45 | 3 | 241 | 18 | 84 | 0 | 0 | 0 | 0 | 48 | 2 | 1031 |
| Active, client continuing in program | 11 | 939 | 84 | 14 | 1978 | 8 | 126 | 0 | 0 | 2 | 45 | 5 | 17 | 3227 |
| Deceased | 1 | 96 | 2 | 0 | 0 | 0 | 12 | 0 | 0 | 0 | 5 | 0 | 2 | 118 |
| Inactive | 100 | 783 | 8 | 0 | 0 | 0 | 92 | 0 | 0 | 0 | 33 | 0 | 0 | 1026 |
| Unknown/unreported | 0 | 66 | 0 | 0 | 0 | 0 | 0 | 821 | 960 | 0 | 0 | 0 | 0 | 1847 |
| SERVICES PROVIDED/CLIENTS SERVED | | | | | | | | | | | | | | |
| IDENTIFIED CLIENTS | | | | | | | | | | | | | | |
| a. Ambulatory/outpatient medical care | | 168 | 59 | 17 | 1947 | 10 | | | | | 83 | | 21 | 1968 |
| b. Mental health services | | | | | 1054 | | | | | | | 53 | 21 | 1094 |
| c. Oral health care | | 0 | | | | | 26 | | | | | | | 100 |
| d. Substance abuse services-outpatient | | 23 | | | | 15 | | | | | | | | 38 |
| e. Substance abuse services-residential | | | | | | | | | | | | | | 0 |
| f. Rehabilitation services | | | | | | | | | | | 13 | | | 147 |
| g. Home health/professional care | | 134 | | | | | 143 | | | | | | | 277 |
| h. Home health, professional care | | 1 | | | | | | | | | | | | 1 |
| i. Home health, specialized care | | 10 | | | | | | | | | | | 21 | 31 |
| j. Case management services | 70 | 2399 | | | | | | | | | | | | 2490 |
| k. Buddy/companion service | | 0 | | | | | | | | | | | | 0 |
| l. Child care services | | 0 | | | | | 170 | | | | | | | 170 |
| m. Child welfare services | | 0 | | | | | 170 | | | | | | | 170 |
| n. Client advocacy | | 0 | | | | | | | | | | | | 0 |
| o. Day or respite care for adults | | 0 | | | | | | | | | | | | 0 |
| p. Developmental assessment/early intervention services | | 0 | | | | | | | | | | | | 0 |
| q. Early intervention services for Titles I and II | | 0 | | | | | | | | | | | | 0 |
| r. Emergency financial assistance | | 363 | | | | | | | | | | | | 363 |
| s. Food bank/home-delivered meals | | 1236 | | | | | | | | | | | | 1236 |
| t. Health education/risk reduction | | 0 | | | | 1 | | | | | | | 21 | 21 |
| u. Housing services | 42 | 549 | | | | | | 776 | | | | | | 1367 |
| v. Legal services | | 0 | | | | | | | | | | | | 0 |
| w. Nutritional counseling | | 0 | | | | | | | | | | | | 0 |
| x. Outreach services | | 0 | | | | | | | | | | | | 0 |
| y. Permanency planning | | 0 | | | | | | | 244 | | | | 21 | 265 |
| z. Psychosocial support services | | 0 | | | | | | | | | | | 21 | 21 |
| aa. Referral for health care/supportive services | | 0 | | | | | | | | | | | | 0 |
| ab. Referrals to clinical research | | 0 | | | | | | | | | | | | 0 |
| ac. Residential or in-home hospice care | | 0 | | | | | | | | | | | | 0 |
| ad. Transportation services | 9 | 711 | | | | | | | | | | | 21 | 720 |
| ae. Treatment adherence counseling | | 151 | | | | | | | | | | | | 151 |
| af. Other services | | 281 | | | | | | 821 | | | | | | 1102 |

