Voices

A Summary Report from the
HIV Health and Wellness Assessment Project and Exploratory Study
Locally….

“The demographic with the most infections, nationally and across South Florida: men age 40 and younger, especially those who have sex with men without using protection.

Dr. Nabil El Sanadi, chief of emergency medicine at the Broward Health hospital system, said it’s no coincidence that South Florida also has the highest per-capita HIV infection rates in the nation. HIV is a known risk factor for contracting syphilis, and vice versa.

"Broward County, particularly Fort Lauderdale, is a party town,” El Sanadi said, pointing to excessive drinking, drug use and unprotected sex among [young] partyers as the catalyst for the county's increasing sexually transmitted disease rates. “We live in the epicenter of communicable diseases.”

Then there's the stealth factor: In syphilis' earliest stages, when the disease is most infectious, many people don't recognize the symptoms, increasing the likelihood of unwittingly spreading the infection.

"People need to know that some of the population in this area has the potential of being carriers of communicable diseases" and how to protect themselves, said El Sanadi, one of several "physician ambassadors." (Sun Sentinel, 2013)
Globally….

A report commissioned by three London boroughs into drug use during sex has highlighted significant risks to sexual and mental health of gay and bisexual men, Your Local Guardian reports.

Councils in Lambeth, Southwark and Lewisham – boroughs that have high populations of gay men – said they are determined to tackle the growing problems associated with “chemsex.”

The findings of the report produced by experts in HIV and sexual health at the London School of Hygiene and Tropical Medicine, will inform the response to the problem, the Your Local Guardian article said.

Health Experts have previously raised concerns that ‘chemsex’, or sex under the influence of drugs such as crystal methamphetamine, GHB/GBL and mephedrone, could be behind the rising rates of HIV and STIs in gay men, Your Local Guardian reports.

Lambeth has the highest prevalence of HIV in the UK (14 per 1,000 residents aged 15-59) and Southwark has the second highest (12 per 1,000).

Jim Dickson, Lambeth’s Cabinet Member for Health and Wellbeing, said “This research provides essential insight into the complex needs of the particular at risk group of our local residents. It will enable us to work with partner organizations to find new approaches to reducing harm and to support the health and wellbeing of affected men.”

The Chemsex Study, published on March 28, 2014 is the first research of its kind in the UK to look at the complex relationship between drug use and sexual behavior and documents the harms that some gay men experience, Your Local Guardian Reports. (Washington Blade, 2014)
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Since 1981, HIV disease has claimed the lives of more than 300,000 gay and bisexual men in the United States. Today, gay and bisexual men represent the largest percent of persons living with HIV in the US and account for more than 50 percent of all new infections. It is estimated that 21,100 persons are living with HIV disease in Broward through 2011, and 3,334 (15.8%) are unaware of their HIV status. The largest concentration of HIV cases is in the greater Fort Lauderdale area. In 2011, more than 1,000 new cases of HIV were reported, an increase of 25% from 2010. Most new cases in this area affect persons between the ages of 40 and 49. (BRHPC, 2013). In the largest urban centers in the US, gay and bisexual men make up between 70% and 92% of all persons living with HIV. In Broward County they make up approximately 70% of all infections.

Thirty years into the US epidemic, gay and bisexual men still account for the largest number of new infections. Gay and bisexual men are the most heavily impacted by HIV and carry the lion’s share of disease burden. What can be done to lighten the load and slow the progression of disease across the entire population of gay and bisexual men in the US? This HIV Health and Wellness Assessment and Exploratory Study of gay, bisexual and other men who have sex with men (MSM), and transgender women in Broward County seeks to uncover some of the answers to the question and gain a better understanding of the factors contributing to the continuance of new HIV infection rates among gay, bisexual and other men who have sex with men and transgender women.

Three previous studies, Survey of People Living with HIV/AIDS (2004), Report of Findings: Epidemiology (2004) and MSM Living with HIV/AIDS in Broward County EMA (2005-2006) funded by Broward County have all noted the incidence and prevalence of HIV/AIDS among gay, bisexual and other men who have sex with men. The previous Broward County MSM studies have provided information and details that profile persons living with HIV within the county, identified risks factors and behaviors associated with HIV infection, offered recommendations for preventing transmission and suggested strategies for changing the course of the Broward County HIV epidemic. This project and exploratory study selected an alternative approach.

This report, Voices, is a summary of the HIV Health and Wellness Assessment Project and Exploratory Study which took a multifaceted approach to assessing the Broward County epidemic among gay, bisexual and other men who have sex with men, often referred to as MSMs. The project included the establishment of a community advisory workgroup, a review of pertinent literature, key informant interviews, focus groups of consumers of HIV prevention and healthcare services and consumer surveys. The assessment project and exploratory study sought to assess and understand the current realities of gay, bisexual and other men who have sex with men living with and at risk for HIV from a qualitative methodological point of view and does not negate the needs for supportive, educational and intervention services of other individuals at risk for and living with HIV in Broward County.

Qualitative research methods are very often utilized to help define problems, explore gaps in knowledge related to those problems, and further understand the nature of the problems. In the case of this exploratory study, the utilization of qualitative methodologies was designed to assist in taking a snapshot of the gay, bisexual, men who have sex with men and transgender women lifestyles. This picture enables a clearer understanding of risk behaviors and choices; a greater knowledge of the realities of those men who have sex with men living with HIV; and answers to queries about what the HIV community care and healthcare network providers can do to improve Broward County’s HIV response.
Acknowledgements

*Voices*, the HIV Health and Wellness Assessment Project and Exploratory Study would not have been possible without the engagement, assistance and support from many individuals. The members of the Community Advisory Group provided valuable information, feedback and guidance throughout the exploratory study. The members included: Tiffany Ariegas, Arianna Lint, SunServe; Brad Gammell, Poverello Center; Patricia Fleurinord, Broward House; Jorge Gardela, Pride Center; Frank Gurucharri, Pride Center; Jason King, AIDS Healthcare Foundation; Lorenzo Robertson, Pride Center; Gregory Timmer, Latinos Salud; PJ Williams, business owner; Ex-Officio Government observers included: William Green, Leonard Jones, Evelyn Ullah. Ariela Eshel (staff), Michele Rosiere (staff), Jodi Riechman (Participant).

Many thanks to the members of the Community Advisory Group, the local HIV planning members and HIV providers who provided valuable information on the state of the epidemic in Broward, the needs of those at risk for and living with HIV, and those that shared their thoughts and ideas about how best to address those needs. They include:

Tiffany Ariegas, SunServe; Brad Gammell, Poverello Center; Patricia Fleurinord, Broward House; Frank Gurucharri, Pride Center; Jason King, AIDS Healthcare Foundation; Lorenzo Robertson, Pride Center; PJ Williams, business owner; Steven Fallon, Latinos Salud; Kristoffer Feigenbush, Pride Center; Tashara Taylor, Care Resources; Joey Wynn, RWPC; Karlene Tomilson, Dept. of Children and Family Services; Esther Shulman, MD, AIDS Healthcare Foundation; Hon. Dale V. Holness, Broward County Commissioner; Mario DeSantis, HOPWA; Dionne Proulx, Memorial Health Services; Claudette Grant, Broward Health; Ana Puga, MD, Children’s Diagnostic Center; George Castratano, attorney; and Rick Siclari, Care Resource.

Eighty-eight gay, bisexual men who have sex with men and transgender individuals agreed to participate in a series of seventeen focus groups. They shared their ideas, thoughts, and experiences about being gay, being transgender, living with HIV, and living in Broward County. Their honesty, willingness to share, their forthrightness, and level of engagement made the content from the focus groups the center piece of this exploratory study.

This assessment project and exploratory study could not have been executed without the participation and hard work of a stellar team of professionals who met with the community advisory group, reviewed the literature and epidemiologic data, participated in the participant observation sessions, attended gay community events, reviewed the exploratory study design, facilitated the focus groups, and wrote sections of, made contributions to and reviewed this final report. These professionals are Barbara Green-Ajufo, PhD; William DiStefano, MSW; Gregory W. Edwards, PhD; Shelley Hayes, JD; Angela Martin, MBA; William Smith, PhD; and Sarah Whitehead, BA.

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Study Consultant Coordinator
**Introduction to this report**

This report, entitled *Voices*, is the summary report of the 2013-2014 gay, bisexual men who have sex with men HIV Health and Wellness Assessment Project and Exploratory Study. *Voices* was designed to capture the ‘voices’ and ‘experiences’ of gay, bisexual and other men who have sex with men, and transgender women living with HIV and those of unknown HIV status living in Broward County, Florida, and those who serve and represent them. It is a qualitative study, and as such, the findings represent the experiences of the assessment and study participants. Wherever possible, when presenting ‘findings,’ every effort has been made to preserve the ‘voice’ and reflect the sentiment of the informants and focus group participants who shared their opinions, thoughts and experience(s). Summary statements are used to give brief highlights and introduce the subject area.

The report is divided into nine sections. Each section represents a key component of the overall assessment project and the exploratory study.

**Section I: Introduction**

This section provides an overview of the assessment project and the study. It includes the rationale for the study, a review of the study’s methodological approach, highlights from the review of literature and the study limitations.

**Section II. The Setting: Gay Broward**

This section of the report describes how Broward County has transitioned from the spring break vacation capitol of the 60s, 70s and 80s to the number one LGBT choice for fun in the sun, clothing optional.

**Section III. The Challenge: Addressing the MSM Population**

This section outlines the challenges confronting community, private and public health leaders including the escalating rates of HIV among gay, bisexual men who have sex with men and transgender women.

**Section IV. Socio-cultural Context: Broward County: A New Gay Mecca**

This section provides an overview of the socio-sexual-cultural realities of gay and bisexual men in South Florida. It describes the population of men of unknown HIV sero-status most at risk for HIV infection and how the local health and human services agencies and their grantees plan for, fund and implement HIV service programs. Variance across age, race/ethnicity, social and behavioral determents of health is also presented.
Section V. HIV/AIDS among MSM Communities in South Florida: An Epidemiological Profile

This section highlights the epidemiology of HIV/AIDS among gay, bisexual and other men who have sex with men in the US, in Florida but most specifically in Broward, Dade and Palm Beach counties. The differences among gay, bisexual and other men who have sex with men living with and at risk for HIV in the three counties are highlighted. In Broward, white gay men have historically been the most heavily impacted group, however increasingly Black and Latino gay, bisexual men who have sex with men are increasing in numbers of the newly infected. In Miami, Latinos are leading the number of newly HIV infected. In Palm Beach County, Blacks have the highest rates of HIV in the county. The strategies for addressing HIV among MSMs differ across the jurisdictions, as do the resources.

Section VI. HIV Health and Wellness Assessment Project and Exploratory Study Design

This section describes the methodological approach taken to carry out the project and study. The project and study were divided into two main components: Unknown HIV sero-status and Known HIV Sero-status Health and Wellness (all participants diagnosed and known to be HIV positive). A description of the data collection and data analysis methodology, including focus groups, informant interviews, surveys, participant observation and a community advisory group is presented. The data analysis strategy is identified.

Section VII. Assessment Project and Exploratory Study Components and Findings

This section presents the findings from the focus groups, informant interviews, community advisory group meetings, surveys, participant observations for both components: Unknown HIV sero-status and Known HIV Sero-status Health and Wellness (all participants diagnosed and known to be HIV positive). Included is a profile of the study participants, data from the focus groups and perceptions of needs from the informant interviews.

Section VIII. Conclusion

This section briefly summarizes the highlights from the assessment project and exploratory study; and encourages a coordinated and integrated approach to planning and implementing services for men who have sex with men at risk for and living with HIV.

Section IX. Study Implications: Needs and Recommendations

This section highlights the needs and recommendations derived from the information shared by study participants and key informants. The recommendations range from creating a new conversation/discussion among providers and community leaders on HIV among gay, bisexual men who have sex with men and transgender women to establishing a gay men’s advisory group to establishing an integration task force to work on HIV planning across planning bodies.
Section I. Overview of the assessment project and exploratory study

In 2009, the HIV epidemic among gay, bisexual and other men who have sex with men (MSM) in Broward and Dade Counties ranked number one in HIV incidence; ahead of New York City, Los Angeles, Houston, Chicago and San Francisco (CDC, 2011). Between 2009 and 2013, Broward County’s epidemic surged ahead of many metropolitan areas with historically high rates of HIV infection among gay, bisexual and other men who have sex with men (MSM) to become the leader amongst the South Florida Counties and several US urban jurisdictions. This HIV Health and Wellness Assessment Project and Exploratory Study, entitled VOICES, explores how and what these statistics mean for Broward County. It investigates the attitudes, behaviors, and initiatives taken by MSMs and others that have resulted into this socio-sexual dilemma. What happened that Broward County moved into the number one position for new HIV infections among MSM in the US? What factors contributes to the increase in HIV infections? This HIV Health and Wellness Assessment Project and Exploratory Study will seek to identify, explore and give voice to the factors contributing to the increase in HIV infection in Broward County.

Many gay, bisexual men and transgender persons report practicing safe sex (use of a protective barrier such as condoms), sero-sorting (choosing sex partners based on HIV status) and reducing the frequency of anonymous sex and number of sex partners. These early community-developed, community tested safer sex and lifesaving prevention strategies have been well documented by the US Centers for Disease Control and Prevention and have been shown to be effective. (AmFAR, 2011) New infections in the United States dropped from an all-time high of 90,000 in the mid-nineties to just under 40,000 new infections in 2011. These data raise an alarming and imposing question regarding what is occurring among gay, bisexual, men who have sex with men, and transgender women in Broward County that reversed the trend. Understanding the interplay of behavioral risks and environmental factors that contribute to HIV transmission and new infections can be key and crucial to the discovery and development of effective prevention, care, and treatment programs.

Finally, behavioral and environmental risks alone do not account for the high HIV incidence among gay, bisexual men who have sex with men and transgender women. Several investigative questions emerge when addressing this issue. What are the socio-sexual-cultural circumstances that lead to increased risk for Broward County gay, bisexual men and transgender women? Are Broward County gay, bisexual and transgender residents at greater risk for HIV infection? Among Broward County gay and bisexual men who know their HIV sero-status, do they know how to prevent transmission of HIV to others? Are HIV positive MSM and transgender women participating in regular and ongoing HIV medical care? For gay, bisexual men who have sex with men and transgender women who are unaware of their HIV sero-status, do they know where to get an HIV test? Are they educated about HIV transmission, HIV prevention strategies, and on how to remain HIV negative while continuing to be sexually active? What social-sexual-cultural-behavioral and geographic variables contribute to the spread of HIV across and into Broward County? Identifying and uncovering the answers to these questions is the second objective of this study and key to the development of culturally appropriate and culturally relevant HIV prevention, care and treatment programs for gay and bisexual men.
A. Methodological Approach

Are there unique circumstances that put Broward County gay, bisexual men who have sex with men and transgender women at increased risk for HIV infection and HIV transmission? Are HIV positive gay, bisexual men who have sex with men and transgender women engaged in regular and on-going medical care? In order to uncover and identify answers to these and the preceding questions, this assessment project and exploratory study of gay, bisexual men who have sex with men and transgender women employed a subset of qualitative methods, anthropological methods, for data collection. These methods included participant observation; informant interviews; surveys, focus groups; and an HIV community advisory group. Anthropological methods are defined as “ways of studying people from an on the ground, in the field anthropological perspective.” The “ways” include various approaches that anthropologists, ethnographers and other social scientists use to ‘learn about a given people or culture’, such as participant observation; interviews; surveys; key informants; focus groups. (Bernard, 1993)

The decision to use an anthropological approach to data collection in this assessment project and exploratory study was based on the need for assistance with uncovering and understanding the HIV related experiences, beliefs and behaviors of gay, bisexual men who have sex with men and transgender women. The initial study design included an online survey of 250 gay, bisexual and other men who have sex with men of unknown HIV sero-status, informant interviews and focus groups and an online survey of 250 MSM diagnosed with HIV/AIDS (the known HIV sero-status health and wellness component). After reviewing information and data shared from the initial interviews with key informants and several focus groups with the Community Advisory Group, it was determined that the study should focus on collecting more qualitative data through expansion of the number of focus groups and eliminating the online survey for the exploratory study. The initial information collected from several of the key informants included the following concerns, needs, issues:

- Fort Lauderdale as the new gay ‘party town’ was articulated repeatedly;
- Many felt the circuit parties and hook-up apps contribute to HIV transmission;
- Many felt that people don’t think about HIV like they use to, no longer fear HIV;
- Drugs and alcohol use/abuse is a major problem in Broward, reducing inhibitions;
- There is need for more support for people who are positive, especially gay men;
- The need for continuous education about HIV in all neighborhoods;
- Stigma and denial were identified as barriers to care and services for HIV positive folks;
- Managing intimacy, effective communication and relationship skills is difficult for some.

The initial focus groups with men and transgender women of unknown status revealed the importance of understanding the cultural context of the lives of those at risk for HIV and living with HIV. Taken together the information from the initial informant interviews and focus groups suggested the need for increased understanding about the socio-sexual-behavioral-cultural realities of gay, bisexual and transgender women.

After discussing the initial responses, it was agreed that understanding the population of gay, bisexual men who have sex with men in Broward and lived experiences of those with HIV/AIDS in greater Fort Lauderdale would be extremely helpful before launching a larger quantitative study. The Community Advisory Group supported...
the change in the data collection strategy to include an anthropologic approach: more informant interviews, focus groups and community observations.

The anthropologic approach can also support the way to identify and explain what impacts the beliefs, behaviors, and actions of a given population, in this case gay, bisexual, men who have sex with men and transgender women. Anthropological methods lead to identifying phenomena in the field; and at the same time, to crafting explanations of the phenomena from the field. (Bernard, 1993) These methods can help to understand different perspectives from different vantage points; uncover underlying motivations and factors that influence behavior; and provide valuable information for further study.

Consistent with this approach, the assessment project and exploratory study utilized a variety of data sources to gain insight into the HIV related concerns and needs of gay, bisexual men who have sex with men and transgender women. This data strategy, methodological and data triangulation was well suited for uncovering and identifying the dynamics of HIV infection, one of the foci of this exploratory study. Methodological triangulation is the use of multiple methods to study a topic, such as focus groups, interviews, surveys, and advisory groups. Data triangulation is the use of several different data sources for examining phenomena and comparing the data to develop a broader understanding and leading to confirming hypothesis. (Bernard, 1993)

Data and methodological triangulation supports utilization of more than one anthropological approach to data collection and also multiple data sources. Data from each source is collected, shared, discussed and compared as part of a data feedback loop and exchange with key informants and stakeholders in an effort to cross validate what was being found, illustrated and discovered. For example, data collected from the Unknown HIV Sero-status component (transgender women and MSM of unknown status) of the study, the informant interviews, focus groups, and community observations were collected, reviewed and shared with members of the community advisory group to determine areas of agreement, consistency as well as difference and divergence. This process was repeated for the Known HIV Sero-status Health and Wellness component (HIV positive of known sero-status) of the study.

**B. Review of Literature**

A literature review was completed to provide theoretical framework for this HIV Health and Wellness Assessment Project and Exploratory Study. Specifically the literature review helped to:

Provide a greater understanding and examining the current state of the epidemic in Broward County as it pertains to gay, bisexual men who have sex with men living with HIV in South Florida.

Provide Broward County health officials with literature and data to guide its future work in strengthening and improving access to treatment and education services for MSM living with HIV in the county.

Provide a reference document that can be used for identifying scientific evidence, program “best practices” and culturally relevant materials.

The literature review focused on HIV among men who have sex with men in South Florida, the socio-sexual-cultural context of those at risk for HIV, behavioral dynamics and barriers to effective engagement in care and treatment services for men living with HIV. The goal of the literature review was to identify relevant literature
for use in gaining a clearer understanding of HIV epidemic among gay men and developing useful program interventions and models.

C. Limitations of this assessment project and exploratory study

This assessment project and exploratory study was limited by a number of factors. The project and study set out to give voice to and explore gaps in knowledge, and as such, the descriptive findings might not be generalizable or transferable to all gay, bisexual and other men who have sex with men, and transgender women at risk for and living with HIV without further study. The Voices project and study were designed to capture qualitative data from individuals working in the field of HIV intervention services, individuals at risk for and living with HIV, and individuals with knowledge of and experience with Broward County’s gay community who were available to participate in telephone interviews and focus groups at agencies. Due to the convenience nature and size of the sample, the project and study did not include the experiences of those individuals who were not employed by nor clients of nor unknown to the selected professionals, agencies and/or organizations working in the field of HIV services in greater Broward County. Finally, findings from focus groups, interviews, surveys and observations are subject to personal biases and are not verifiable. The descriptive data can be used to inform further and future study.

As the writer below reminds us, there is much to be told, much to be understood, and much to learn about the lived experience of gay, bisexual, other men who have sex with men, and transgender women living with HIV and those at risk for infection, and also much to be done. Voices seeks to contribute to a continued telling of the story, to greater understanding of the lived experiences of positive men and clarity about how to enhance, improve and expand the current mix of treatment and prevention services in Broward County.

"The Truth? It f.... sucks. That is the deepest and most honest answer someone who is HIV positive can tell you about living with the disease. Is it manageable and tolerable? Yes, of course. With advancement in treatments, living with HIV does not have to be burdensome, but no-one-pill-a-day will ever take away the real truth that there is a deep pain felt inside those of us who are positive. I personally know how easy it is to trivialize what it’s truly like to live with HIV....Are we convincing others and ourselves that HIV is not as big a deal as it really is? Get tested. Know your status. You can take one pill a day. Undetectable makes it safe. These are the phrases that we are pouring over gay youth while educating them. Is HIV going to kill you? No, most likely not. Can you live with it, and live a normal life? With treatment adherence, most can.

I am all about showing the world that I am just another person, living a normal life, while also being an HIV positive man. I feel that I am doing exactly that. But what I am guilty of not doing is talking about something that needs to be discussed more by others who are also HIV positive: the reality that life with HIV will never be the same and the mental and social ramifications of having HIV are heartbreaking...self-acceptance comes with a long and dark journey...disclosing your positive status is one of the most gut wrenching processes that you will have to repeatedly go through, and it won’t ever get easier. Figuring out how to strategically hide your medicine bottle so that your friends, neighbors, repair people, and airport security guards don’t see it will become routine...For me, self-acceptance can after two years of denial, heavy drinking, and abundant shame, and embarrassment...Being a single man, disclosure is still incredibly difficult. Sometimes it is just easier to not meet that person or to end an online conversation instead of uttering those three letters.

I’d like to say that I no longer feel shame, but I think there will always an underlying layer of shame that will remain with me. But...why not speak about what we are truly feeling? Why not tell our stories of hope and encouragement but also tell the truths of the mental pain HIV causes. I am ready to change tactics and I truly hope others are as well." (Duran, 2014)
D. Background

This HIV Health and Wellness Assessment Project and Exploratory Study 2013–2014 was undertaken on behalf of Broward County Regional HIV Planning Council (BRHPC) in response to community requests for an assessment of the needs of gay and bisexual men who have sex with men. The goal of the assessment project is to identify, explore and give voice to the HIV health and wellness concerns among gay and bisexual men, other men sex who have sex with men, and transgendered women. MSM, for purposes of the study, is inclusive of gay, bisexual men and other men sex who have sex with men. As they do not identify as men, transgender women who participated in this exploratory study are not included in the MSM definition. They are their own participant category in the project study. Wellness, for purposes of this study is defined as “more than the absence of illness, it is a dynamic process and requires the conditions necessary for the achievement of physical, emotional and social wellbeing...a deliberate, self-directed journey toward a healthy life...learning to make healthier lifestyle choices that enable...achievement of full potential. A harmonious blend of the following nine domains of wellness can result in improved health outcomes: social, spiritual, emotional, environmental, financial, intellectual, mental, physical and sexual…. (BWHI, 2011)

Voices is an update to the MSM Living with HIV in Broward, a 2005–2006 study for the Broward Regional Health Planning Council; which also provides a glimpse into the life and contemporary times of gay, bisexual, men who have sex with men and transgender women at risk for and living with HIV.

Since the 2005-2006 study, Broward County has seen growth in same sex couple households in several mid-sized and small communities. Fort Lauderdale now ranks first among mid-sized cities for population-adjusted rates of same-sex couples per 1,000 households; Hollywood ranks 24th among mid-sized cities for same-sex couples. Among small cities, Wilton Manors ranks 2nd, and Oakland Park ranks 10th for population-adjusted rates of same sex couples per 1,000 households.

In addition, Broward County’s large tourist population, attracting 10.4 million visitors annually, includes 1 million gay and lesbian visitors. Some gay and lesbians choose to make Broward their home. These population shifts – gay tourism, the growth in same sex households, and the intra-county migration among the three South Florida counties for play and pleasure - has made South Florida the new gay resort Mecca.

But this development has come with a downside. It has placed Broward County at the center of the South Florida HIV epidemic. The Centers for Disease Control and Prevention (CDC) reports that the Broward County Division of the MSA ranked highest in the United States for population-adjusted living AIDS rates in 2010 (with a case rate of 36.5%), second only to Miami/Dade County for population-adjusted HIV (not-AIDS) rates (with a case rate of 55.2%). The Broward County Division’s population-adjusted living AIDS and HIV (not-AIDS) case rates far exceed the Florida AIDS and HIV (not-AIDS) case rates (19.7% and 31.2%, respectively). More recent data from the Florida Department of Health demonstrates that in 2011 Broward County had more cases of HIV and AIDS than Miami/Dade Country. That year, Broward had a population-adjusted AIDS case rate of 35.0% and an HIV (not-AIDS) case rate of 59.3%. In contrast, Miami/Dade County had a population-adjusted AIDS case rate of 29.2% and an HIV (not-AIDS) case rate of 51.7%. (Hidalgo, 2012)
E. Outline of the Assessment Project and Exploratory Study Design

In response to the updated information above, the Broward Regional Health Planning Council funded a new study to revisit and review the earlier findings and update the 2006-2008 study with the findings from this 2013−14 HIV Health and Wellness Assessment Project and Exploratory Study.

The goal of the assessment project and exploratory study is to provide updated information on the experience of gay and bisexual men and other men who have sex with men (MSM) in Broward County and transgender women.

*Voices* covers a broad range of topics:

- Emerging gay community in Broward County;
- Socio-sexual-cultural context of gay, bisexual and other men who have sex with men;
- Epidemiological profile of MSM in South Florida;
- Impact of HIV/AIDS on general and sexual health well-being;
- Mental health, substance use, homelessness; and
- Participant in on-going HIV medical care, supportive and prevention services.

A review of the literature was completed that identified information about the emerging factors impacting HIV transmission: the new gay community of south Florida; HIV among gay, bisexual men, and other men who have sex with men and HIV risk; HIV prevention strategies and MSM; and the HIV epidemiological profile of MSM in the US, South Florida and Broward County.

A community advisory workgroup of key community leaders and stakeholders representing services providers, individuals living with HIV, members of the transgender community and public health was established to provide on-going advice. The community advisory workgroup served as an important data source and a data review and validation group.

This multifaceted assessment project and exploratory study is divided into two main components: **Unknown HIV Sero-status component** which included informant interviews and focus groups with persons of unknown HIV status; and the **Known HIV Sero-status Health and Wellness component** (known sero-status with positive diagnosis) which included informant interviews, focus groups with HIV positive individuals, participant observation and paper and pencil surveys.

The exploratory study’s design used a mixed method approach to data collection. Qualitative data was collected through focus groups, informant interviews, surveys, community venue participant observation and a community advisory workgroup. And while the focus of this study is the men who have sex with men at risk for and living with HIV in Broward County, it is important to note that Broward County, the location of this study, is, in and of itself, a critically important aspect, if not a variable in the study.

There is worldwide agreement that location and place shape health, exposure to risks, pathogens and environmental factors that impact health, health seeking behavior and access to health promotion and intervention resources. (Gatrell & Rigby, 2004) In the case of HIV, the geography of South Florida does play a
Fort Lauderdale is a city with a multitude of options for its gay residents and visitors, building its base from the ever-growing and increasingly active gay community. With a host of bed and breakfasts, resorts, bars, clubs, restaurants and other businesses catering to the community, this resort city has stepped out of the shadow of its famous neighbor to the South, establishing itself as a destination in its own right. Its attractions are simple: a broad, long white sand beach, warm, blue ocean water, a friendly and courteous "family" oriented gay community, an affordable option to the pricey Miami Beach and easy access, by air, from anywhere in the United States, Canada and aboard.

Due to the tireless efforts of the local gay community and an enterprising Convention and Visitors Bureau, Fort Lauderdale has become more popular than ever with gay travelers....With its gay bed & breakfasts, mainstream gay-friendly hotels, several gay beaches, alternative and mainstream gay nightlife, tourist attractions, Fort Lauderdale’s got it all. (FunMaps.com, 2013-2014)
Section II. The Setting: Gay Broward

“A need to understand we didn’t do anything wrong we were just living our lives. There was no talk about using condoms back then for me.”

A headline from the New Times News on January 14, 2010, reads “Broward County Replaces South Beach as America's Gay Playground— call it the great gay migration north. The epicenter—and the future—of the South Florida gay community might not be South Beach anymore but in Broward County.” In 2006, Fort Lauderdale ranked number six nationally for gay travelers, according to the city's tourism board, surpassing Miami. The following year, gay vacationers accounted for about $800 million in tourist dollars—11 percent of the city's annual tourism-based income. In Fort Lauderdale and Wilton Manors, gay entertainers find work more easily, queer yuppies can afford spacious homes, and transgendered ladies feel safer walking to the corner store. (NTN, 2010)

Thanks to the Convention and Visitor's Bureau of Greater Fort Lauderdale, which recognized years ago that the gay community was a good investment, Fort Lauderdale has become one of the premier gay destinations in the world. It would be difficult to find an area as gay friendly as Greater Fort Lauderdale, with its more than 30 gay guest houses, its multitude of gay-owned restaurants, gay bars, and nightclubs and its top-notch entertainment throughout the year.

Fort Lauderdale and Wilton Manors, which lies at the heart of gay Greater Fort Lauderdale, now claim 150 gay-owned shops and establishments. The area also hosts the largest PrideFest in the state, with more than 40,000 attendees and with 250 vendors, many of them corporations.

Over the past decade and a half, Wilton Manors has become one of the liveliest gay areas in the state of Florida. With an openly gay mayor, out city council members, and a booming gay population, Wilton Manors is the place to be in South Florida if you are gay. (Maloney, 2013) Gay- and lesbian-owned businesses line Wilton Drive, one of the city’s main thoroughfares, and their numbers continue to grow year after year.

Greater Fort Lauderdale has come a long way since officially rolling out the rainbow carpet to gay and lesbian travelers in the mid-1990s. Back then, tourism officials annually spent $35,000 on gay marketing. Now, the city’s gay marketing budget is about $750,000 yearly, and it is aimed at building Greater Fort Lauderdale's reputation as a top choice for lesbian, gay, bisexual, and transgender (LGBT) travelers.

"Greater Fort Lauderdale is recognized as Florida's largest and most popular diverse gay capital with the largest resident lesbian and gay community and the most gay-owned and -operated businesses in the state," according to the Greater Fort Lauderdale Convention & Visitors Bureau brochure. It further states, "We're the No. 1 LGBT resort destination in the U.S. and 8th-most-popular American LGBT destination."
Fort Lauderdale’s gay tourism caters especially to gay and bisexual men, other men who have sex with men and transgender women. There are plenty of clothing optional resorts, several men only bathhouses and sex clubs offering ‘adventurous’ fun and accoutrements for sex play. The gay friendly restaurants offer drag brunches with sultry and stimulating performers, shows with ‘the hottest’ exotic and erotic dancers for intimate fun. The ‘part-sexy’ circuit parties, held several times a year, offer dusk to dawn non-stop partying, drinking and ‘unspeakable, unforgettable and uninhibited’ fun. Below is a sampling of the promotional pitches of some of these hot spots.

- **Clothing optional pool & hot tub, smoke-free**: near the center of the gay entertainment center of Wilton Manors, Ft. Lauderdale. No other guest house is closer to gay nightlife. 100% tobacco free, have a large pool and hot tub. Pool, sundeck, hot tub are clothing optional and get full sun 365 days a year. Or maybe a short two blocks to the beach.

- **Clothing optional men's resort, 24 hour pool & Jacuzzi**: All rooms renovated. Private sunny courtyard. Playful & frisky or romantic & loving, the choice is yours. Paradise is as close as your imagination. Come and enjoy the adventurous atmosphere.

- **Clothing optional with complimentary expanded continental breakfast**: Evening cocktail party for guests. Every amenity for the comfort and pleasure of our guests is offered. Central location to beaches and nightlife. Come relax, enjoy, and you will come back.

- **Gay owned & operated guest house & resort**: proudly serving the community for many years. The guest house & resort has catered to the international community with 11 Suites and Studios, all equipped with a full leather sling, with a heated swimming pool, hot tub, outdoor sling, showers, GH area, lockers, it makes our resort a great place to be even for the day pass guests that come to spend some time with us every day.

- **Join us and our friends from the Gulf Coast**: as we come together to raise funds at what promises to be a wet and slippery time. Our lube wrestling fundraiser got such rave reviews last time that we’re doing it again. There's a $15 cover at the door that gets you an open bar, food and entrance into the Dungeon. Yeah, we're here to wrestle and raise money, but why not have some ‘fun’ as well. We are a full service leather store addressing the needs of gay men and the greater fetish community. In some jurisdictions there may be narrow minded prudes who do not understand our culture.

- **Huge playspace**: filled with slings, cubicles, suck ramps and other nooks and crannies to play in. Also features a live DJ in the cage every Friday and Saturday night, and you can bring your own booze! Always packed, especially on weekends.

- **Good clean fun**: A private men's club, open all hours for good fun anytime. Besides a state-of-the-art gym, it also features private rooms, a sauna and a pool. Check out the weekend poolside cookouts from 2-4pm.

- **Men's club with lots of specials**: Popular with the bear and leather crowd, and features all the essentials for a great bathhouse experience: private showers, steam room, sauna, whirlpool and video lounge. The action happens between the hours of 11am and 3pm. Known to be a very friendly venue that welcomes all types of men. Best days are Wednesdays and Saturdays.

- **Strip bar known for attracting a porn star or two**: a different event every night of the week--but every event has strippers, strippers, strippers, so you'll always find something (or someone) you like.
- **Trans hot spot**: Drag queens, transgender, even heterosexual "cross-dressers," you'll find them all, as well as the men who love them. Shows start nightly at 10 pm.

- **Five fabulous day and nights**: nearly a week of non-stop dances and parties…. 

- **All male, all nude, all night, continuous…..**

If the above listed places fail to fulfill or address the social and sexual needs of the moment, the Internet offers alternatives: a wide selection of online social and sexual hookup sites. These sites have many advantages. They are fun, easy to find, open around the clock and users can remain anonymous. One such site, has exploded into the largest and most popular all-male, location-based social network in the world. Promising that “you’ll always find a new date, buddy, or friend,” it has built an international membership of 4 million. Approximately 10,000 new users download the app every day. This app makes use of the location-based services of each user’s mobile phone to identify the members who are in closest proximity.

Gay, bisexual, and transgender sexuality has not been easily accepted by the U.S. population as a whole. Attitudes and behaviors toward “gay people” are changing ever so slowly. However until there is full acceptance of LGBT persons and violence against them has ended, settings such as Wilton Manors and venues like the ones listed above will remain essential gathering spots for social and sexual expression without fear of rejection and/or violence. Gay communities are critically important for those looking for positive and affirming climates where they can live openly and enjoy their life. As social acceptance of LGBT people began to increase in the 1980s, HIV entered the LGBT community and expanded its reach as well. It has been part of the community ever since.
Section III. The Challenge: Addressing the MSM Population

“There is no stopping HIV/AIDS...it is not going to end.” “People today are going to be people.” “In the Latino Community you tell them about HIV – it’s a death sentence. They will never understand.”

HIV and AIDS continue to pose a serious threat to the health and wellbeing of gay, bisexual and other men who have sex with men, and transgender women. Available evidence strongly suggests that behavioral and socio-cultural strategies have been inadequate to stop or even control HIV transmissions. On the other hand, recent studies have brought some good news: HIV positive gay and bisexual men with fully suppressed virus and undetectable viral load are less likely to transmit HIV infection and those who utilized combination prevention interventions including pre-exposure prophylactics are less likely to acquire HIV. Why, then, do men who have sex with men, many of whom identify as “gay,” continue to be more severely affected by HIV than any other group in the United States? This assessment project and exploratory study seeks to contribute to the answer to that question at least in Broward County. Before looking to the field for answers, it is important to understand the recent literature on HIV among gay, bisexual and other men who have sex with men, with a particular focus on South Florida.

A review of the literature offers a quantitative and qualitative snapshot of the US epidemic and provides a context for examining the local HIV epidemic among men who have sex with men, risk factors and from a qualitative perspective, the socio-sexual-cultural realities. What can be understood from a review of recent literature and science on HIV and men who have sex with men is the importance of understanding the socio-sexual-cultural realities of gay, bisexual and other men who have sex with men. The highlights from the literature review set the stage for understanding the study context, the study subjects, the study design and use of qualitative methods. Four major areas dominate the literature review: context, epidemiology, risk behavior and community.

Setting the Stage

Men who have sex with men are the only group for which the annual number of HIV diagnoses increased from 28,077 in 2007 to 30,573 in 2010. Male-to-male sexual contact accounted from 65% of all HIV diagnoses reported in 2011 (CDC, 2013). Further, CDC estimated that the number of incident HIV infections (new infections—diagnosed or not) increased 12% among MSM from 2008 to 2010. Of the 47,500 estimated incident HIV infections in 2010 in the United States, 63% were estimated to have occurred among MSM. Among men who have sex with men, blacks are disproportionately affected by HIV infections attributed to male-to-male sexual contact (Wejnert et al., 2013). This data underscores the need for new understanding and new approaches to address the broader socio-sexual-cultural and economic factors and contexts that contribute to increases in HIV infection among men who have sex with men.
The numbers tell one aspect of the story, biology tells another. Biology leaves gay, bisexual and other men who have sex with men and transgender persons vulnerable to HIV infection. When it comes to the transmission of HIV, an individual who has unprotected anal intercourse is at especially high risk. HIV transmits more easily via anal intercourse. Research has shown that being on the receiving end of anal intercourse is equally risky whether you're a man or a woman. The risk was estimated at 1.4 percent per sex act with an infected person -- about 18 times more risky than male-to-female vaginal intercourse.

However, gay and bisexual men remain especially vulnerable to infection due to their sexual play choices, despite a heavy emphasis on condoms and HIV testing. They make up the bulk of HIV cases in the United States and most Western countries. Studies have also shown the greater use of prevention approaches -- such as condoms, more medical treatment for those who are already infected and use of medication that can prevent infection -- could shrink new HIV cases among gay and bisexual men by one-fourth over the next decade. (Beyrer, 2012)

High levels of virus circulating in communities with large populations of men who have sex with men underscore the need to reach all gay, bisexual and other men who have sex with men with innovative user-friendly prevention strategies and messages that work. Correct and consistent use of condoms is not the answer for many gay, bisexual men who have sex with men. Behavioral interventions which are designed to “equip men with the knowledge, motivation, skills needed to reduce HIV risk” work for some men and not for others. Additionally, socio-cultural behavioral, political economic and political factors such as homophobia, racism, mental illness, violence, substance abuse and low or no-income impede successful utilization. (AmFAR, 2010)

Current efforts to reduce the number of new HIV infections in the US among gay, bisexual and other men who have sex with men include efforts to increase awareness of one’s HIV status and to reduce behaviors that may increase acquisition and/or transmission of HIV.

In July 2010, President Barack Obama released the National HIV/AIDS Strategy. The strategy is designed in part to address HIV among gay and bisexual men. The President said:

“We must re-orient our efforts by giving much more attention and resources to the following populations at highest risk of HIV infection: Gay and bisexual men. According to the Centers for Disease Control and Prevention, gay men comprise approximately 2 percent of the U.S. population, but 53 percent of new infections. Among gay men, White gay men constitute the greatest number of new infections, but Black and Latino gay men are at disproportionate risk for infection.”
(NHAS, 2010)

Additionally, research has shown that an HIV infected persons not aware of his/her HIV infection is more likely to engage in behaviors that place their sexual partners at risk of HIV acquisition. Moreover, estimates indicate that they account for the majority of sexual HIV transmissions in the United States (Marks et al., 2006). Persons uninfected by HIV are equally at risk of HIV acquisition when engaging in behaviors with sexual and needle-sharing partners of unknown HIV sero-status, as the following vignette illustrates.

A 15-year old boy told his mother, several weeks after the incident occurred, that he had sexual intercourse with an adult male he met through a mobile phone app. The older man invited the younger man to his home, asked him if he was 18 years old, and the boy told him he was not. After the boy informed him he was younger, the man proceeded to have unprotected sexual intercourse with him. A friend later told the boy that the adult male maintains a secret Facebook page where he post videos of himself engaging in lewd sex acts with males that appear to be minors and that the adult was
likely HIV positive. The mother took her son to a local hospital where it was verified that her son had in fact contracted HIV, the virus that can cause AIDS. Men who have sex with men, or MSMs as termed in the public health nomenclature, represent 74% of all AIDS cases in the United States (FDHBHA, 2013).

Notably, the infection of this 15-year old boy happened in Broward County. It is a powerful reminder of the challenge ahead for both those who are negative, those who are positive and those serving both. This vignette, notwithstanding the issues and concerns about the age of participants, consent, abuse and betrayal, highlights the ongoing need for HIV prevention education and services, appropriate access to testing resources for knowing one’s HIV status and the importance of participating in regular HIV care and treatment services. With access to community support, a condom, a pre-exposure prophylactic and an undetectable viral load this transmission could have been prevented.
Section IV. Socio-cultural Context: Broward County: A New Gay Mecca

“People come here and lose their inhibitions.”

Beginning in the late 1990s, gay men began to flee Miami Beach for smaller cities where they could find affordable housing, safe streets, and cultural attractions. Wilton Manors, a small city 25 miles north of Miami Beach, was one of the new destinations. It offered rents and houses at substantially lower costs than other nearby communities; an openly gay mayor who welcomed newcomers; and a gay-friendly commercial culture. In the next few years, rainbow flags, chic bars and restaurants, and gay-owned shops sprang up on the main boulevard.

Fort Lauderdale also became an attractive alternative to Miami Beach. Shedding its reputation as a spring-break destination for college students, the city courted a new demographic: childless gays and lesbians with discretionary income. It promoted its open parking, less expensive commercial space, and its booming national and international tourist business as a draw for gay club owners and other businesses.

The public health implication of this migration has not been fully appreciated nor examined by local government officials, social service organizations and community leaders. In former times the I-95 corridor represented daily and seasonal transiency, people coming and going for fun in the sun. As noted earlier in this report, the New Times News reported people are no longer coming and going, they are coming and staying (NTN,2010). A review of the literature on Fort Lauderdale’s standing among America’s gay communities reveal it has replaced San Francisco as the gay Mecca.

As a result of the new gay migration and gay tourism, Broward County became the new Gay Mecca while no one was really paying attention. Along with the title and reputation for fun in the sun came something else: a growing HIV epidemic. As one person put it, referring to the HIV epidemic and response, “we are where San Francisco was 25 years ago.”

A. Social and Behavioral Determinants

Condom-less sexual activity is central to HIV transmission. Gay men are most closely linked to HIV transmission as a result of sex without a condom although they have not been the sole group to have sex without a condom, and it is not the sole modality for transmission of HIV. As one focus group participant noted, ‘straights for the most part do not have to use condoms…it is not fair.” Individual sexual behavior and choices are strongly influenced by cultural context, social environments, and social institutions. These larger determinants affect individual perception of risks, condom usage, and tendency to disclose or not one’s HIV status.
Combining tourism and anonymity with migration from the Caribbean, Central and South America and other parts of the world, Broward County becomes and creates a “socio-ecological camp for risky sexual behaviors, recreational drug use, and ultimately, HIV infection. For some in Fort Lauderdale and its environs they comfortably own the label a “gay resort Mecca.” For public health, the intimate connections between recreational drug use, circuit parties, “party and play packets,” and sexual freedom in this socio-sexual-cultural ecological community can create a rash of devastating and adverse health outcomes for residents identified as gay, bisexual and MSMs. (Egan, 2011).

Understanding gay men’s health within the context of LGBT health starts with understanding the history of oppression and discrimination that these communities have faced. Research suggests that LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBT persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Experiences of violence and victimization are frequent for LGBT individuals, and have long-lasting effects on the individual and the community. Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBT individuals. For example, in part because bars and clubs were often the only safe places where LGBT individuals could gather, alcohol abuse has been an ongoing problem (Healthy People 2020).

Behavioral scientists recognize the essential need and attraction of gay neighborhoods. They understand that these gay neighborhoods primarily serve as safe havens for same-sex couples and households, and they have found them to be protective with regards to health and health promotion. For gay men especially, they provide safe and secure comfort from violence, assault and discrimination. (NTN, 2010) They offer socialization and information dissemination pertinent to the gay culture. And support economic exchange and growth among a select and creative group of entrepreneurs. Overall, gay neighborhoods have become a viable locale and social environment for those looking for safe and supportive community.

However, a “fast lane’ element often exists in these communities. It can facilitate risk behaviors such as excessive alcohol, drug use and unsafe sex. As noted above, the gay bar scene can also facilitate alcohol and drug use during sex, which lowers inhibitions and produces a sexual assertiveness and expression that becomes the norm. Recent reports have found that MSM tend to self-select to live in areas that are more tolerant of substance use. Over the past 10 years, Wilton Manors has had a flux of MSM migrate into its borders. Along with them have come highly visible gay social venues, businesses, alcohol pouring and flowing bars and drug-copping areas (Buttram, 2013).

B. Age

Among Baby Boomers, those born between 1946 and 1964, there are two distinct gay generations. One is the Stonewall Generation, those who emerged during the gay rights movement of the late 60s and early 70s. The other is those who survived the outbreak of the AIDS epidemic of the early and mid-80s, namely the AIDS Generation. Sex and substance abuse remain risk factors for both groups. On the other hand, age is increasingly emerging as a key factor in HIV between several age groups. Older gays remember when HIV was not around, when the epidemic devastated the community and many friends and loved ones died. Today’s younger gay and bisexual men have grown up during an era of treatments and one pill a day. HIV/AIDS is not a death sentence.
to the young gay, bisexual men. In fact many believe they cannot avoid HIV. HIV infection is an inevitability to many. The attitudinal differences related to age, in all three groups of gay, bisexual and other men who have sex with men, and transgender women, must be appreciated when crafting prevention messages and delivering HIV related care and treatment services. The relationship to HIV infection differs across age cohorts.

A recent study (Halkitis, 2013) of South Florida residents found unprecedentedly high rates of unprotected sex among men from 40–94, with particularly high rates among those ages 40–59. Most of these men met their sex partners in the same or similar settings: bars and clubs, the Internet, and bathhouses and backrooms. The study also found that men who have fewer emotional conflicts about their sexuality are more likely to engage in risky sexual behaviors. The findings for younger men, even those aged 18–21, also showed fewer conflicts about their sexual identity and practices. In essence, men with less internalized homophobia and stronger connections to or affinities within the gay community tended to engage in more sexual risks. For these men, taking sexual risks is an expression of their own gay pride and identity.

In a study of “club and drug using” gay men, there was no difference for those HIV positive men who participated in unprotected anal sex, older men and young men alike. Risk taking was not limited to sex. It also included use of marijuana, alcohol, poppers, and such illicit drugs as crystal meth and cocaine. The behaviors of HIV negative men differed only slightly. (Halkitis, 2007)

Older MSM take the same health risks as younger MSM. However, no matter how similar their behaviors may be to those of younger MSM, they deal with a very different set of health conditions, complications, and risks. Moreover, far fewer health promotions are designed to reach them. The epidemic has compromised the physical, emotional, and social well-being of MSM in the older generations. Prevention methods and adherence strategies for this population must address social needs and mental health needs that interact at this stage in the development and aging of these generations of gay and bisexual men.

It is true that young gay men have a similar challenge, as well as a host of other issues related to social interaction and sexual behaviors, particularly with regards to HIV. They do not go to the bars for social interaction. They report limiting their social interactions to the apps on their phones. HIV prevalence for young MSM (under 30) is lower than older men’s because they are less likely to know their HIV status. Accordingly, nearly 63% of MSM between the ages of 18–29 who have HIV do not know it in contrast to only 37% of those 30 and older. (CDC, 2008) The CDC study also illuminates other factors that impact HIV infection rates among young MSM locally, including education. Prevalence was higher for those with less education and less income.

C. Race and Ethnicity

Racial and ethnic groups continue to be front and center in the HIV epidemic among MSM. Of the nearly 100,000 persons diagnosed with HIV in Florida, Blacks account for 49%. In Broward County, the number is relatively the same, 46%. Black MSM with HIV were the most likely to be unaware of their infection at 59%, compared to 46% for Hispanics, and 25% for Whites. Younger MSM of color were less likely than Whites to know they were infected. Of Blacks under 30, 71% were unaware of their infection. Of Hispanics under 30, 63% were unaware. Of all MSM who were infected, 40% were under the age of 30.

CDC attributes MSM’s low awareness of their HIV status to a number of factors: their infections occurred more recently, they underestimate their personal risk, they may have had fewer opportunities to get tested, or they
believe that the recent advancements in HIV treatment lessens their threat or risk of infection. In Broward County, it is just as likely that HIV prevention education, HIV testing and communitywide awareness efforts have not reached those with the greatest need.

Particularly for young MSM of color, lack of education, discrimination and socioeconomic factors like poverty, homophobia, stigma, and limited public health care may pose critical challenges.

As MSMs continue to bear the greatest burden of HIV cases throughout the United States, it is important for there to be relevant information about them. Their populations and socio-sexual cultural realities must be better defined. Credible estimates of MSM populations by community, zip codes, and ethnic/racial identity can inform and guide HIV/AIDS surveillance, resource allocation, and advocacy. This information is necessary for planning, implementing, and evaluating meaningful HIV prevention, care and treatment programs and other services.

Cultural competency as it pertains to specific groups, lifestyles, races, and ethnicities is also greatly important for addressing cultural influences and for strengthening the positive social connections that can be used to modify attitudes and behaviors and, at the same time, induce self-empowerment and improve conditions that affect quality of life. As they retool their efforts, outreach providers must consider all social and circumstantial contexts.

A new generation of communication modalities has come of age since the onset of the domestic HIV/AIDS epidemic. Some have created new ways of addressing the issues and challenges that impact MSM. Others, however, have not yet been studied for their effectiveness in improving the delivery and the outcomes of HIV messaging. But they should be studied. If used appropriately, this new generation of communication modalities could lead to effective HIV prevention interventions that reach MSM where they are. For example, smart and mobile phones can deliver evidence-based HIV education, prevention, and treatment programs cost effectively to homes or venues frequented by MSM. HIV prevention messaging has been shown to reduce or delay high-risk behaviors in young MSMs (Kingdon, 2013).

D. The Public Health Response: HIV Planning for the Delivery of HIV Services

D.1. A New HIV Planning Process

A new local HIV prevention planning process began in Broward County in February 2013. Its major goals are to increase HIV prevention services in communities hardest hit by HIV, expand effective combinations of evidenced-based prevention approaches, and provide education on HIV and how to expand the HIV prevention message. These goals were cited by the Broward County HIV Prevention Planning Council Co-Chair (South Florida Gay News, 2013).

The core of the plan, its development coordinated by Florida Department of Health, Broward County and funded with dollars from US Centers for Disease Control and Prevention. CDC, specifically for Broward County, is focused on the implementation of high impact prevention. The CDC developed strategy, High Impact Prevention (HIP) intervention plan includes: (1) prevention for HIV-positive people, (2) condom distribution, (3) increased HIV testing, (4) social marketing, and (5) structural initiatives to align policies with HIV strategies. HIP will be implemented under the guidance of the Florida Department of Health, Broward County, by three teams: Epidemiology and Research; High Impact Prevention; and Policy. There are four work groups
led by community members, one to target each of four major communities: Blacks, Latinos, MSM of all races, and Transgenders (McShee, 2013).

Broward County HIV infection rates have sounded a wake-up call to the community and HIV health leadership. Broward’s number-one national ranking has created an expanded partnership between CDC and the Florida Department of Health Broward County to ensure resources earmarked for Broward’s response reach the community. The fact that CDC has dedicated specific resources for Broward, speaks volumes about CDC’s understanding of the need and national commitment to develop capacity, infrastructure and an effective community response.

It also demands attention from a broad cross-section of social, political, health and medical, and community spheres. Opportunities for effective high impact methods and interventions exist, and federal funding has been granted to implement them. Both tried-and-true best practices—such as information dissemination and education, social media and condom use campaigns, and public service announcements—must be integrated with new and emerging technologies to better meet the complex needs of all those at risk for HIV infection and also to help to chart a course for ending the HIV epidemic.

D.2. HIV Care Planning

Unlike the recent resources described above from the CDC for infrastructure, capacity, education and services, Broward County Department of Human Services has been the recipient of federal resources from the Health Services Resources Administration (HRSA) to support care, treatment and community based supportive services for persons living with HIV for more than twenty years. And while funding has not kept up with need, community planning and priority setting for allocation of care funds are essential components of the delivery of HIV care services in Broward County. HRSA requires each eligible jurisdiction to develop and complete a comprehensive plan, and an assessment of unmet need is a critical action step before completion. Unmet need refers to those individuals who are HIV positive, aware of their status and not in regular HIV medical care and services. Key to the success of reaching these individuals is an integrated approach, inclusive of community outreach, awareness and education programs, referral and linkage to care services, early intervention services, clinical medical services, familial and community support. Voices is a component of the assessment of local HIV care and treatment needs and will contribute to the overall assessment of needs of gay, bisexual, men who have sex with men and transgender women.

To ensure culturally appropriate services and programs, a local comprehensive plan is developed and updated regularly, covering multiple years and is designed to support a comprehensive and responsive system of care that addresses the needs and challenges of the community. The Comprehensive Plan is a living document that serves as a roadmap for the provision of the federally funded Ryan White Part A continuum of care that will be used to guide program, services , policy discussions, and decision-making over a period of three years.

The comprehensive plan reflects the greater Broward community's vision and values regarding how best to deliver HIV/AIDS services. The planning process reflects a diverse perspective from members of the Broward County Regional HIV Planning Council, affiliated and unaffiliated consumers, HIV service providers, representatives of community-based organizations, and other stakeholders.

The Comprehensive Plan provides an opportunity to achieve the vision of an “ideal” system of care through review of needs assessment data, examining existing resources to meet those needs, identification and the
review of barriers to care and finally establishing priorities for funding. The Plan also aids the Ryan White Part A program in responding to changes in the epidemic, identification of individuals unaware of their HIV status and linking them to care, and to address the unmet need of those aware of their status but not in care. (BRHPC, 2013) The information from this HIV Health and Wellness Assessment Project and Exploratory Study will contribute to the overall assessment of needs of MSM in Broward. The information in this report is specific to men who have sex with men and does not negate the service needs of all persons living with HIV in Broward County. The needs of all populations are considered in the development of the Comprehensive Plan.

E. Outline of Services for those of Unknown and Unknown HIV Sero-status

Services for those men who have sex with men of Unknown HIV Sero-status can include: testing services, partner services and disclosure assistance, linkage to medical care and ancillary services, health education/risk reduction activities to addressing drivers and co-factors of HIV, community mobilization efforts, public information and social marketing initiatives, biomedical modalities such as post exposure prophylaxis, PEP and/or pre-exposure prophylaxis, PrEP, condoms, syringe access and related co-morbidities.

Services for those men of Known HIV Sero-status can include: engagement in care and treatment adherence, linkage to medical care and ancillary services, medical case management, medication access and ADAP services, HIV specialty medical care, behavioral health services (mental health and substance use services), home support and community-based medical care services, non-medical Case management services, food and nutrition services, client advocacy-related Services, emergency financial assistance, legal services, housing services, oral healthcare, on-going outreach services treatment guidelines, peer navigation.

HIV service system monitoring and evaluation activities can include: surveillance, medical monitoring, national and local HIV behavior risk surveys, special surveillance projects, such as monitoring community viral load, and local research and clinical trials.

Taken together these activities represent a systemic approach to the development of a comprehensive HIV response and the necessary ingredients for achieving development and implementation of HIV/AIDS national program goals, and for providing long-term and on-going support for delivery of HIV prevention, care and treatment services. To turn the tide on new infections in Broward County...“it will be necessary to make certain that HIV prevention services and HIV healthcare services are ‘planned together and work together...to coordinate and develop a streamlined system of care...More people need to get tested so that those who learn they are positive enter care earlier, reduce their viral load, and ultimately lessen the possibility that they will share the virus with someone else.

For persons living with HIV...it is necessary to ensure that they are supported, adhering to their medical regimens and equally educated on how to prevent transmitting the virus. Data suggests that more than fifty percent of the new infections are transmitted by twenty-one percent of people who are infected with HIV but do not know it...one of the biggest challenges to getting people enrolled in treatment earlier is getting them tested at all. Once tested, it is imperative that those who test positive begin treatment immediately...Prevention and care must not operate independently because the efforts are so closely united.” (Jones and Ullah, 2014)
Section V. MSM Communities in South Florida: An Epidemiological Profile

“South Florida is behind the times, we are where San Francisco and others cities were 25 years ago in HIV progressive education and fighting the disease.”

“My boyfriend gave it to me. I was in a monogamous relationship with him. He went out on me. He gave it to me. I want to kill him.”

“What does risk really mean? Condomless sex? Bottom only? What is it?”

Men who have sex with men (MSM) continue to fuel the national HIV/AIDS epidemic. Annual HIV infections reported among MSM in the United States increased from 28,077 in 2007 to 30,573 in 2010. MSM were the only group whose HIV case numbers increased during that period. Estimates of the number of MSM living in the United States vary. The CDC estimates that between 4% and 7% of the adult male population are men who have sex with men.

In 2007, an estimated 7.1 million MSM (≥ 18 years of ages) were residing in the United States. Florida ranked fifth in its percentage of the U.S. MSM population (7.1%). The State was behind California (8.2%), Massachusetts (7.8%), Nevada (7.3%), and the District of Columbia (13.2%). Of the 517,299 MSM estimated to be living in Florida, 67.3% were White, representing 7.9% of all White males ages 18 or older, followed by Hispanics (20.4%; 7.6%) and Blacks/African Americans (10.6%; 6.1%).

In 2010, male-to-male sex accounted for more than three-fourths (78%) of new HIV infections among men and nearly two-thirds (63%) of all new infections nationwide. HIV diagnoses of men in Florida have paralleled the national rise in MSM HIV cases. In 2011, Florida ranked second only to California in newly diagnosed HIV infections (5,408 and 5,973, respectively) and third to Maryland and Louisiana in case rates per 100,000 residents (30.6, 30.2, and 28.4, respectively). Florida ranked third to New York and California in AIDS diagnoses (3,440, 3,574, and 3,623, respectively). For adult males in Florida, the most common risk factor for HIV and AIDS in 2012 was being a man who has sex with men (75% and 61%, respectively).

In Florida, the geographic distribution of HIV cases diagnosed during the 5 years between 2008–2012 is greatest along the southeastern tip of the state in three counties which, in 2010, reported the majority of people living with HIV/AIDS (PLWHA): Miami–Dade County (25,372), Broward County (16,456), and Palm Beach County (7,853).

From 2010–2011, HIV infections rose by 25% in Broward County, 30% in Palm Beach County, and 21% statewide. Over the same period, new cases of AIDS rose by 6% to 8% in those areas. In 2012, slightly more than 45% of the state’s 5,388 HIV cases and 43% of the 2,775 AIDS diagnoses were reported from Miami-Dade County.

Section V. Highlights:
In US, more than 30,000 new infections in 2010 and 10% are living in Florida;
In Florida and Broward County males represent the greatest number of those living with HIV;
In all Florida counties Blacks comprise the population that experiences the greatest disparity;
In Broward County white males represent the greatest numbers of persons living with HIV;
In Dade County Latinos are most heavily impacted by HIV;
In Palm Beach County Blacks are the most heavily impacted by HIV.
(23.4% and 22.3%), Broward (16.4% and 13.6%), and Palm-Beach (6.2% and 7.4%) counties, respectively. HIV case rates ranged from 15.1% to 30% (Palm Beach) to above 30% for Miami-Dade and Broward, compared to the state average of 28.1%. AIDS rates for all three counties ranged from 15.1% to 30% compared to the state of 14.6%.

A. Broward County

In 2012, the estimated population for Broward County was greater than 1.8 million people. The largest share of this population was White (66.1%), followed by Blacks (27.9%). More than a quarter of the two races reporting Hispanic ethnicity. In 2012, approximately 1% of the county’s residents were living with HIV or AIDS (n=16,632) which excludes the Department of Corrections and those under 13 years of age. More than 70% of the PLWHA in the community are male. Three-fifths of the 12,873 males living with the virus were infected in male-to-male sexual contact and HIV positive White males outnumbered HIV positive Hispanic and Black males by approximately 3,000 each. By December 31, 2012 1% (n=18,030) of Broward’s adult population (≥ age 13) was living with the virus, and almost half were MSM. The concentration of PLWHA was highest in six zip codes along the mid-eastern border of the county. Case numbers ranged from 232–462 in zip codes 33309 and 33312 to 463–697 in zip codes 33304, 33305, 33311, and 33334.

The annual numbers of new HIV and AIDS cases reported for Broward decreased from 2008 to 2012 (1,476 vs. 882 and 826 vs. 377, respectively) based on a change in case definition. Males represented the majority of cases reported during the 5 year period (74.5% in 2008 and 65.9% in 2012). The country’s male HIV case rates decreased over the same years, from 125.2% to 83.5% per 100,000 people and was significantly higher than state rates (62.9% vs. 44.9%); similarly, AIDS case rates decreased (60.9% vs. 31.6%) and trumped state rates (34.5 vs. 21.3).

In 2012, 882 new HIV cases and 377 AIDS cases were reported for Broward County. HIV transmission and AIDS progression was greatest for men who reported male-to-male sexual contact. Greater than 50% of male HIV and AIDS cases (78% and 59%, respectively) occurred among the MSM population. The proportion of MSM HIV cases was highest for Whites (56.7%), followed by Blacks (22.4%) and Hispanics (20.9%); the racial/ethnic distribution of AIDS cases was 47.2%, 33.8%, and 19%, respectively. An increase in the number of HIV/AIDS cases was noted in 2013. By December 31st, 1033 HIV and 489 AIDS cases were reported for people ≥ age 13; 79% of new HIV infections were reported among males, 69% of them had been transmitted through male-to-male sex. (FHBHASR, 2013)

CDC estimates that 21% of the 1.1 million U.S. residents infected with HIV don't know it. The reasons why people resist HIV testing are many and complex and the pending consequences can be devastating. Researchers conclude that 24% to 45% of people who test HIV positive are categorized as late testers. In Broward, 168 of the HIV/AIDS cases reported in 2013 were diagnosed late. This number represents 19% of HIV cases and 39% of AIDS cases diagnosed with concurrent HIV and AIDS.

From 2008 to 2012, 3,259 HIV cases in Broward County, Florida, were co-infected with a sexually transmitted disease (STD): Syphilis, Gonorrhea and/or Chlamydia. Approximately 90% of the HIV/STD co-infected cases were male, and 92.3% of the co-infected males were men with MSM risk. The highest number of STD cases with HIV co-infection were reported for zip codes 33304, 33305, 33309, 33311, and 33334 (40–83 cases) and 33301, 33312, 33313, 33319, 33320, 33323, 33369 (16–39 cases).
B. Dade County

In 2012, an estimated 2,591,035 people lived in Miami-Dade County. The majority was White (77.6%); Blacks/African Americans made up less than 20% of the county, and all other racial groups composed approximately 3%. Approximately 64% of the population reported Hispanic heritage. One in 67 adult males (≥ age 13) were living with HIV or AIDS compared to 1 in 134 statewide. The impact of the epidemic was most pronounced among Blacks: 1 in 32 was living with the virus compared to 1 in 70 Whites, 1 in 92 Hispanics, and 1 in 106 people of other races.

In 2012, 1,262 HIV cases were reported. Blacks/African Americans were 2.4% and 3.3% times more likely to be diagnosed with HIV than Whites and Hispanics, respectively. The disparity in AIDS diagnosis was greater. Of the 620 cases diagnosed, 45.5% were Black/African American, 44.7% were Hispanic, and 7.9% were White. The Black/African American case rate was 5.2% times the White rate and 3.9% times higher than the Hispanic rate.

HIV infection and AIDS case rates decreased for all race/ethnic groups. From 2008 to 2012, the HIV case rate for Blacks/African Americans decreased from 188 to 113.1 (39.8%), a stark difference from the decrease in the rate for Whites (50.6% to 48.1%, 4.9%) and Hispanics (45.2% to 34.7%, 23.2%). The percent decrease in AIDS rates was greatest for Whites (24.9% to 12.7%, 49%), followed by Blacks/African Americans (125.5 to 65.6, 47.7%) and Hispanics (24.1 to 16.7, 30.7%).

From 2008 to 2012, males represented 75% of Miami-Dade County’s reported HIV cases and 70% of its AIDS cases. In 2012, the share of males was 79% and 74%, respectively, and MSM represented 80% of newly diagnosed HIV infections and 67% of AIDS cases reported among adult men (ages 13+). Statewide, MSM comprised 61% and 75%, of newly diagnosed HIV cases and AIDS cases, respectively. For men, sex with other men was the highest risk for all racial groups. More than 60% of the county’s population is Hispanic, and 59% percent of MSM living with HIV/AIDS are Hispanic; 19% are White; 17% are Blacks/African Americans, and 3% Haitians.

C. Palm Beach County

In 2012, 76.9% of the population of Palm Beach County, Florida, was White. About 20% of them reported Hispanic ethnicity. Blacks/African Americans were less than 20% of the county’s population. At the end of 2010, 7,678 people—8.0% of the statewide PLWHA population—were reported to be living with HIV/AIDS in Palm Beach. Sixty percent of the 3,059 PLWH were Black/African American, 26% were White, and 13% were Hispanic (60%). The majority of cases were split between people ages 20–44 (50%) and 45 and older (48%). A third of the cases were reported to be among MSMs. In 2012, 238 people were living with the virus per 100,000 residents.

By the end of 2010, 4,619 people were living with AIDS, representing an AIDS prevalence rate of 359 per 100,000 population. The majority of PLWA were Black/African American (64%), followed by Whites (22%) and Hispanics (13%). Sixty-three percent were males, 64% were older adults (greater than age 44), and 34% were age 20-44). As with HIV, sex between men was the most frequent exposure category (29%).

Highlights of HIV/AIDS trends in Palm Beach County from the Florida Department of Health Charts Database and other sources report the following. The trends indicate that since 1997—when HIV reporting began—
through October 31, 2011, 11,136 AIDS cases were reported for Palm Beach County, and 7,866 persons were living with HIV/AIDS. It is estimated that the number of PLWHA might have been 20% greater because reporting does not take into account persons who are infected but have not been tested, persons in care but whose test results have not been reported, and persons in care but whose test results were reported from another state. Palm Beach County HIV/AIDS case rates have decreased over time. Males continue to dominate the epidemic. Racial/ethnic disparities exist, and the county ranked fourth in number of HIV cases and third in AIDS cases reported statewide in 2012. Additionally during 2008–2012, 882 HIV cases and 377 AIDS cases were reported, representing 6.6% and 7.2% of cases reported statewide during the same period. The majority of both HIV and AIDS cases were reported among Blacks/African Americans (60.6 and 64.3), followed by Whites (23.8 and 18.9) and Hispanics (approximately 14% of cases for each). While a decrease over time in HIV and AIDS case rates for all race/ethnic groups is evident, in 2012, 86.6 Blacks/African Americans HIV cases were reported per 100,000 population compared to 17.3% Hispanic and 11.3% White cases. Similarly, 63.6% Black/African American AIDS cases were reported compared to 8.6% Hispanic and 4.6% White cases.

The disparities in HIV and recent surge in new HIV infections and AIDS diagnoses reported for South Florida is a wakeup call and opportunity to address HIV/AIDS by targeting MSM—the most impacted population—and by eliminating the racial/ethnic disparities that exit within the MSM population. Concerns that Broward County’s HIV numbers may be rising due to the interstate and inter-county transiency—people diagnosed elsewhere relocating to Broward’s gay areas for services and support—have also been raised. Concomitant is the question of whether Broward County is getting its fair share of federal and state resources given the size of its HIV problem and where and how ‘cases are counted’. The money needs to follow the patient, in this case, to Broward County.

D. Funding challenges in State of Florida

To address the needs of the growing population of MSM at risk for and living with HIV, the US Centers for Disease Control and Prevention and the US Health Resources Services Administration provide grants to the state of Florida. As reported in the 2012-2014 State of Florida Jurisdictional HIV Prevention Plan, of the $39.2 million in HIV prevention funding in Florida, $23.8 million (60.8%) is used to target the state’s seven priority populations.

The priority populations are: Black heterosexuals, 26.4%; White MSM, 21.8%; Latino MSM, 11.3% Black MSM, 10.5%; Hispanic heterosexuals, 5.5%; White heterosexuals, 4.6% and others, 19.9%. Black heterosexuals and other combined represent 46.3% of the priority populations. Additionally, a sizeable proportion of the HIV prevention funding in Florida is not targeted to any specific, racial/ethnic or risk group (e.g., staff positions, condoms, ECHPP) and cannot be allocated by priority population.

Thus, such funding is allocated to an “all at-risk populations” category. Funding may be used for HIV prevention efforts targeting all at-risk persons, the general public, or local priority populations (which may differ from the statewide priority populations). (FLDOH, 2011)

MSM, while comprising 70 percent of the local epidemic, comprise only 43.6% of the state of Florida priority populations—which suggests that MSM in Palm Beach, Broward and Dade counties may receive less than their ‘fair share’ of funding. Consequently funding may not go to those areas with greatest needs nor with the most at risk populations.
E. HIV Care and Treatment Funding in the Tri-Counties

E.1 In the Broward County Eligible Metropolitan Area the average per capita funds for care and treatment dropped from $2,326 in FY 2008, to $2,300 in FY 2009, and $2,186 in FY 2010. This represents a 6% decrease between FY 2008 and FY 2010, or a loss of $140 per client served by Part A. The loss of Part A funds coupled with a serious decline in ADAP funds and flat Part C and Part D funding in Broward County has created a dire situation.

HIV providers were surveyed in late 2011 to assess service capacity and identify factors contributing to service gaps. One-third of providers reported that access to Outpatient Ambulatory Medical Care (OAMC) and specialty care had worsened, while one-quarter reported that access to mental health services had worsened. Some service providers reported that it was hard to make a referral to critical services. The most common factors identified by providers as impeding HIV+ clients from starting medical services include lack of transportation, cost of care, and lack of knowledge about available services. The most common factors impeding HIV+ clients from staying in OAMC include client co-morbidities (particularly substance abuse and mental illness), lack of transportation, unstable housing, negative behavior of HIV clinic staff, appointment waiting times, and cost of care.

Among core providers, one-quarter reported that their HIV program does not have enough capacity to increase the number of HIV+ clients served and one-third reported that they could only expand capacity by 10%. Providers reported heavy dependence on Ryan White Part A funds. Part A funds comprised 55% of the average monthly HIV program revenue of core providers and 93% of support providers. All providers reported applying for other funds, but only 17% were successful in those efforts. Broward HIV providers reported structural barriers that impeded them from expanding to serve the sharply growing number of HIV+ residents (BRHPC, 2013). Inadequate Part A funding persists at a time when the prevalence of new HIV/AIDS cases in the Broward County EMA is high and growing. The life expectancy of HIV+ individuals continues to increase due to high quality services and the benefits of Highly Active AntiRetroviral Therapy HAART). Part A medical sub-grantees are experiencing sharply increased demand for visits, medications, and other services. Steady in-migration of HIV positive individuals, for which the federal HIV/AIDS Bureau does not adjust for its Part A formula awards, also contributes to the already stressed system. Increased demand for services has resulted in sharply longer appointment waiting times for outpatient and medical case management visits. (BRHPC, 2013)

E.2. Dade County Eligible Metropolitan Area faced numerous financial stresses in providing services to Persons Living with HIV/AIDS in FY2010-2011 and anticipated even greater pressures in FY 2012-2013. In May 2010, the Department of Health in Dade County informed the community that the AIDS Drug Assistance Program (ADAP) had essentially run out of money for the fiscal year due to the poor economy in Florida, increased patient enrollment, client’s lack of health insurance, level federal funding, and decreased state revenue and allocations. To address the needs of existing clients, ADAP needed to engage in several draconian cost-cutting measures, including instituting a waiting list for new client enrollments, reducing numbers of drugs and drug classes on its formulary, and dis-enrolling clients whenever possible. This shifted responsibility for non-ARV medical support to the Ryan White Program (RWP) for many clients.

At the same time, the Florida AIDS Insurance Continuation Program (AICP) instituted a waiting list because of limited funding. The AICP allows PLWHA with private insurance to maintain their insurance after they are no
longer able to work, thereby reducing the demand for RWP-funded medical care and prescription drug services. With revenues from the State reduced because of recession, the Miami-Dade HIV/AIDS Partnership raised the budget request for prescription drugs services to $2.6 million dollars, cutting support service budgets across the board to support the anticipated prescription drug needs of PLWHA in Ryan White Program-funded care and treatment in the absence of adequate ARV support from ADAP…Municipal resources have also been cut due to the County revenue shortfalls…

Most of the shortfall has been absorbed by cuts to personnel related costs, etc…however, Dade County funded support for community-based organizations, including those that support HIV/AIDS education and prevention services, had to be cut by as much as 50%. (MDHAP, 2013)

**E.3 Palm County Eligible Metropolitan County** has received a reduction of almost a million dollars, approximately 10%, in funding since 2005. Further cuts have led to additional reduction or and the elimination of some support services. The impact of reductions on the Continuum of Care has had a detrimental impact, and will continue to do so if funding cuts continue. The implementation of the 75%-25% medical/support category and the restructuring of core medical and support has severely impacted the provision of support services to the PLWH/A community.

Resources from the State of Florida such as the Florida State Part B Supplemental, ADAP and AICP have been reduced for the Palm County Eligible Metropolitan Area. Both ADAP and AICP invoked waitlists over the last few years, which has led to Part A funds having to close the gap for some client services.

Due to all of the factors mentioned above the CARE Council prepared for cuts with the creation of a budget for an overall reduction in funding. This budget holds much of the medical services harmless and reduces funding for the support services. Additionally, the CARE Council is working with the Grantee on the cost savings measures described including the reduction in costs for medical and non-medical case management (supportive), implementation of a Peer Mentor Program, and revising the eligibility criteria. As more PLHWA come into care each year the cost for medical services increases. Accommodating the medical service needs is a top priority. In order to do so, funding for support services has been and will continue to be reduced or eliminated completely. Although Palm Beach County understands that in many instances the receipt of support services allows clients to remain in care, in an effort to reduce cost for services, minimal support services are provided rather than elimination completely. (Care Council, 2013)
With reductions in funding on the federal, state and local levels, HIV prevention, care, treatment and support services in Broward County and its sister counties have been reduced at a time when demand is increasing due to successes in treatment. To address the budget challenges within the county, Broward health and human service leadership has agreed to develop a new strategy for working together and integrating the countywide response thereby eliminating duplication and redundancy in programming along the HIV care continuum. This integrated planning is encouraged by the US Centers for Disease Control and Prevention and the Health Resources Services Administration in a dear colleague letter in the spring of 2013.

May 22, 2013

Dear Ryan White HIV/AIDS Program and CDC HIV Prevention Colleagues:

The Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) are pleased to support integrated HIV prevention and care planning groups and activities. Integrated planning, reports, and activities will help further progress in reaching the goals of the National HIV/AIDS Strategy.

HIV prevention planning groups supported by CDC review existing resources, needs, gaps, current activities, and impacted populations for HIV prevention services and develop a jurisdictional HIV prevention plan that guides HIV prevention activities. The Ryan White HIV/AIDS Program planning groups supported by HRSA are required to annually plan, prioritize services and recommend allocation of resources to address the HIV service needs of people living with HIV (PLWH). Implementing a comprehensive HIV prevention, care and treatment planning body provides an opportunity for integration, synergy, and efficiency in responding to jurisdictional needs and federal requirements, and these have been successful in many states and local health departments.

Good planning is imperative for effective local and state decision making to develop systems of prevention and care that are responsive to the needs of persons at risk for HIV infection and PLWH. Activities to collaborate and/or develop a joint planning body are supported by both CDC and HRSA. Community involvement is an essential component for planning comprehensive, effective HIV prevention and care programs in this country. Integrated planning activities may include but are not limited to, needs assessment activities, information sharing, cross representation on prevention and care planning bodies, coordinated/combined projects, combined meetings, and merged planning bodies. Planning groups are encouraged to streamline their approaches to HIV planning in a manner that increases access to and effectiveness of prevention, care and treatment services within the jurisdictions.

We look forward to our continued work with all our partners and stakeholders involved in HIV prevention and care and treatment planning and our continued work to accomplish the goals set forth in the National/HIV/AIDS Strategy.

Sincerely,

Jonathan H. Mermin, M.D. M.P.H. Laura W. Cheever, M.D., ScM
CDC HRSA
Section VI. HIV Health and Wellness Exploratory Study Design
The HIV Health and Wellness Exploratory study was conducted in two component parts: HIV Prevention and HIV Health and Wellness. The study utilized a mixed method approach to data collection, including focus groups, surveys, informant interviews and a community advisory group.

A. Unknown HIV Sero-status, Informant Interviews and Focus Groups

The Unknown HIV sero-status sample reflected the demographic profile of men and transgender women who are of unknown HIV sero-status, at risk for HIV transmission living in Broward County. The sample consisted of persons who regularly participate in HIV prevention services as well as those who do not and identify as a man who has sex with men, a gay or bisexual man and a transgender woman.

A.1. Focus Groups

Focus group participants were recruited by providers and agency staff funded to provide HIV prevention services. Participants were asked how much they understand HIV/AIDS, testing and safer sex behaviors. Focus groups were conducted to engage MSM in discussions that enable them to, in a sense, “go beyond” and elaborate on their beliefs, opinions, and experiences. Seven focus groups, with a total of 31 participants were held with persons identified through outreach to agencies, businesses frequented by gay and bisexual men, community based prevention providers, prevention case managers, and HIV testing sites. The focus groups provided additional in-depth qualitative data on issues not usually accessed through on-line interviews. Focus group participants reflected a cross section of men, representing different subgroups within the MSM population: different age cohorts, different race/ethnic groupings, and the presence of different co-morbidity issues such as substance abuse and mental health. Two additional focus group were added to insure the participation of transgender woman at risk for HIV.

A.2. Informant Interviews

Informant interviews were conducted with staff representatives from local Broward County organizations and agencies funded to provide a variety HIV prevention services. The selection of those interviewed was inclusive of agencies serving or representing the various socio-cultural groups and geographic areas in the County. Providers from both public and private agencies involved in the delivery of HIV prevention services to different age groups, different racial/ethnic groups, groups of different socioeconomic status, and groups with different co-occuring problems were engaged.

PART B: Known Sero-status HIV Health and Wellness Interviews, Focus Groups, Surveys

The Known HIV Sero-status, HIV Healthcare and Wellness sample reflected a demographic profile of men who are living in Broward County with representation from gay and bisexual men living with HIV in the County. The sample consisted of HIV positive persons of known HIV sero-status who identify as a man who has sex with men, a gay or bisexual man who also participates in HIV care and treatment.
B.1. Focus Groups with MSM

A sample of 54 men diagnosed with HIV was identified for the HIV Health and Wellness Assessment component of this study. Participants were recruited from HIV care, food and nutrition, housing and social support programs. All Known Status HIV Health and Wellness focus group participants were invited to complete a client assessment survey which included questions about their demographic characteristics, their HIV care and treatment experiences, their general life experiences since their HIV diagnoses and their social and sexual experiences. In addition, participants were asked to share information about co-morbidity issues. An additional focus group was added to insure the participation of transgender women living with HIV.

B.2. Interviews with Community Healthcare Providers

Interviews were conducted with community based HIV healthcare providers. The selection of those interviewed was inclusive of agencies serving or representing the various socio-cultural groups and geographic areas in the County. Providers from both public and private agencies involved in the delivery of medical services to different age groups, different racial/ethnic groups, groups of different socioeconomic status, and groups with different co-occurring problems were be engaged.

B.3. Client Assessment and Sexual Health Surveys

Two surveys were administered to the participants of the HIV Healthcare and Wellness focus groups. The client survey asked participants to share basic demographic information, their experiences using HIV healthcare services and any areas of unmet need. Participants were also asked to complete a survey on their social and sexual experiences since their HIV diagnosis.

C. Data Triangulation and Analysis

The study utilized a variety of data sources (described above) to gain insight into the HIV related concerns and needs of gay, bisexual men who have sex with men and transgender women, and those who serve them. Data collection included focus groups, informant interviews; and surveys. Data analysis involved members of community advisory group and key informants who helped to affirm the course and direction the study was taking, providing a critical data exchange feedback loop. Data from each source was collected, shared, discussed and compared as part of a data feedback loop and exchange with advisory group members, key informants and stakeholders in an effort to cross validate what was being found, illustrated and discovered.

The Community Advisory Workgroup met each month during the design and data collection phases of the study. Members of the study research coordination team met with the Community Advisory Workgroup from the outset to discuss any suggestions, insights, ideas for implementing the study, to provide the community members with regular updates and to ensure that the research team was continually updated about the needs of gay, bisexual, non-identifying men who have sex with men and MtF transpersons in the greater Broward community. Chief among the activities of the Community Advisory Workgroup was the data feedback loop and exchange of information from the focus groups, key informant interviews and initial observations. As information flowed in from the data sources it was shared in the Workgroup meetings.
Some of the early observations and findings shared and discussed included:

- emergence and identification of gay Broward;
- the ever present circuit party scene;
- denial, shame and stigma as risk factors;
- lack of basic and on-going HIV treatment education;
- age cohort differences among those at risk for HIV and those living with HIV;
- the need for culturally competent services for LGBT persons at risk for HIV;
- the need for alternative options for gay and bisexual men beyond the on-line hook ups and party scene;
- the discreet needs of transgender women;
- the substance use and abuse issues among gay, bisexual men who have sex with men and transgender women; and
- the need for a place to discuss the needs of gay, bisexual men who have sex with men.

The information/data collected from the Unknown HIV Sero-status component of the study, the informant interviews, focus groups and community observations as noted above were collected, reviewed and shared with members of the community advisory group to determine areas of agreement, consistency as well as difference and divergence. This process was repeated for the Known HIV Sero-status HIV Health and Wellness component of the study. Descriptive analysis of the survey results offer a demographic profile of the overall study participants, noting age, race/ethnicity, immigrant status, home zip code, and other demographic information. The data collected presented a snapshot of participants’ beliefs, attitudes, knowledge base, HIV health care utilization, and HIV/AIDS history.

Findings from each component are presented using three principle formats: verbatim responses presented in italics and quotation; summary highlights, and diagrams. This approach allows the participants to speak for themselves as much as possible, keeping true to their words and intention. The summary highlights in paragraph form are used to describe context and present generalized comments that were expressed by each focus group as a whole. Finally, the diagrams are used to present descriptive quantitative data in the aggregate.

The goal of the findings section is to provide a portrait of the lives of gay, bisexual and other men who have sex with men and transgender women at risk for and living with HIV. By presenting the socio-sexual-cultural contexts of MSM’s lives in the most true to life manner first, then to offer a fresh understanding based of the experiences of the study participants, it is hoped that the information will inform the design and implementation of prevention care and treatment individual, community and structural interventions.
Section VII. Review of Assessment Project and Exploratory Study Components and Findings

“We are talking about names, people, not just numbers on a sheet of paper.”

“Doctors have to ask about drug use.”

Voices, the 2013-2014 HIV Health and Wellness Assessment Project and Exploratory Study seeks to assess and understand the current realities of gay, bisexual and other men who have sex with men living with and at risk for HIV from a qualitative methodological point of view. Qualitative research methods were utilized to help define the HIV realities for gay, bisexual men and transgender women; to help to identify and explore gaps in knowledge related to HIV transmission and treatment services; and further understanding of the challenges facing those living with HIV. Specifically this exploratory study utilized qualitative methodologies that were designed to assist in gaining a better glimpse into the lives of gay, bisexual, men who have sex with men and transgender women; a clearer understanding of risk behavior and choices; a greater knowledge of the realities of those living with HIV. The study also included queries about what the HIV service network providers can do to improve Broward County’s HIV response overall.

The study employed a subset of qualitative methods, namely anthropological methods, for data collection. These methods included: participant observation; informant interviews; surveys, focus groups; and an HIV community advisory group. The exploratory study was conducted to provide an update on the following:

- Socio-sexual-cultural context of gay, bisexual and other men who have sex with men;
- Emerging gay community in Broward County;
- Epidemiological profile of MSM in South Florida;
- Impact of HIV/AIDS on general and sexual health well-being;
- Mental health, substance use, homelessness; and
- Participation in on-going HIV medical care, supportive and prevention services.

The exploratory study was divided into two primary components: Unknown HIV Sero-Status Component and Known Sero-status HIV Health and Wellness. The study design utilized a mixed-method approach to data collection, which included informant interviews, focus groups, paper and pencil surveys, community venue participant observation, and a community advisory group. What follows are the findings for the informant interviews and focus groups from each component.
Part A. Unknown HIV Sero-status Study Component Descriptive Findings

A.1 Findings from the Providers of Prevention Services Informant Interviews

“Primary symptom of stigma and shame is to hide, and that keeps people from talking and telling their story. People have to be more empowered.”

Twelve informant interviews were conducted between December 2013 and January 2014. Providers from HIV prevention, care and treatment agencies, community stakeholders and members of the HIV prevention planning body were asked to answer a series of open-ended questions about the local HIV epidemic. Respondents were asked to share their opinion about factors that contribute to the spread of HIV in Broward County and factors that contribute to successful engagement in HIV prevention, care, and treatment. Interviews were conducted with staff representatives from AIDS Healthcare Foundation, SunServe, Broward House, Care Resource, Pride Center, Latinos Salud, M Project, South Beach AIDS Project, LIFE Project, and several local business owners.

The interview questions asked the key informants to identify three factors that, in their opinion, contribute to the spread of HIV among gay and bisexual men, other men who have sex with men, and transgender women in Broward County.

The respondents from prevention agency and community identified a range of factors, behaviors, and issues that were confronting these men and women and that were contributing to the spread of HIV. Factors identified were:

“They don’t identify as a man who has sex with other men…denial.”

“There exists a real and persistent lack of education about HIV and transmission risk. People still act under the idea that you can tell if someone has HIV.”

“There is something I call low-risk sensitization due to the media exaggeration of the effectiveness of treatment and the ‘cure’ is just around the corner.”

“It has become clear there is a real lack of communication skills among gay men and their partners. They do not know how to deal with intimacy or how to navigate a healthy sexual relationship.”

“Fort Lauderdale is a party town...we are known for this. Need to get the bar owners and the party promoters involved. Until then, nothing will change. In fact it is getting worse.”

“Drug and alcohol intersection with sexual expression. All the ads and online apps ask about BB or bare-backing, Do you BB?”

“Substance abuse and alcoholism…and they are not accessing services.”
“Too many restrictions on how to expand HIV testing, how to use the funds. There are structural barriers. If we are serious about addressing HIV, we need to remove the barriers.”

“Mental health issues, depression, low-self-esteem, loneliness.”

“Prevention education is not in the forefront of the local HIV response. Folks are tired of the safe sex message. People tune out the HIV message.”

“Non-use of condoms…no one uses them anymore.”

“We need more conversations in the Trans world. Condoms interfere with how things function. The girls prefer ‘skin to skin’…the sex is more exciting and more rewarding.”

The study’s key informants suggested actions that could be taken to mitigate the influence of the factors that they had identified. Their suggestions ranged from offering basic HIV prevention education services to expanded social marketing programs to employment services and life skills training.

“We need culturally appropriate social marketing.”

“We need an ongoing anti-stigma campaign that helps to create a safer community environment.”

“Education, actually doing more of the HIV 101 classes with substance abuse intervention services”

“Expand peer education program. Give the guys who have been living with HIV the longest something to do. Give them some value. The younger gays need the older gays.”

“We need more employment. Many come here looking to party and end up moving in with someone, having sex the way they want it because they have no money and no place to live.”

“Establish a new community norm. You do not need to get HIV. It is preventable.”

“Better balance between programs that provide information/education and programs that help people develop better skills. Relationship and communication skills are different from information and knowledge. The gay men we see need life skills, relationship skills.”

The participants in the informant interviews were also asked to identify the socio-cultural, economic, political, spiritual, and environmental barriers that contribute to the spread of HIV among MSM in Broward. The majority of the respondents emphasized the need to address stigma.

“Shame and stigma, disclosing status are core issues. People have to feel loved—and they are looking for validation through sex. What is my value, what is my self-worth?”

“People are living a dual reality with lots of secrets. It is very difficult to deal with the fear of ‘someone finding out’ the truth, worrying about being ‘sinful,’ and feeling broken and afraid of HIV.”

“Conversations cannot just be about sex. Comfort with true identity, self-worth, equipping people with real life skills, communication and negotiation skills have to be the goals of HIV prevention programs.”

“No one is accountable to the local HIV epidemic because the revenues coming in are too good.”

“The South Florida porn industry is where L.A.’s used to be. Not using condoms. I can get $500 for 3 hours of condom-less sex in South Florida.”

“Broward is a sex charged community.”
Finally respondents suggested the following program improvements and new directions.

“We need to start to increase testing—increase everyone’s knowledge of their status.”

“Need to get the word out about PrEP. Not just PrEP alone, all together with all of the prevention strategies.”

“Home test kits need to be everywhere in the gay community. Every service provider should offer them to their clients.

“Need more concentrated events, health fairs, and other HIV awareness educational events. More test sites that are discreet. Need more vans. Put information in the church bulletins.”

“Everyone is busy...we need to change the community norms. We cannot do it ourselves.”

A.2. Unknown Sero-status Focus Group Summaries

“It’s more difficult for me to get older than to have HIV.”

“They gave it to me so I’ll give it to someone.”

“HIV stops with me...when I die.”

On December 9-11, 2013, a series of focus groups were held with men and transgender persons of unknown HIV status. The purpose of these focus groups was twofold: (1) gather information about the socio-cultural context of the lives of gay and bisexual men, other men who have sex with men, and transgender persons and (2) to ascertain their opinions about what could be done to prevent the spread of HIV in the greater Broward County community.

In the more than 30 years since the first cases of HIV were identified, much has changed. More than 1.4 million people in the United States are living with HIV. Approximately 40,000 persons are infected every year. Once infected, many of them unknowingly place others at risk of HIV because they are not aware of their own HIV-positive status. To reduce transmission and risk of infection, HIV prevention and risk reduction services have focused on education, HIV counseling and testing, behavioral interventions and cutting edge social marketing. The combination HIV prevention approach has helped to bring the incidence of new infections down from an epidemic-level 90,000 to less than 40,000.

The focus groups with men and transgender persons of unknown HIV status engaged gay and bisexual men, other men who have sex with men, and transgender persons in a non-threatening environment to, in a sense, “go beyond” the generic discussions on HIV. The focus groups also provided participants with an opportunity to elaborate on their beliefs, opinions, and experiences related to the broader Fort Lauderdale community, HIV in general, and how to prevent acquisition of HIV in particular. Six focus groups, with a total of 31 men and transgender persons, were conducted. Focus group participants were identified through outreach to community-based prevention providers, prevention case managers, and HIV testing sites. Focus group participants reflected a cross section of the characteristics of those most at risk for and living with HIV: men who have sex with men of all races and ethnicity, transgender women, and youth of color.
The focus groups were held in the afternoon and early evening and lasted for between 1 and 1.5 hours. Focus group respondents were given incentives in the form of $25 grocery store gift cards. The HIV prevention focus groups were facilitated by a psychologist.

The discussions and comments from the Unknown HIV Sero-status focus groups provide a glimpse into the community and cultural context of the lives of those most at risk for HIV infection in Broward County.

### A.3 Unknown HIV Sero-status Focus Groups

#### Descriptive Findings by Demographics

#### A.3.1 Latinos (gay males)

“Latinos trust and listen to Latinos with cultural discretion.”

Culture impacts behavior. It plays a strong role in the lives of some Latino men who have sex with men. Among males, machismo is expected and respected from early ages. Men who fail to demonstrate these character traits are ostracized and condemned by the community and especially other males. Latino men who identify as gay, bisexual, or MSM question their self-worth and possess low self-esteem.

These are often the residual psychological and emotional effects of cultural beliefs that were passed on during their upbringing.

Several outside influences affect Latino culture. Religion in general and the Catholic Church in particular play a dominant role. The Pope and his doctrine determine choices people make regarding sex and sexuality, gender roles, condom use, contraceptives, and general health practices. As a result, Latinos tend to stigmatize homosexuality and believe “HIV is something outside that affects other people or does not affect us.” Those who do practice homosexuality or identify as gay do not seek public health information or education out of “shame.” the “community” in southern Florida is so spread out that “somebody could find out and tell somebody in your family.”

Like others, Latino MSMs see South Florida as a number-one destination for gay people. This fact helps to market the area and the open and accepted gay lifestyle. “People come here and lose their inhibitions.” “Men want their moments of pleasure,” and HIV prevention messages are the last things they want hear. The vacation traffic influences the locals, and both visitors and locals participate in “substance use such as drugs and alcohol.
that impairs their thinking and often accept *barebacking* as a lifestyle.” This wrong-minded thinking and as one focus group member put it “this bad information” gets acted out and repeated consistently until the larger community is impacted. Young MSMs are particularly at risk as they are too “focused on partying and expressing their sexuality,” especially if they are born outside the United States. Too many young gay men have “too few or no positive role models, therefore they have little information on how to protect themselves sexually.” In Broward County, the Latino community is divided and impoverished and denial plays a role in potential HIV infections. Some MSMs who have migrated from other areas might take on a “friend with benefits” and willingly compromise his own health status in order to help financially support his extended family locally or back home. Immigration status and complications keep some men from accessing medical treatment out of “fear” of deportation.

In order for messages to be effective in the Latino community they must be communicated by a “trusted” medium in ways that are consistent with its culture. In this community, “a picture is worth a thousand words, and prevention messages MUST use them.” Family would be the most successful medium if the barrier to getting families to discuss the issue were possible. One set of messages should be adopted for use by families and parents. Another set should be adopted for use by children and youths. Then, still another set – one that is totally different from the others – for the club crowd and the general public. In the Latino community, these three demographics are often worlds apart. “Latinos need to see themselves in HIV care situations.” They will “listen to information if it comes from celebrities, people they see every day in *telenovellas* (soap operas), or movie stars.” They “do not trust the health department.” Those who come to the “community with HIV messages and testing MUST be Latino and in unmarked white vans,” or else community members will not respond.

### A.3.2 African-American MSM (mature)

“*Black folks need to stop condemning and start loving...God loves us too.*”

Mature African-Americans men who sleep with men (AA-MSM) believe that their demographic takes sexual risks for various reasons but share similar outcomes. Condom use is more often espoused than actually practiced: “It’s the right thing to say.” Yet behind closed doors and when the opportunity to feel affirmed or receive affection from another presents itself, personal responsibility and values evaporate. Recreational drug use is not as frequent among African-American MSM as it is with their White counterparts, though it is used. They believe that under the influence or not, acceptance and acknowledgement from another man outweighs prevention precautions or options. When a potential sex partner shows attention, interest, or attraction, that mere demonstration “will keep you from doing anything that might jeopardize or threaten getting laid.” Thus the acts of negotiating safer sex, of suggesting condom use, or of communicating openly about sexual needs, interests, or even HIV status are not considered. The personal affirmation overrides any potential risks.

African-American culture dictates belief and behaviors via its known social structures. The Black Church is one of the most prominent and powerful social structure in the Black community. It is perceived by some to be ‘homophobic’ and heavily influences the collective belief systems in many parts of the Black community. Since some religious institutions condemn homosexual practices as sinful and/or “the work of the devil.” many Black gay men who have been brought up in the church believe they have been brainwashed to hate themselves. After “being beaten up on enough and told you are no good so much, after a while, you begin to believe and accept it.” “You are condemned by the church, and the devil is in you.” “No one really cares about us.” Phrases
and comments such as these permeate AA-MSM discussions, and they reflect men’s low self-esteem, little or absent self-worth, or feelings of inadequacy. Friends are seldom strong enough to help friends because they battle the same “demons” of self-hatred, depression, poverty, social alienation, or rejection from family and society. It is as if being black and gay is a double-curse.

As a result of community pressure denial is the main barrier to effective communication in dealing with HIV in the Black community. “People don’t talk to each other: parents don’t talk to their children, family members to their family members, or friends to friends. There is a huge issue related to “shame” for being gay, or practicing homosexuality, or having a gay family member in the community. Children learn about sex and sexuality from their peers and bend to peer-pressure and myths. These children become practicing adults, and stigma and prejudices are perpetuated. The majority of the black community feels that HIV does not affect them, so they have no interest in education or information about prevention messages. Some gay African-Americans feel the health department, the churches, and the medical community are all too “casual” about the high infection rates and turn blind eyes to avoid facing the issues. Making HIV testing and screening routine for all might be the best approach to turn denial and misinformation on their head and reduce HIV and AIDS rates.

A.3.3 African-American MSMs (young)

“It worked for cigarettes and seat belts, so maybe we should go back to scaring folks.”

For young African-American MSMs, the fact that sex is too accessible and anonymous is at the crux of high and increasing infection rates in southern Florida. “This is an extremely sensual lifestyle and relaxed environment…people come here to undress, have fun, and have sex, and the atmosphere actually supports it all.” Another perspective says that the problem is rooted in the culture and social politics of the region. Some believe it is a “closeted” area, where things like sex and sexual identity are not openly discussed or communicated. Local “bisexual” and married men and vacationers merge at a gay oasis, where risky MSM behaviors are normalized, promoted, and abundant. Modern communication technology has only increased the interactivity and eased the exchange via smart phone apps and the Internet. Safe havens exist at clothing-optional gay resorts, bathhouses, and bars that attract clientele from locations in the U.S. Midwest, Europe, and the world. South Florida’s proximity to the Caribbean—places like Jamaica and the Bahamas, where homosexuality practices are taboo—afford a kid-in-the-candy-store outlet for visitors who may be under-informed about HIV prevention practices.

The Black community owns its own set of challenges and barriers according to young, Black gay MSM. Sex education in the schools is not comprehensive. It fails to provide instruction on diverse sexuality and gender identity. “At home, parents fail their children in the same way, out of their own ignorance” and because of discriminatory belief systems. In southern culture, people may feel uncomfortable discussing sex and sexuality. As a result, communication on topics regarding STD prevention and the inundation of HIV prevention messages in public arenas is hindered or encumbered by ignorance, shame, or fear of self-indictment. Even among Black gay MSMs, there exist tacit “don’t ask, don’t tell” agreements regarding HIV status. In online ads and on popular gay Internet cruise sites such as Adam for Adam and Grindr, “everyone lies and is negative and plays safe.” However, the truth is apparently far from reality as infections continue to skyrocket. Several young African-American gay men believe there are “more HIV positive than HIV negative gay black men in the area.”
“Tourism, the budding local porn and pharmaceutical industries feed HIV here.” “No one is accountable to the local HIV epidemic because the revenues coming in are too good.” According to one young Black man who has sex with men, no integrity, no honesty, no trust, no self-esteem, and no self-confidence contributes to the problem. Black people “need to take their health more personally and more seriously.” Fear used to be an effective incentive for keeping people mindful and “conscious” about HIV infection. “It worked for cigarettes and seat belts, so maybe we should go back to scaring folks.” African-Americans have to be made to realize there are some things more common in “our community like high-blood pressure and heart disease and HIV.” Prevention messages “must be re-invented to tell people what they need to know but might not want to hear. They should tell people what they do not know and have no reliable and trusted source to ask.” Prevention messages must also affirm that everyone “has the personal power to care about themselves, their families, and their loved ones no matter their lifestyle or sexuality.”

A.3.4 Transgenders (young)

“...the message is the same; Trans people do not deserve love.”

The Trans community is very closed and “disconnected” “We hate ourselves and the community hates us.” It is not news that Transgender people must contend with issues that result in low quality of life. This is as true for Transgender people in South Florida as anywhere else. Stigma remains the overriding force in their lives, and with it comes discrimination, violence, and poverty related to inability to hold or get employment. A lot of the same discrimination that Transgender people experience outside their community also exists within the community. “We are more alike than we are different, but still we don’t talk to each other, try to help each other, or communicate among ourselves.” Yet there exists have a common bond: they are all undergoing transformation in their lives.

Mature Trangender who have lived through the evolution of the AIDS epidemic feel that HIV infection has been “glamorized.” Too many advertisements on billboards, in magazines, and others places show too many “smiling faces” of people with great bodies and in “romantic relations.” The ads seem to scream, “We’re HIV and proud.” Some believe “the old fears have diminished,” and that the fear needs to come back to bring people back to the “reality.” They maintain and remember, in the past, the scare tactics of seeing visible skin lesions, having to take a lot of pills, and succumbing to inevitable death, changed behaviors. So much of the progress made in the prevention fight came as a result of folks, getting their act together ”cause they wanted to be pretty and not look like that.”

For a group of African-American transgender people, race and culture cannot be ignored. In the Black community and family, “maleness” is admired and held in high-esteem. If you did not fit into that mold, you were at “a huge disadvantage.” Because religion and the Black Church affirmed this notion of maleness, being gay—not to mention a “femme”—could feel like an affliction, “some kind of sick disease that is for White folks.” You were an immediate “outcast” even in your own family. The role of the church was so strong it had a mental and detrimental effect on my “self.” “Today, I can be getting it on with some hot man and going through my mind is if my soul will go to eternal hell for this.” As if it were not enough to be ostracized by family and community for being gay, being Black in American society exacerbated things. As one participant explained, her already injured values related to self-esteem, self-worth, and self-perception were further damaged on learning that because of her “skin color and race she is less” than others. The message is not much different for
African-American Transgenders within the larger Trans community. “Because we do not meet a certain standard of beauty, then we cannot be beautiful, it’s the same thing Black women were told for years.”

“People go out of their way to put you down.” Among other transgender women and within the gay community the animosities are felt and conveyed “with venom”. Wherever transgender people go, “the message is the same: Trans people do not deserve love.” No wonder then that the hatred and violence perpetuated against the Trans community is so prevalent and, unfortunately, accepted as a way of life. Popular culture continues to facilitate and enable a sense of “hate” toward the Trans community. Rap music with its homophobic rants and lyrics that hail masculinity and male prowess, openly condemns homosexuality and representations of male gender ambiguity. The phenomenon of rap music and culture, which was once predominantly Black, has spilled over into the young White community, where many emulate it. In several major American urban centers, violence against and murder of Transgender people go uninvestigated or unsolved. This inaction sends a resounding and alarming message that underscores the Trans community’s negative self-perception.

With the apparent and severe damage to Transgender people’s self-perception and the Trans experience, HIV prevention messages first need to address values such as self-esteem, lifestyle, and community. “No one else is going to take care of us, so we better start to look out for ourselves.” Since “escorting” is an accepted lifestyle that many male-to-female Transgenders adopt, HIV prevention messages about condom use are essential. Messages must also be directed toward “johns” and men attracted to transgender escort services. “Condom companies need to ‘get it’ when men say the condoms are too uncomfortable, or not big enough and they mean it. They need to hear it!” Transgender women could, themselves, benefit from revisiting some of the basic tenets of self-preservation: “love yourself,” “come together,” and “get involved—“be seen.”

A3.5 Transgenders (mature)

“Trans girls don’t have any choices...”

Some Transgender women believe that sharing syringes through illegal hormone access is increasing the rate of HIV infection among their peers, especially the young. Others are convinced that a sense of “powerlessness” related to their demographics, socio-economics, and blatant discrimination impacts their inability to negotiate condom use and other safer sexual practices, or overcome their own low self-esteem issues due to consistent societal rejection for their lifestyles. “Trans girls don’t have any choices...”

Discrimination is the overriding factor in the lives and lifestyles of most Transgender women. More mature Trans women recount the fear and self-consciousness they experienced with medical professionals who “mistreat,” “disrespect” and “spitefully misuse pronouns” to degrade or offend. “We live in the shadow of society” and are “made to feel we belong there, in the shadows, or not to be here at all.” After families learn the orientation of their transgender relatives, bigotry is a way of life. Bigotry also affects their lives on the streets, in the workplace if they are able to find employment, and in other facet of society. The lack of a social security card is a barrier to getting a W-4 or being a considered for a job. After a legal change in gender identity, transgender people must await assignment of a new social security number and receipt of a new identification card. Official gender records must match appearance. In the meantime, the lack of this important government-issued documentation prevents some transgender people moving on with their lives.

Transgender women who are lucky enough to get hired face harassment and personal attacks by co-workers with no managerial support or recourse; toilet-use restrictions, e.g., “you are not permitted to use either gender-
designated restroom”; or confront dress codes, physical health and safety issues that others never have to endure.

Job discrimination and the barriers to mainstream employment leave transgender women with few other options outside of escort and sex work. As a result, these women have more sex than average individuals and with a higher number of partners over a short span of time. “It [sex work] is the only means to an end of eating or not, having some place to sleep or not, or just getting along.” The last thing “a girl will do is argue over condom use or safe sex if it’s going to get in the way of making her money.” “Trans girls don’t have libidos, they have bank accounts.” Moreover, for some, the “riskier” the mode or activity, the more “money you get paid.” Powerlessness is not only a lifestyle; it is “her only option.”

Most men who “deal” with Trans girls believe they are not at risk as long as they are “doing the going in” or are in the “top” position or active sexual role. Most Trans girls “don’t want to know their HIV status as a defense against HIV infection criminalization.” They can always say, “I didn’t know!” In bars and venues frequented by transgender women and the men who are attracted to them, it is not uncommon to find individual “johns” who are considered “community pieces” because they are well-known and are sexually active with several of the “girls.” And they are comfortable practicing unsafe sex which spreads HIV infection and other STDs.

Finally and most critically, many mature Transgender women are convinced that HIV is transmitted through illegal hormone use from shared syringes. “On the street, the same $4.00 hormone shot you pay for in a doctor’s office costs $50 bucks and all the girls in the room use the same needle.” Some see younger Trans girls falling into this “trap” out of desperation “to become real women;” avoiding the fear and loathing from dealing directly with legitimate medical professionals and avoiding disrespectful behaviors. They say that, because younger Transgender girls “missed” the horrendous scene and experiences of the 1980s, when HIV and AIDS devastated the gay communities nationwide, they believe the infection is treatable with one pill.”

Transgender women do not make it a priority to accept personal accountability and responsibility. Though they might view these qualities as important, other more basic considerations overshadow them. Survival is not a choice. “We are at the bottom tier of society,” one mature Transgender women said. “A girl's gotta’ think about where and how she’s gonna sleep and eat...and it ain’t got to do with wearing a condom.” Still, some take a more civil stand and demand that federal policy and social justice actions pave a way that leads them out a powerless survival mode. “Despite society’s response to us, there is a place for us in this world.”

A.3.6 Long-Term Thrivers, sometimes referred to as survivors (white and gay)

“Lack of personal responsibility and shame are limiting us”

Social interactions and dynamics at play in HIV among MSMs in southern Florida are complex and intricate. No collective identity exists and intra-group differences inflict a disconnection though many groups share the same social and sexual experiences. To label a few groups, bears, trans women, twinks, Blacks, Latinos, femmes, butch clones, muscle studs, leather, and the closeted bi-men, the HIV positive and the HIV negative men all share in the common practices as men who sleep with men (MSM) but clearly share little common ground except for where they live and socialize.

Common themes emerge among all these groups and individuals. The themes include lack of self-esteem, lack of connection or communication, and denial surrounding personal perception and responsibility. Blacks feel
inferior to white and HIV positives feel rejected by HIV negatives. Men who do not identify with being gay men yet participate in sexual activities with other men are outcasts or preyed on once their behaviors are exposed. Poverty limits the have-nots from associations with the haves; and some men who are HIV positive are perceived to hold a “privileged” status as they have access to better and focused healthcare, “wellness” education and opportunities, and financial support in the form of disability assistance.

“South Florida is behind the times, we are where San Francisco and other cities were 25 years ago in HIV progressive education and fighting the disease.” Residents believe the Southern Florida mentality is to blame. “So much is so hidden, and the Internet has created greater access to sex and increased hiding in the dark and denial for gays, MSMs, married men, etc.

Existing and current prevention “messages” are no longer effective and the sources of these messages and campaigns are not respected, valued, or revered as they do not take into account the diverse “cultural” perceptions of the populations. African-Americans and Latinos and other racial minority groups honor church and religious doctrines and dogma. Until these strong community forces change, there is limited chance their community constituents will be able to hear the messages and change their behavior. People, who feel shame or are made to feel shame about their behaviors, very often suffer from low self-esteem and take risks. Increased HIV infection is the outcome.

Drug use is prevalent and clouds critical decision making in sexual relations. Bars and bathhouse are inundated with signs, slogans, and campaigns but “no one pays attention because of the over-kill.” Apparently, new and novel approaches need to be designed, identified, and implemented. The newly re-located gay porn industry and gay international tourism exacerbates the current HIV infection rate hikes. Southern Florida is viewed as the new international gay scene, where the dream of sun and fun with no responsibility reigns.
B.1 HIV Care Informant Interviews

“They do not understand health care coverage. They are afraid to come into care for fear of the bill.”

Twelve informant interviews were conducted between January 2014 and March 2014. Providers from HIV care and treatment agencies, community stakeholders and official members of the Ryan White Part A HIV Planning Council were asked to answer a series of open-ended questions about the local HIV epidemic. Respondents were asked to share their opinion about factors that contribute to the spread of HIV in Broward County and factors that contribute to successful engagement in HIV care and treatment services. Interviews were conducted with representatives from AIDS Healthcare Foundation, Poverello, Broward House, Care Resource, HOPWA, LIFE Project, Memorial Healthcare, Broward Health, Department of Children and Family Services, Legal Services, RW Planning Council, elected officials and several local business owners.

The interview questions asked the key informants to identify factors, in their opinion, that contribute to the spread of HIV among transgender women, gay, bisexual and other men who have sex with men in Broward County.

The HIV care and treatment program agency and community respondents identified a range of factors, behaviors and issues confronting gay, bisexual, other men who have sex with men and transgender women that were contributing to the spread of HIV. Factors identified were:

“Proliferation of public sex environments and online sex/hook up access apps. Need safe spaces to do ‘bad’ things...Relative ease and access to drugs and alcohol.”

“People need to play an active role in the health.”

“You can take a pill and live healthy the rest of my life. Misconception that ‘undetectable’ means negative. There is a general lack of transmission information.”

“They feel they are going to get it anyway sooner or later...a lot are promiscuous and have sex anywhere not being prepared...meaning without protective barriers.”
“Availability of easy sex and impulse control disorder”

“The people today lack the experience with the devastation of the disease early on in the epidemic. They lack basic education and understanding and consequently they think ‘just take a pill’...the new treatments are no big deal.”

“People have a fear of being known as gay and the fear of being known as HIV positive.”

“People come here in vacation mode. Positives think everyone is positive. Negatives don’t think about it. They don’t want to have the conversations. We are on vacation.”

“Lack of safe sex practices and the use of drugs. Getting high, being high makes it easier to take risks and not to practice safe sex.”

“Stigma is still very real. Stigma is out there.”

“Need to consider developing resources for the men and transpeople who are out here now. Is what we offer now what is needed by those getting HIV today? We have to ask ourselves these questions. Are our services the right mix, delivered in the most effective and efficient manner?”

Several of providers suggested actions that could be taken to educate and help people living with HIV and at risk for infection to prevent HIV transmission and HIV infection.

“We need to work with families, friends and other supporters...HIV positive persons may not do it for themselves, however they will do it (go to the doctor, take medicine) for other people.”

“Messages are out of sync with the reality. We need to update the messages. The messages have to be culturally appropriate...reflective of the realities of living with HIV and the implications for the gay lifestyle and the gay community.”

“Cannot prevent the horse from going out of the barn, we can teach how to protect self from getting HIV, infecting others and avoiding other sexually transmitted diseases.”

“People don’t know we are here. They wait to seek healthcare until they are sick...afraid of the medical bills...the perceived cost for care. We need a paradigm shift. People think care equals cost. They don’t know there is coverage. And even free medication.”

“We have to stop this thing. The young men should not be getting infected. This is not about taking antibiotics...this is a lifetime thing. They do not understand what HIV infection really means. There is this generational thing: older gays have lived through it, the younger gays did not see the 25-50 pills a day, the non-stop diarrhea. They think it is one pill and undetectable, meaning negative. Somehow, someway we have to really educate about this thing.”

When asked about what agencies can do to change things, responses included:

“We need a common sense approach. If everyone is on medicine and has a suppressed viral load, we will break the cycle.”

“We need resources dedicated to address the HIV epidemic among MSM. There is a new generation of gay men who need very basic information.”

“We need to work toward the day when there is widespread availability of medication.”

“We need more patient centered medical homes. Customer service is key. We need to make sure on that first visit we “usher them in” and offer a personalize system of care.”
“We need there to be that sense of urgency. It is tough though….we do not want people to be scared; however we need people to understand the serious nature of HIV infection.”

“We do not have the money for this. It is not our responsibility, really.”

“We need resources that support introduction to and retention in care.”

“We need to see more gays working in the HIV area and treatment agencies.”

“Agencies need to help men talk with their partners, they need to learn to talk about HIV.”

B.2. Known HIV Sero-status Focus Groups

Descriptive Findings

“Educate family and friends. Your family and those in your life don’t understand that you’re not well”

From January 20-22, 2014 a series of focus groups were held with men diagnosed with HIV to ascertain their opinions about living with HIV and HIV care and treatment services in the greater Broward County community. A total of 54 individuals participated. A focus group with HIV positive transgender women was held on March 7, 2014. Three transgender women participated.

Living with HIV and participating in HIV care and treatment services have changed with advancements in understanding and science. HIV is referred to by some as a chronic disease. Living with HIV is perceived to be manageable, and less taxing on the health and well-being of the positive person. The Known HIV Sero-status Health and Wellness focus groups were structured to create a space for those living with HIV to share ‘their reality.’

The focus group participants had been living with HIV for range of less than one year to more than 29 years. The discussions in the focus groups reflected the differences in the lived experiences of HIV. Those living with HIV for more than twenty years represented

Finding Highlights from Known HIV Sero-status Health and Wellness Focus Groups:

Some young and older gay men experience social isolation, disaffiliation and limited choices for socialization and healthy relationships. Many have strained familial relations. HIV infection is felt to be ‘just a matter of time.’ Many spoke of ‘bug chasers.’

For some gay men who have been living with HIV for more than 15 years, HIV messages are not relevant to their experiences. There is a need to create inclusive messaging for all persons living with HIV.

Special attention must be given to educate families of those living with HIV. Many families still reject their positive family members and demand that they ‘leave’ the family household, eat on separate dishes and not share the home facilities.

Drug and alcohol abuse is felt by many to be the leading contributor to HIV transmission among gay, bisexual men who have sex with men, and transgender women in Broward County.

The availability and accessibility of venues and multi-day circuit parties that promote sexual play and risk-taking behaviors also contribute to the spread of HIV among gay and bisexual men, and transgender women, in Broward County.

Online ‘hookups’ that advertise ‘bareback sex play’ create the perception that it is no longer a socio-sexual cultural norm to use protective barriers during sexual intercourse.

Gay, bisexual men who have sex with men living with HIV, many of whom experience shame, low self-esteem and isolation have very limited venues for positive self expression and health promotion.

Transgender women living with HIV are fearful of seeking care for fear of disclosure by others. Services for transgender women must be culturally sensitive and culturally relevant.
an older AIDS cohort describing experiences that included a lot of sickness, fear, death and dying. Those living with HIV under five years described an entirely different relationship to the disease, the experience and the HIV care system. Very strong feelings of betrayal were shared by several of the focus group participants. Some participants attribute their HIV infection to having sexual intercourse with their partners, believing they were in a mutually monogamous relationship. In a few instances for those in sero-discordant relationships, knowledge of their partner’s positive sero-status did not lead to application of proven treatment as prevention practices, including pre-exposure prophylactic medication, viral suppression and/or consistent condom use.

The focus groups were held during the morning, afternoon and early evening and lasted for between one and two hours. The location of the focus groups included HIV healthcare and social service agencies. Focus group members also completed two paper and pencil inventories about their social and sexual experiences living with HIV and their experiences in HIV care. Focus group respondents were given incentives in the form of $25 grocery store gift cards.

What follows are very brief highlights from the focus group meetings and the salient and reoccurring themes discussed during the focus group sessions.

**B.2.1 Young Black MSMs**

Young African American gay men are isolated in Broward County. Many have been ‘kicked out of family’ for ‘being gay’ and ‘hook up’ with older men in an effort to replace family. Many have basically ‘raised themselves’ and do not know what healthy or good family life is like. Most spend their time online looking to hook up and find that ‘special someone,’ instead they find older men who are ‘rude, mean, disrespectful and simply not nice.’ “We do not go to the bars.” If you want to reach these young men you have to reach them through social media, music and house parties. Drugs are everywhere, as is bareback sex. HIV knowledge is not great—although they are living with HIV.

Highlights from AA Focus Group

**Key HIV and LGBT themes emerging from the focus groups**

“There’s no stopping HIV/AIDS; it’s not going to end.”

“The goal is to be undetectable; it’s false hope to try to stop it.”

“Nothing can be done People today are going to be people; will either they do the right thing or not.”

“HIV is here to stay; it’s not going no where”

“Society effects behavior; gay porn bare-backing--in the past the actors wore condoms and now they don’t so it glamorizes unprotected sex ...so now on line sites all asking ‘are you BB’; you’re not man enough or hot enough or a pansy if you don’t bareback.”

What is needed to change the course of the HIV epidemic in South Florida?

“Continued HIV education is needed and should be targeted toward family members of persons with HIV and doctors who treat them.

“Family and friends should be more informed to better understand stigma and to not be afraid.”
“Doctors need to ask about substance abuse, alcohol use, cocaine, crystal meth and also mental health questions-how your feelings affect HIV. There can be shame and guilt to tell your doctor about your substance use.”

“Put more white people in HIV ads – put a hetero white couple.”

Perception of the most salient need/concern expressed related to HIV.

“Substance abuse and mental health issues related to HIV infection.”

“With crystal meth all walls come down. I used to be HIV phobic but crystal meth tears down all of that and makes you behave the way you want to and brings you to recklessness and careless about contracting HIV. You think ‘I’m probably gonna get it anyway’”.

“Need to focus on mental health issues; recovery groups and low self esteem.”

B.2.2 Highlights from Mixed Gay group 40’s-50’s

Middle aged white and Latino gay men the majority of whom have been living with HIV for more than fifteen years. These men are very well informed about HIV, the importance of adherence to care and following their treatment regime. Interested in understanding how to reach others in the community, especially the younger gays, also concerned about the online hookup and social media world of HIV.

Key HIV and LGBT themes emerging from the focus group

“Messages presented by HIV agencies seem ambiguous and unclear.”

“HIV stops with me – “stigmatizes me; I can’t stop it overall.”

“We are stronger than AIDS – “There is still a lot of ignorance about difference between HIV and AIDS – I had to explain to my doctor that according to the government’s definition once diagnosed with AIDS, I have AIDS forever even now when my HIV is undetectable.”

“Treatment is prevention – “Perhaps it should read, ‘Treatment prevents progression’- it’s also not always easy to get treatment. Sending a risky message like Truvada is the cure-all drug.”

“Bug Parties” – We really need a focus on youth education. They do not get it.

“Youth don’t see it as a big deal getting HIV, ‘Look at you, you’ve lived with it for 26 years.”

“Bug Parties (where the objective is to get infected with HIV); 18 and 19 year olds want to be part of this sub-culture (of the gay community) and get ‘biohazard tattoos’; also the thinking is if I have it now I don’t have to worry about getting it anymore.”

“Poor people also see it as a way to get their social services needs met; being positive has benefits – disability, get food.”

“I take HIV and mental health meds and my boyfriend has mental health needs and I get treatment and benefits and my boyfriend can’t.”

“The message is: we’ve got you covered – it is not scary anymore. The people in the ads all look like models and healthy or they use the ‘pretty boys who are positive’ in the ads. Maybe they need to make it like those cigarette ads. ‘If I get it I will be taken care of but ads don’t show how you feel and how sick you really get!”
Perception of the most salient need/concern expressed related to HIV.

“Aging with HIV. I call it “Old Age and Old AIDS.”

“HIV meds raise cholesterol – I had bypass surgery 6 weeks ago.”

“Kidney disease as a result of HIV disease, the cost of living with the disease and taking meds.”

“HIV meds can give you arthritis – docs don’t always tell you that.”

“People die of heart disease or kidney disease but was it attributable to taking HIV meds; deceiving to the statistics.”

What can public health and or HIV focused agencies do to address the concern.

“When I first told my sister and I went to her house she sanitized the bathroom after I used it because she was afraid I had to tell her she could not catch it that way. Families and friends need more education. These messages are not out there.”

B.2.3 Mixed Group of MSM 40’s-50’s

A mixed group of white, African-American and Latino MSMs. Acceptance and acknowledgement of HIV status, sexual identity and disclosure remain issues for all of the participants. Shame and stigma were issues for all of the members of this group. The migration of MSMS to South Florida was discussed by several of the participants who described their own experience of trying to fit in and find the community.

Highlights from the Focus Groups

A. Key HIV and LGBT themes emerging from the focus groups

“Everyone has to know your status – “All ages, shapes, sizes and colors of people.” “Hit social media and links instead of signs.”

“Treatment is prevention – “If no trace of viral load and condom breaks, take Truvada.”; “only speaks to HIV community.”

“Broward Co. is #1 in new infections every year since 2009 – “lots of traffic from everywhere here”, “the trend can be reversed and people need to educated”, “if more people knew that stat they might protect themselves better”, “break down stigma of HIV especially if Latino and African American and with the ministers”, “South Florida is very transient; broadcasting must include everyone”, “Truvada being used as prevention – there’s no fear”, “quick fix dating hook up websites and apps – used to be bathhouses and bookstores now you can do it secretly and you don’t care.”

“When it happened to me I was addicted to a drug but now there is no fear; there needs to be fear again.” “Drug addictions don’t let you think, because the meth took my brain – Florida is the Meth State; lack of inhibition.”

“Meth addiction is rampant – in 2005 barely any participants in a treatment groups, now meetings are crowded.”

“Lots of people who are HIV are Bi-Polar and go on sex-capades – lots of mental health – I know at least 20 people in the bars who are Bi-Polar.”

“Young population into bug chasing; we get benefits ‘Ryan White and disability’ go to bath houses and ask if you can infect me. Once infected then you don’t have to worry about it and get tested anymore.”

“Kids not educated about taking meds – bugs me, I’d give them mine if I could.”
“There should be a requirement that doctors, family and friends be made to be more aware and sensitive.”

“It’s a sexually transmitted disease – you can’t get it from sleeping in my bed next to me or by wearing my clothes.”

“We used to eat together, now I am eating alone and now I have to use the same plate, fork, and cup for every meal.”

“Custom tailor treatment to fit each person.”

Perception of the most salient need/concern expressed related to HIV.

“Prison setting--something really needs to be done; you’re not gonna’ stop the sex – Need prison advocacy.”

“No sexual activity in the handbook but they know it is going on and there’s no education about HIV in prison and no condoms.”

“It is too easy to go to prison.”

What can public health and or HIV focused agencies do to address the concern.

“Broward does a great job – much better than Dade.”

“The agencies are overloaded but they keep it together well – they don’t turn anyone down.”

B.2.4 Mixed Group MSM 40’s-50’s

A mixed group of mostly Latino MSM, one or two white and African American MSM. All of the members of this group have been living with HIV for more than 20 years. Most expressed appreciation for and left the meeting feeling very good about the focus group and wanting to talk about living with HIV. All feel very good about their doctors and the care they are receiving.

Highlights from the Focus Group

Key HIV and LGBT themes emerging from the focus group

“Substances including Viagra effect HIV infection.”

“Lots of education needed – major drug problems, crystal meth, heroine, prostitution ensues, effects every population.”

“Viagra – notice more older men at my HIV doctors office.”

“Education must start in school to get it under control.”

“People don’t care and bug chasers are real.”

“Don’t bottom or top without a condom”

“Was approached by a kid who wanted to be converted by someone who never had venereal disease or hepatitis.”

“It’s not a favor to infect someone, you need to go to jail.”

“Most people don’t ask if I’m positive and if I’ll use a condom, and when you’re drinking in a bar they don’t care.”

“Everyone meets virtually now and most lie and say they’re negative and they’re really positive.”

Perception of the most salient need/concern expressed related to HIV.
“Contracting HIV “innocently”.

“I feel funny in that I don’t feel comfortable having sex with someone unless it’s my partner; and then I got it from him and didn’t know he had it.”

“I caught HIV from a female; she was real pretty I never thought she could have it. I got pneumonia and in the hospital found out I had HIV. I was faithful to her.”

“You gave it to me so we’re not breaking up; you’re not dating no one else, you did this to me. I’m 26 and I didn’t have any diseases until I was 25 and with him.”

“You didn’t tell me – that’s a problem – its betrayal – you didn’t love me; it’s gonna keep going.”

What can public health and or HIV focused agencies do to address the concern.

“Perhaps a message to target the partners who deceived their loved ones and don’t get tested and risk passing it on to their loved ones or the importance of and how to disclose your positive status or even untested status to your loved one so that they can choose to practice protected sex”.

“I don’t believe (it’s going to improve) so – gonna’ get worse; some people don’t care, repeat cycles of doing things to innocent parties; taking their lives, because they’re afraid of getting tested. It makes you into a mean person.”

B.2.5 Mixed Group MSM  23-59 y/o

A mixed group of mostly white gay men and two African American MSMs. This group represented the gay ‘old timers’ and the newly diagnosed. The older men knew ‘everything about HIV and had been living with HIV longer than the two African Americans have been living. The differences in experiences made for important teachable moments.

Highlights from the Focus Group

Key HIV and LGBT themes emerging from the focus group

“My Grandmother said I was an abomination.”

“Straight friends has lots of sex without condoms and don’t care.” “Not us.”

“What you really go through having HIV – I had 6 to 8 months of diarrhea, felt sick every day.”

“I was fighting my partner in bed in the middle of the night from a medicine.”

“Lucky I have an incredible support system.”

“Be able to tell your doctor anything.”

“Everyday I’m grateful to be alive-my time is not to be wasted.”

“We are greater than AIDS – “Catch phrase” “wanted to laugh” “the slogans are ambiguous – like they’re from a marketing team that’s locked away in a closet.”

“Know your status “should be followed up with specific information on where you can go to be tested”
“My meds used to cost $2,600/mo and I was working and they said I made to much for benefits. If you’re caught in that financial bracket you can’t afford meds. I’m hoping Obama care will fix this with Ryan White.”

**Perception of the most salient need/concern expressed related to HIV.**

“Need to advertise and market in a very different, more modern way.”

“Advertise on Adam for Adam and Grindr and also social media and Youtube.”

“Use music or other venues to interest younger audiences, use it to educate.

“YouTube is a way to hit this up”

“Rock bands need to talks about HIV and testing”

**What can public health and or HIV focused agencies do to address the concern.**

“Have to tailor outreach efforts and marketing to specific communities—speaking their language in order to engage them; resources are reportedly not the same in all neighborhoods.”

“I’m from the gay white neighborhood” “I’m the dude in the hood” “How can you make the ads more hip?”

“More urban support groups for positive people.”

“We can do better in how we reach out to everyone, to suburbs, they have nothing.”

“Music and sex go hand in hand; maybe hip hop advertising.”

“We don’t talk about it in the black community; first thing you think is that you’re gonna die.”

**B.2.6. Mixed Group MSM 30’s-60’s**

A mixed group of white, African American and Latino MSMs. This group of men have been living with HIV on average 20 years. Several of the men volunteer at the Center. The men were very appreciative of the opportunity to talk about living with HIV, what could be done to improve services and to stop the spread of HIV in the community.

Highlights from the Focus Group

**Key HIV and LGBT themes emerging from the focus group**

“Tired of seeing Magic Johnson, he’s not gay (can’t relate to him)”

“What about people who don’t live here but come for testing and leave; if you don’t reside here but get tested or treatment here so you get counted in the rate of infection numbers for Broward?”

“Maybe our community benefits from Ryan White for these high numbers?”

“The mouth swab HIV tests are not accurate.”

“Young people don’t know about going to 2 funerals a week like in the ‘80s”

“People not truthful about their status.”

“Still stigma about being tested.”
“Difficult to disclose status for fear of rejection.”

Perception of the most salient need/concern expressed related to HIV.

“Drug use by MSM.”

“I have this friend who is 75yo and he can’t get off without crystal meth or shooting “Tina” and then he wants to have sex and I don’t do that.”

“People come here to visit and vacation and let your hair down and that leads to behaviors to HIV, partying, drinking, drugs.”

“Crystal meth - we’ve all been there.”

“When I was high I didn’t make clear judgments.”

What can public health and or HIV focused agencies do to address the concern.

“Perhaps partner with County and State substance abuse services to jointly target this population for both substance abuse treatment and HIV prevention. Develop new marketing strategy accordingly.”

“Lots of people in Ft. Lauderdale use drugs and deny using them and lots of them are positive – no respect for anything.”

“Lived here for 10 years and the reason it spreads -- it’s the drug community. Crack heads, crystal meth and drunks. Gay men who do drugs have sex and go to parties and there are many functioning addicts who you don’t know are using”

“People in the community of great influence using drugs and are addicts and they host parties to raise funds for HIV programs.” “Seems to affect all age groups too.”

B.2.7 Mixed Group MSM 20-50’s

This group of mostly mixed white, Latino and African American MSMs were very diverse in the knowledge of HIV disease, what was going on in the community and how to impact the local epidemic. The Internet and online hookups have created greater access to sex and increased barebacking and drug use. Drug use is so prevalent in the online hookups that you walk in ready to get high and have sex. New approaches need to be designed, identified, and implemented. The South Florida barebacking gay porn industry and gay tourism exacerbates the problem.

Highlights from the Focus Group

Key HIV and LGBT themes emerging from the focus group

“Let’s stop HIV together – “Human sexuality is the animal part we all have and it’s very difficult to control. People will have sex even if dangerous and some will do it right (protected sex) and some won’t”

“This is a mixed message for me; I think we need to accept HIV as opposed to stopping it.”

“I used to sleep with strippers at strip clubs; when you are young you do whatever you want – my parents taught me the right way but sometimes people don’t do it.”

“I contracted HIV from my boyfriend; I loved him. I found out from his ‘ex’ that he was positive but it’s my fault too because I didn’t ask.”
‘Be more sensitive when using signs, can cause panic and more discrimination.”

“Disease will still spread because people don’t know.”

“Today is my anniversary. If I live another year I will have had HIV for half of my life. Today is also my mother’s birthday.”

“23 years of incarceration and just got back last year. My nickname is H-I-V. I have nothing to hide. I don’t have to tell you that’s my name.”

“I sometimes don’t have protected sex and sometimes don’t disclose and I’m working on that issue with my therapist-acting like an animal, I know.”

“Straight men can do whatever they want but gay men have to be careful and worried.”

“I lost all of my family when I was growing up. I was 14yo and I didn’t say anything but my family thought I was gay and I had to leave. I did everything in my life by myself. I got myself an education and made a living and now I’m old. All of them are dead and I took care of my mother when she was dying and I’m still here.”

“I have a very open relationship with my mom; she taught me nothing but love. Friends you can choose and they’re the ones I love but I also learned it’s ok if they leave because it’s what needed to happen as they’re not your friend.”

“Sometimes family screws you bad. Keep it to yourself. My brother posted on Facebook about me. I got real depressed so they helped me here.”

“I’m ok with them disclosing but my family is so uneducated so I don’t disclose.”

**Perception of the most salient need/concern expressed related to HIV.**

“Work to restore some faith in the science, medical and pharmacological community that finding a cure ASAP is a desired goal.”

“Doubt there will ever be a cure”; “They’ don’t want to find a cure because ‘they’ make too much money”;

“Pharmaceuticals make a fortune”; “When AZT first came out it made $316 million in the first year – it’s big business”; “Money talks, we can buy the cure.” “Don’t want to give the cure because ‘they’ lose money”

**What can public health and or HIV focused agencies do to address the concern.**

“Maybe host information sessions or discussion groups to highlight advancements in research for a cure.” “Stop bureaucracy, stop talking, just DO, begin to look for the cure, stop business (of HIV), stop messing with our lives.”

“Pharmaceutical companies run and control everything”

“What about ozone therapy; “wipe out herpes” is totally natural.”

“Everything in the news is a lie.”

**B. 2.8 Mixed Group MSM 30-50’s**

This group of white MSMs and one Latino MSM wanted and needed to talk about living with HIV. Half the group has been living with HIV for less than ten years, the other half for more than 20 years. As a result of the
difference in years living with HIV the group spent a lot of time sharing family and community experiences. Shame and stigma remain issues central to the experience of HIV.

Highlights from the Focus Group

**Key HIV and LGBT themes emerging from the focus group**

“I have issues with getting signed up for services – I brought all of my paperwork from another State and I’m told it’s no good and have to do it all over again in Broward.”

“Will never get easier here because there is no state income tax in Florida and there never will be so the Federal Government pays for it.”

“Very isolative here; where do you go to meet new people and make friends?”

“My mother wants to see me settled; to meet someone again.”

**Perception of the most salient need/concern expressed related to HIV.**

“Shortcomings with coverage; how to get through the donut hole”

“How can (implementation of a) federally funded program differ so much from State to State?”

“I would need $5,000 to get through the “donut hole.”

“Very soon Ryan White will go away because of the infighting in Washington, DC.”

What can public health and or HIV focused agencies do to address the concern.

“Develop a strategy to address policies and procedures that create an undue burden on disabled folks to be able to move within the state of Florida without a discontinuance of coverage – the expensive “donut hole.”

**B. 2.9 Mixed Group Transgender Women 40’s-60’s**

A mixed group of HIV positive transgender women of color who had been living with HIV for less than a year and more than ten years discussed the need for more education about transgender people for public health providers. The transgender women in this group reported a long history of providing outreach and educational services to other transgender women—the young girls who don’t have HIV yet, and the working girls who we “know have HIV but won’t talk about it, or think they may be positive but fear criminal actions, so they would rather not know.” The group discussed a variety of issues related to HIV including disclosure and criminalization; the relationship between HIV prostitution and sex work—a girl’s gotta’ eat; and violence.

Highlights from the Focus Group

**Key HIV and LGBT themes emerging from the focus group**

“We get blamed and accused of infecting guys we have sex with all the time. And it is not possible. I was accused of giving HIV to one man I had been with, and I did not even have HIV at the time.”

“I take my partner(s) to the doctor with me. My doctor writes his name in my chart so if they accuse me, or charge me under the Florida HIV criminal laws, my doctor can testify for me. His name is in my medical record. He knew.”
“A lot of the young girls want to get it. They think getting the little $710 a month is a way to live, to make it. I don’t understand what happened to working for a living. And they think that doing sex work is the answer. I can tell you it is not. It is rough on the street.”

“We have to help the girls understand they can have a better life. Yes they can make money. Making money is not a good life. I used to make good money, it is not the good life.”

“Treatment is prevention is the best idea. We are trying to help people get treatment, if people are on the correct treatment and are adherent, it is the best thing. We have to change the laws because maybe if you are undetectable for 3-4 years, you cannot be charged for not disclosing.”

“If you do not take you meds, you will die from it. Treatment will prevent you from dying. That is preventing death. So treatment is prevention. That is part of the message.”

“The problem is people are very ignorant about transgenders. They think it is something related to gay. Many men who want to have sex with transgenders have sex with maybe three or four biological women. Not gay men. The people are very ignorant about trans sexuality. These men sleep with women.”

**Perception of the most salient need/concern expressed related to HIV.**

“People need to be educated; they say and think all kind of things.”

“I think the most important is to change laws and guidelines.”

“Disclosure can become a safety issue...a lot of the guys we are with are violent with us. It is like there is a war going on inside of them and after sex they cannot deal with it and they attack. If we disclose, it can be worse for us.”

“People want to experience different kinds of sex, they want a variety, and they come to us. They want to try it with a ‘trannie.’ Then they cannot handle it. We are blamed for whatever. And if they have HIV, we definitely get blamed for infecting him.”

“People are coming and going. South Florida is a port of entry. It is very transient. Men come down here on business, leaving their wives and families at home. They come down here and they want to do crazy things and want to be with ‘transgenders.’”

**What can public health and/or HIV focused agencies do to address the concern.**

“They are not focusing on the whole community. They are focusing on the gay places and in Wilton Manors. There are other places where they need to be testing. There are all these different events on the beach. No one is testing on the beach.”

“Agencies are competing with each other. That should not be happening. The agencies should be working together to make sure all the areas are covered.”

“There is this thing about using a condom when you are having intercourse. A lot of the girls think oral sex is safe. So they do not use a condom for oral sex, then they end up with an STD or don’t know the risk factors that are associated with oral sex...agencies need to educate about oral sex.”
“Health departments have to think about transgender women and public health. The health department staff think because we are transgender we are stupid. It is not correct. We are human. We are very educated and working in the community for change. The health department staff need to be more culturally sensitive.”

“I have seen a lot of change. There was a time when you would walk into a doctor’s office and you were looked at like a joke. Like when I would go to the doctor and the staff would be standing in the back “kiki-ing, laughing under their breath.” A lot of the health care community has come on board. We need more of that. So when a girl does find out she is positive, she can feel ok about getting the care t need.”

“It is time for the billboards to go up…so others can see that the health department is here for the transgender community. It is time for the health department to hire more transpeople. We have to see somebody that looks like us.”

“Little by little more transgender women will come forward, come out. You just have to keep at it.”

C. Observations: Social Networking

During some focus group meetings, key informant interviews and community advisory group meetings bars as socio-sexual places for hooking up were discussed. At the same time several of the community advisory group members and focus group participants of color commented that outreach programs needed to go beyond focusing on and looking to the bars and places just in gay Broward, mainly Wilton Manors, and expand into the ‘hood.’ In an effort to understand a bit more about the state of the socio-sexual dynamics in the bars in ‘gay Broward’ as a hook up spot, participant observational site visits were completed at several bars and restaurants. What was observed is highlighted below.

“Blacks are still hiding.”

“We do not go to the bars, we get together at house parties.”

“The bars are for the older crowd. I would not know what to do in a bar situation. I do not go out on dates. I do not know how to ask anyone out.”

In the 1990s and early 2000s, because the HIV epidemic was concentrated within the ‘gay community.’ HIV prevention services included frequent HIV outreach and HIV prevention education trips to the gay bars, restaurants, bathhouses and sex clubs. Outreach workers, crisis intervention specialists and HIV test counselors trying to reach gay, bisexual and other men who have sex with men ‘made regular stops’ at bars, restaurants, bathhouses and the like to drop off condoms, HIV prevention brochures and offer HIV testing and referrals to the clientele. The bars, bathhouses and sex clubs were places for ‘gay guys’ to meet for fun times and for HIV prevention agencies to raise awareness about HIV infection.

As the immediacy of the HIV crisis began to subside, and alternatives to the ‘gay bar scene” emerged, the longstanding gay spots seemed to lose their position as an important gay social venue for HIV prevention education and HIV testing. Some owners were also tiring of the association and perception of a direct relationship between ‘hanging at the bar’ ‘going to a bathhouse’ and HIV transmission—asking the outreach staff to stop dropping off condoms, HIV brochures, approaching clients in the area of the bar or stop parking the testing van around the corner or and at a nearby parking lot.
In late January 2014, five Wilton Manors food and beverage establishments were visited to observe and make note of any social and sexual networking being carried out in light of the HIV epidemic in the greater Fort Lauderdale community. The community participant observation “re-visiting” activity took place between the hours of 7 pm and 11 pm. The site visits included entering the bar and/or restaurant, observing the ethnic/racial/age diversity among the patrons, and attempting to ascertain the level of “hooking up” activity taking place. What follows are highlights from the five “site visits.”

Venue 1. The bar was crowded, with most of the Black men congregating in the patio area in couples, small and large groups. Some couples and groups were racially mixed. Black men in the interior were primarily dining at booths and standing tables. Some racial mixing was observed. Black men appeared to be late arrivers, populating the place starting at 10:30PM. Approximately 10% are Black, 4% are Latino.

Venue 2. A group of Black men were engaged in a card game of Hearts, another group of Black men were playing pool with a couple of white men also playing pool. A couple of mixed groups, including white women, were conversing in a small group seating area. The men around the bar in the next room were a mix of all racial/ethnic groups with white men being the predominate group populating the bar/lounge. At large 15% of the patrons were Black, 1% Latino (excluding the staff). A considerable among of cell phone watching and texting was occurring among the younger patrons who comprise about 10% of the patrons.

Venue 3. Less than 5% of the patrons were Black, and most were linked to groups and couples of white men. Discernible Hispanics/Latinos were less than 2% of the patrons. Hairy, muscular and robust men populated the bar. A DJ was spinning records and dancing was taking place. The music was exclusively club and house.

Venue 4. Mature white and Black men populated this bar/lounge. Less than 5% of the men were Black or Hispanic/Latino. Men of color present were well mixed/integrated in couples or groups of white men. The space was small and intimate. Music volume level was conducive to conversation. In the sidewalk café area men smoked cigars, a couple of Black men also participated in this activity.

Venue 5. Fewer than 5% of the men populating the restaurant/bar were men of color. Most were in racially and ethnically segregated groups and there were only two racially and ethnically mixed couples.

These observational descriptions strongly suggest that black and Hispanic men who have sex with men do not frequent bars and restaurants in the ‘gay neighborhood.’ In Broward County the rate of HIV infection among black men is nearly twice that for white men. Fifty-three percent of persons living with HIV/AIDS are black, thirty-three percent are white and twelve percent are Latinos. (FLDOH, 2012) And while black men may be over represented in the cases of HIV/AIDS in Broward County, they are not using the above listed bars in the “openly gay community” as their social and sexual networking zone. They may be using more contemporary technologies and venues away from home for finding and confirming their hookups, pickups and play dates.

D. Profile of Exploratory Study Participants

“I’m 44 y/o and I just got it a couple of years ago; I was so tired of always worrying about it I said,  Just the hell with it.”

The participants in the Known Sero-status HIV Health and Wellness component of this exploratory study were a diverse group persons living with HIV recruited from programs providing services along the HIV healthcare and services continuum: community clinics, food and nutrition programs, pharmacies, housing, support services and word of mouth. The participants were diverse in age, background, income, years living with HIV
and experiences in the HIV community support and healthcare service system. Community representatives and agency staff were asked to recruit from individuals known to be HIV positive and from agency client lists. A $25 grocery store gift card incentive was offered to the participants.

A total of 52 individuals agreed to participate in the focus groups and agreed to complete a sexual health and well-being survey and a client service assessment survey. The profile of the participants follows.

Race/Ethnicity

Just over half (52%) of those interviewed identified as white (non-Hispanic), 25% identified as Black Americans, and 23% as Hispanic or Latino. The majority (77%) reported they were born in the US.

![Primary Race or Ethnicity](chart1)

![Place of Birth](chart2)

Highlights: Profile of HIV positive participants

- 63% of participants live in Ft Lauderdale
- 52% white, 25% Black, 23% Latino; 77% US born
- 81% identified as gay, 8% MSM, 6% Bi
- 77% contracted HIV from male to male sexual contact
- 50% of respondents HIV + for more than 15 years
- 50% of those with HIV also have an AIDS diagnosis
- 45-54 years of age—48%
- 35-44 years of age—19%
- 87% of participants reported being engaged in regular HIV care
- 67% of the participants reported undetectable viral load
- All reported less sexual activity since HIV diagnosis
- 50% reported thinking about HIV all the time
- 59% reported rejection due to HIV serostatus
- 54% reported using online hook ups for sex
- 35% reported they never disclose status online
- 74% reported being single at the time of the survey
Sexual Orientation

Eighty-one (81) percent of the respondents self-identified as gay, 8% as a man who has sex with men, 6% as bisexual, 4% heterosexual and 2% other.

Age

Just under half of the respondents were between the ages of 45-54 (48%). The next highest age group was those respondents between the ages of 35-44 (19%). Two-thirds of the respondents were between the ages of 45-64, 63%.
Residence – The majority (65%) of the respondents reported they live in Fort Lauderdale.

![Broward Location Graph]

Similar to other studies only twenty-six percent of the respondents reported ever being prison.

![Ever Been in Prison Graph]

Number of years with HIV

The majority of respondents have been living with HIV for ten plus years. Fifty percent of the respondents have been living with HIV for more than fifteen years. Only 6% of the respondents have been living with HIV for less than one year.

![How Long Ago Did You Test Positive? Graph]
AIDS Diagnosis – Fifty percent of those diagnosed with HIV (26) were also diagnosed with AIDS.

HIV Risk Factors – Seventy-seven percent of the respondents reported sexual transmission with men having sex with men as the largest percentage overall and 79% of those who acquired HIV through sexual contact.
Engagement in Care – Eighty-seven percent of the respondents are engaged in regular HIV care as evidenced by their response to the number of doctor visits completed in the last year.

HIV Treatment – Ninety (90) percent of the respondents diagnosed with HIV/AIDS are taking medication and are adherent to their treatment regimen.
Most Recent Viral Load – Two-thirds of the participants (35) reported that their viral load was in the undetectable range.

![More Recent Viral Load Diagram](image)

Most Recent T-Cell Count – Sixty (60) percent of the participants reported a CD4 count of greater than 350.

![Most Recent T-Cell Count Diagram](image)
Employment status – Thirty-three (33) percent or 17 of the respondents are working full or part-time. Twenty-seven percent (14) reported that they are unable to work; twenty-one percent (11) are looking for work.

Income – Just over half, fifty-one percent (27) of the respondents reported no income or an income less than $10,000. Twenty-seven percent (14) reported an income range of $10,000-$20,000. Eight percent (4) of the respondents reported an income of more than $40,000.
Sexual Health – Twenty-five percent (13) of the respondents reported being treated for a sexually transmitted infection in the last six months.

Behavioral health needs – Thirty-five percent (18) of the respondents reported feelings of depression during the past year. Twenty-nine percent reported depressive symptoms ever.

Alcohol and/or Drug Experiences – Twenty-four percent reported yes in the last five years; including the last 12 months. Nineteen percent said yes at some point previously in life.
Housing Status – Sixty-two percent (32) of the respondents own or rent their own place. Thirty percent (16) either live with friends/family or in a residential facility.

### Housing Status

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent/Own</td>
<td>32</td>
</tr>
<tr>
<td>Homeless</td>
<td>8</td>
</tr>
<tr>
<td>Shelter</td>
<td>8</td>
</tr>
<tr>
<td>Living with Relative or Friends</td>
<td>2</td>
</tr>
<tr>
<td>AIDS Group/Assisted Housing or Residential Treatment/Group Home</td>
<td>2</td>
</tr>
</tbody>
</table>

#### E. HIV Related Service Needs

“I talk to my patients about condom use as a health issue, not a moral issue. A lot of my positives—I talk to them about using condoms. It is part of being healthy. My clients are 90% virally suppressed and I still talk to them about using condoms. If they want to be as healthy as they can be, they need to use a condom. It is that simple. It is about their health, not morality.”

The needs of HIV positive transgender women, gay, bisexual men who have sex with men are diverse, multifaceted and ever-changing. As the highlights from the findings on the preceding pages illustrate, HIV among gay, bisexual men and transgender women is a complex, socio-sexual cultural conundrum that requires fresh appreciation of myriad dynamics. Additionally, as the US HIV epidemic matures and changes, and advancements in science and technology offer new approaches to prevention, care and treatment, understanding HIV related service needs and current service utilization of HIV positive men who have sex with men and transgender women will play a significant role in organizing and implementing an effective, efficient and efficacious response.

To help to shed some light on the HIV related service needs, the client assessment survey asked a series of questions about service needs and utilization. It is important to note that the majority of respondents were engaged in regular HIV health related services and none of the respondents indicated unmet needs for services. A few key findings are presented below.
When asked what they and their physician talked about during the last six months, chief among the topics were: medical or dental treatment, including about taking HIV medications, mental health care and practicing safer sex.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don't have a Primary Medical Dr.</td>
<td>3.98</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2.65</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>3.33</td>
</tr>
<tr>
<td>HIV risk reduction education/counseling</td>
<td>3.06</td>
</tr>
<tr>
<td>Practicing Safer sex</td>
<td>2.73</td>
</tr>
<tr>
<td>Taking HIV meds</td>
<td>2.15</td>
</tr>
<tr>
<td>Your medical treat or dental care</td>
<td>1.92</td>
</tr>
<tr>
<td>None of the above</td>
<td>3.58</td>
</tr>
</tbody>
</table>

1=Yes   2=No   3=Not Applicable   4=No Answer
The majority of respondents stated that they did not have a case manager, however for those who did have one, they reported that their case manager helped with medical/dental care, ADAP and mental health services.

### 2. Does Case Manager Provide Assistance with or For the following:

<table>
<thead>
<tr>
<th>Service</th>
<th>1 (Yes)</th>
<th>2 (No)</th>
<th>3 (Not Applicable)</th>
<th>4 (No Answer)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don't have a Case Manager</td>
<td>3.82</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Supportive Svc (Food, Emergency Financial Assistance)</td>
<td>3.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI/SSDI</td>
<td>3.94</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADAP/MDAP/SPAP</td>
<td>3.08</td>
<td></td>
<td>3.6</td>
<td></td>
</tr>
<tr>
<td>HIV Risk Reduction education/Counseling</td>
<td>3.42</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Counseling</td>
<td>3.71</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Counseling</td>
<td>3.31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Adherence Counseling</td>
<td>2.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td>3.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical or Dental</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None of the Above</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1=Yes  2=No  3=Not Applicable  4=No Answer
When asked about service utilization and difficulties accessing the HIV related healthcare system the chief concerns were waiting a little too long to set up appointments and waiting a little too long for return telephone calls. With the exception of the ‘waiting time issues’ the majority of respondents did not express any concerns about HIV related service utilization.

3. In the Last 6 Months, How Often Did You...

1=Always  2=Most of the time  3=Sometimes  4= Not much of the time  5=Never  6=N/A
Similarly, with the exception of transportation services and housing services, the majority of respondents did not need nor did they receive any particular ‘needed’ service(s). As has been noted elsewhere in this report, the HIV positive gay, bisexual men who have sex with men and transgender women who participated in this assessment project and exploratory study actively participate in their HIV related medical care and take their prescribed medications as evidenced by the high percentage of viral suppression among the participants.

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Placement and/or Training Services</td>
<td>1</td>
<td>2.81</td>
</tr>
<tr>
<td>Transportation Services</td>
<td>2</td>
<td>2.12</td>
</tr>
<tr>
<td>Legal Services</td>
<td>3</td>
<td>2.73</td>
</tr>
<tr>
<td>Housing Services</td>
<td>4</td>
<td>2.33</td>
</tr>
<tr>
<td>Safe Sex Counseling</td>
<td>5</td>
<td>2.56</td>
</tr>
<tr>
<td>Emergency Financial Assistance</td>
<td>6</td>
<td>2.46</td>
</tr>
<tr>
<td>Child Care Service</td>
<td>7</td>
<td>2.98</td>
</tr>
<tr>
<td>Substance Abuse Services/Outpatient Supportive Services</td>
<td>8</td>
<td>2.81</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>No Answer</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>2.96</td>
</tr>
</tbody>
</table>

1=Rec’d Svc  2=Needed Svc Didn’t Receive Svc  3=Didn’t need or Receive Svc  4=No Answer
There is an area of concern which has also been highlighted earlier in the report, namely social support. The HIV positive persons participating in the assessment project and exploratory study report high levels of social isolation, low self-esteem and lack of community support. Many of the participants reported trying to find community, that one special someone, or re-engage with family. With the exception of visiting and/or talking with family and friends on a regular basis, the majority of respondents reported participating in any type of accepted form of socialization less that once a month.

### 5. In the Last 6 Months; How Often Did You....

1=Several times a week    2=Once or twice a week    3=Once or twice a Month    4= Less than Once a Month    5=Never    6=Not Applicable
Likewise the gay, bisexual men who participated in the exploratory study felt they had the support of their family and friends if they needed it and could call on them if they needed financial assistance. The majority reported being able to call on their support less than once or twice a month.

6. In the Last 6 Months, How Often Have You Had...

<table>
<thead>
<tr>
<th>Support Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from your family and friends when you needed it</td>
<td>2.31</td>
</tr>
<tr>
<td>Someone to spend time and have fun with</td>
<td>2.52</td>
</tr>
<tr>
<td>Someone who showed you love and affection</td>
<td>2.58</td>
</tr>
<tr>
<td>Someone to help you with money to pay rent to buy food, or to meet other basics needed</td>
<td>3.12</td>
</tr>
<tr>
<td>Someone who would let you stay with them if you had no place to stay</td>
<td>2.88</td>
</tr>
<tr>
<td>Someone to take you to the doctor if needed</td>
<td>2.77</td>
</tr>
<tr>
<td>Someone you could count on to share your feelings with or help you solve a problem</td>
<td>2.33</td>
</tr>
</tbody>
</table>

1 = Several times a week  2 = Once or twice a week  3 = Once or twice a Month  4 = Less than Once a Month  5 = Never  6 = Not Applicable
In keeping with the HIV related needs of HIV positive gay, bisexual men who have sex with men and transgender women; the use of condoms is one area about which everyone talks. However, with incidence and prevalence rates what they are in South Florida, some talkers are not consistent users. As noted below, when asked about condom use, the response moves between sometimes and never, when asked about sex without a condom.

### 7. In the Last 6 Month How Often Did You....

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have sex (anal or vaginal) without a condom while drunk or high</td>
<td>4.35</td>
</tr>
<tr>
<td>Have sex (anal or vaginal) without a condom with an HIV-Positive Person</td>
<td>3.77</td>
</tr>
<tr>
<td>Have sex (anal or vaginal) without a condom with an HIV-negative person</td>
<td>4.65</td>
</tr>
<tr>
<td>Have sex (anal or vaginal) without discussing HIV status</td>
<td>4.65</td>
</tr>
<tr>
<td>Have sex (anal or vaginal) without a condom</td>
<td>3.71</td>
</tr>
</tbody>
</table>

1=Always   2=Most of the time   3=Sometimes   4= Not much of the time   5=Never
F. Sexual Health and Wellness

“ Took me a half a year to get tested; I knew it but I was afraid and as soon as I got tested and it was confirmed I was positive I got sick and then felt depressed and didn’t leave the house. ”

In addition to the client assessment survey, a brief survey which focused on sexual activity developed by POZ magazine was also administered. As stated in the January 2014 issue “ POZ magazine believes everybody—regardless of their HIV status should enjoy sex to the fullest. So, how’s your sex life lately? Has it changed since you became HIV positive? How has having HIV affected your sex life? ” Given the feedback from the focus groups, informant interviews and the preceding question about condom use, a short sexual health survey would help to provide a clearer picture of what is happening on the ground. Are those who are living with HIV using condoms, disclosing their HIV status? What is their relationship status? Answers to these and other questions will provide a glimpse into the “lived” impact of HIV on the sexual lives of gay, bisexual and other men who have sex with men. The sexual health profile of these men suggests a need for ongoing support.

Sexual Health Profile

Partners – When asked how many they had last year twenty-two percent (12) replied zero and twenty-two percent (12) reported more than ten. Thirty-three percent reported 3 and under. Thirty-three percent reported more than seven.

Frequency – when asked how often they have sex, fifty-six percent of the respondents (30) reported between a few times per month to a few times per year. Eleven percent reported never and the largest percentage, thirty-four percent of the respondents reported at least once a week if not more than once a week.
More or less sex since DX – Fifty-seven percent (31) of the respondents reported having less sex. Thirty-five percent said about the same amount.

During sex think about HIV -- The majority of respondents, fifty percent, stated they think about HIV all the time. Thirty-one percent replied sometimes and seventeen (9) percent said never.

Disclosure w/ NEW encounter – Two-third (67%) of the respondents replied “always!”
Confident sexually – Thirty-nine percent of the respondents (21) reported feeling less confident sexually and thirty-nine percent reported no change.

Rejection Due to HIV Status – Fifty-nine percent of the respondents said they had been rejected.

Use of On-line hookups—fifty-four respondents reported sometimes and often, thirty-three percent said never.
Disclosure on-line – Forty-one percent (22) of the respondents said they always disclose their status. Thirty-five percent said never.

Partner Preference – Forty-eight percent (26) of the respondents reported that it does not make a difference. Forty-six percent (25) stated HIV positive.

Current Relationship Status – Seventy-four percent (40) of the respondents are single and Nineteen percent (14) are in a relationship.
Trauma of AIDS Epidemic… (excerpted from the Bay Area Reporter 4/3/2104)

...One of the findings so far of the Silver Project has been a need for health professionals who treat people living with HIV and AIDS to focus on their patients' mental health issues.

The study is confirming what others have noticed, that a lack of social support systems for older individuals with HIV can lead to depression, isolation, and loneliness. And those can all negatively affect not only a patient’s health and wellness but also their ability to utilize services. "It became clear we needed to look at these things," said Malcolm John, MD, as they can impact the "functional status of our patients."

Of 135 patients enrolled in the Silver Project study, 34 percent said they had experienced depression within the last year. Twenty-two percent reported mild loneliness, with 13 percent having severe loneliness. "Almost half our patients are lonely, basically 57 percent ... that is a significant finding to say the least," said John. "We are seeing a lot of patients who aren't clinically depressed need to start medications. It is due to the burden of being an AIDS survivor, the burden of living with chronic disease and co-morbidities. All those things start to weigh on people."

While AIDS in America has been graying for years, service organizations have largely been blind to the issue, said Mark Brennan-Ing, PHD, so programs have been lacking for older people living with HIV and AIDS. Federal funding exacerbates the problem, he noted, as it is largely targeted at youth.

"When we are talking about AIDS, the service organizations really are geared up for serving a younger clientele," he said. "They are very focused on HIV prevention and treatment issues, so they don't know so much about aging issues." The reverse is also true of aging service providers, added Brennan-Ing, who "have extremely limited knowledge of HIV. Really it is a question of building bridges between these two service systems."

"...We just see so many people dealing with addiction issues, mental health issues – suicide rates are just astonishing – so there is definitely something there. There are efforts in many cities to create a greater sense of community around long-term survivors and mutual support for those who need it."

San Francisco’s LGBT Aging Policy Task Force.... noted that older people living with HIV/AIDS "commonly experience increased prevalence of substance abuse and the need for mental health services."

The policy body cited social services, housing and homelessness resources as needed for this segment of the city's LGBT senior adult population, along with "socialization and support group opportunities." The report also reiterated calls for "stronger HIV/AIDS cultural competency among mainstream senior service providers."

The irony of being able to live with HIV and live longer... is that it allows people time to grieve and recall those they have lost. For some the adjustment from fighting not to die to figuring out how to live can be too much of a psychosocial jolt.

"Something I have heard a lot of people say in terms of 'my mental health' is I had the most serious problem after I was getting better. It wasn't when I was so sick,...Yes, I was sad, but my life was so focused and I had so much to do every day. It was when my health came back that I didn't have that clarity of purpose. “ said Sean Strub. "Those were rough years after my health came back, rougher than when I was sick.... "(BAR, 2014)
Section VIII. Conclusion

Thirty-three years into the U.S. epidemic, the needs of gay, bisexual men who have sex with men and transgender women have moved to the center of the US epidemic and its response. The Obama Administration has made addressing the needs of gay, bisexual men who have sex with men a priority of the national HIV/AIDS strategy. As recently as December 2013 the White House released an update on the National HIV/AIDS Strategy which reported that “gay and bisexual men represent two-thirds of all new HIV infections nationwide.” If we are to reach an AIDS-Free Generation, it will be necessary to “re-double efforts to effectively prevent and treat HIV among gay and bisexual men….Each locality must assess how best to deal with its HIV/AIDS challenges while also adhering to science-based approaches and remaining accountable for strategies that reduce new infections and improve the health of people living with HIV. Moreover, it is critical that people living with HIV continue to provide leadership and guidance in policy and program implementation.” (ONAP, 2013). This HIV Health and Wellness Assessment and Exploratory study seeks to assist the Ryan White Part A Grantee with some of the answers on how to best deal with its HIV/AIDS challenges...and include the experiences and voices of those living with HIV and those of unknown HIV Sero-status in policy and program implementation.

The initial finding from this assessment and exploratory study show that Broward County has emerged as the new gay Mecca and one of the newest HIV epicenters. The findings of this study strongly suggest the two are inextricably linked. The findings also suggest that it is time to gain a thorough understanding of the HIV challenge in Gay Broward and implement a well-coordinated, community-wide collaborative response. No one segment of greater Broward County, that is: the gay community, African-American, Caribbean, Latino, immigrant, migrant communities; nor the government, health, behavioral health, public health sectors can address the needs of gay, bisexual men who have sex with men and transgender women living with and at risk for HIV alone. Addressing HIV must be everyone’s business.

As shown throughout the findings of this project and exploratory study, the HIV epidemic in Broward County is influenced by profound socio-sexual-cultural economic dynamics. Broward is home to the largest gay pride festival in Florida and to the greatest number of new HIV infections. In Broward, multi-night circuit parties, all male, all nude, all night sex clubs, and the emerging gay porn industry are in close proximity to each other. It is relatively easy to gain access to ‘anonymous sex, alcohol, and crystal meth, a drug that MSM and transgender women may turn to as a way to ease hardships associated with a lack of social and communications skills, loneliness, isolation, and the exhaustive vigilance required to avoid HIV. As one focus group member put it, these conditions create “the perfect storm” of HIV infection.

The HIV comprehensive planning process carried out annually by the Broward Regional Health Planning Council provides an opportunity to develop and plan for an effective system of care. In responding to the demands of the epidemic, identification of gay, bisexual and other men who have sex with men, unaware of their HIV status and linking them to care –while at the same time ensuring those who in care remain in care becomes an important component of the response. Community supportive care and ongoing medical services are critical to changing the course of the epidemic. The information from this HIV Health and Wellness Assessment Project and Exploratory Study will contribute to the overall assessment of needs of gay, bisexual men who have sex with men and transgender women in Broward County.
This exploratory study, which focuses the assessment lens on the lived experience of men and transgender women who are living with or most at risk of HIV infection, seeks to bring into closer view all of the factors that are contributing to the local HIV epidemic.

Recognizing that efforts and interventions to date have been underfunded and thus limited in their ability to produce significant reductions in HIV infections overall, it may be time to consider moving beyond focusing on healthcare service delivery strategies alone. An integrated comprehensive HIV strategy may be more effective. Such a strategy could include but not necessarily be limited to a mix of programs and biomedical, socio-sexual-cultural, and educational interventions as per the responses from the informant interviews and focus group would indicate.

The information contained in this report undertaken by the Broward Regional Planning Council on behalf of the Broward County Ryan White Part A Grantee suggest the need to examine the current set of HIV health related programs to determine if the mix of services has the capacity and infrastructure to: identify those gay and bisexual men who have sex with men at serious risk for HIV infection and enroll these men in educational and biomedical health promotion programs; expand HIV targeted testing to reach more men who have sex with men of unknown HIV sero-status and venue based HIV screening; modernize the HIV message so that those men who have sex with men at greatest risk for HIV infection understand the serious nature of HIV disease beyond ‘one pill a day’; work with the gay business and commerce leaders, circuit party promoters to advance new socio-sexual-cultural health norms within Broward’s diverse gay community; consistently disseminate educational information about HIV to the entire community; and engage a broad group of HIV community stakeholders, public and private sector health and community leaders in a series of new strategy development sessions.

In Broward County, addressing HIV is everyone’s business.
Section IX. Study Implications: Recommendations

The recommendations presented in this report are provided in the context of the overall HIV epidemic in South Florida with a particular focus on Broward County. Gay, bisexual and other men who have sex with men, transgender women are at greatest risk for HIV infection in Broward County and comprise more than 78 percent of the cases. In 2013, more than 18,030 persons were living with HIV in Broward. It has been estimated that 1 out of 5 people with HIV are unaware they are HIV positive, an estimated 3800 residents. The largest concentration of HIV cases are in the greater Fort Lauderdale area. In 2013, more than 1,000 new cases of HIV were reported and more than 475 new cases of AIDS were reported in Broward County. (FHBCSR, 2013)

The National HIV/AIDS Strategy calls for a reduction in new infections, stopping the spread of HIV and ensuring everyone (those individuals of known HIV sero-status who are HIV positive and those of unknown HIV sero-status at risk for infection) gets the care they need. The current socio-sexual cultural realities for gay and bisexual men who have sex with men in Broward County suggest the need for the HIV service network to come together and assess current population needs and concomitant program approaches. Additionally, in the recurring environment of scarce and limited resources, budget reductions and increased demand, now may be the time to re-think the local response.

The recommendations that follow grow out of the findings from this assessment and exploratory study. The key findings include: (1) the need to assess and address HIV risk and HIV infection of transgender women, and gay and bisexual men within the context of their lives and their social and sexual communities; (2) the need to assess and address cultural competence among behavioral health providers of services to gay, bisexual men who have sex with men in Broward County suggest the need for the HIV service network to come together and assess current population needs and concomitant program approaches. Additionally, in the recurring environment of scarce and limited resources, budget reductions and increased demand, now may be the time to re-think the local response.

Recommendation 1. Establish a Men’s Health and HIV Advisory Workgroup. Work with the Florida Department of Health Broward County HIV prevention program to establish a countywide body to plan for and develop a draft action agenda that identifies and addresses the needs of gay, bisexual men who have sex with men. The advisory group should be inclusive of gay, bisexual men who have sex with men and transgender women of known and unknown HIV sero-status, public and private sectors health providers, corporate and local business leadership, party promoters and resort owners serving the gay, bisexual and transgender community.

Recommendation 2. Expand access to Mental Health and Substance Abuse Services for gay, bisexual men who have sex with men who are living with HIV. Conduct a service category evaluation for the Substance Abuse and Mental Health services categories. This review will analyze the current service category design, service delivery model and cultural competence of the service delivery system. Subsequently, recommendations should be made that ensure the inclusion of best practice models that are culturally competent for the treatment of gay, bisexual men who have sex with men. The recommended models must reflect the unique psychosocial needs of gay and bisexual men including the issues of shame, isolation, stigma and denial, identify and implement best practices for gay men in the area of behavior modification and impulse control, review existing protocols for serving gay, bisexual men who have sex with men, create a ‘first visit’ feedback form, and establish on-going staff development program for providers who serve gay, bisexual men who have sex with men.
Recommendation 3. Establish an intergovernmental HIV planning integration taskforce to focus on the HIV epidemic in the greater Broward Community. Coordinate with the Florida Department of Health Broward County to establish an on-going HIV prevention and care integration task force responsible for ensuring coordination and collaboration across prevention, treatment, care and support. Convene a day-long retreat of care and prevention planning bodies to review national, state and local HIV landscape, Broward County epidemiology and Broward County HIV, health and human service delivery system; identify priorities, gaps in service and unmet needs across prevention, care, treatment and research. Review by-laws of the HIV planning bodies, develop a white paper for education, cross-walk and cross-training, work plans and implementation action steps with goals and objectives that align prevention, treatment, care and support for gay, bisexual men who have sex with men and transgender women.

Recommendation 4. Sponsor an annual Tri-County (Broward, Dade, Palm Beach) Summit on HIV and Gay Men. This annual summit, sponsored by the Broward County Part A Program and the Florida Department of Health at Broward County, will serve as the county collaborative bringing together all of the key stakeholders to address the epidemic, examine issues of cultural competence service delivery, and assess current prevention and care strategies across the tri-county region. Convene the tri-county public health HIV and community leaders’ summit to discuss the creation of a coordinated plan and response to the HIV epidemic among gay, bisexual men in Broward, Dade and Palm Beach Counties; Review national, state and local HIV landscape, the tri-county epidemiological profiles of each county and the South Florida region; Issue a joint info graphic highlighting the state of the epidemic among gay and bisexual men in the Tri-county area; Identify priorities, gaps in service and unmet needs across prevention, care, treatment and research and develop a collaborative Tri-County HIV agenda on gay, bisexual men who have sex with men and transgender women.
Glossary of Terms
Glossary of Terms

Acquisition of HIV
Also known as: acquiring HIV
Acquisition is the act of getting or receiving something, such as HIV. AIDS is an acquired, not an inherited, form of immune deficiency.

Acute HIV Infection
Also known as: Primary HIV Infection
Early stage of HIV infection that extends approximately 2 to 4 weeks from initial infection until the body produces enough HIV antibodies to be detected by an HIV antibody test. Because the virus is replicating rapidly, HIV is highly infectious during this stage of infection.

AIDS Case Definition
Diagnostic criteria for AIDS established by the Centers for Disease Control and Prevention (CDC). To be diagnosed with AIDS, a person with HIV must have an AIDS-defining condition or have a CD4 count less than 200 cells/mm³.

AIDS Drug Assistance Programs (ADAPs)
Federally funded programs that provide medications and other HIV-related services to low-income, uninsured, and underinsured people with HIV/AIDS. Services of AIDS Drug Assistance Programs (ADAPs) are available in all 50 states and U.S. territories.

AIDS Service Organization (ASO)
A non-governmental organization that provides services related to the prevention and treatment of HIV/AIDS.

AIDS-Defining Condition
Any HIV-related illness included in the Centers for Disease Control and Prevention’s (CDC) list of diagnostic criteria for AIDS. AIDS-defining conditions include opportunistic infections and cancers that are life-threatening in a person with HIV.

AIDS-Related Complex (ARC)
Symptoms that signal the transition from asymptomatic HIV infection to symptomatic HIV infection (but not full-blown AIDS). Symptoms can include recurring fever, unexplained weight loss, swollen lymph glands, diarrhea, or fungal infection of the mouth.

Asymptomatic HIV Infection
Also known as: Clinical Latency
Stage of HIV infection during which there are no symptoms of HIV infection. During this stage of HIV infection, which varies in length of time from person to person, HIV slowly destroys the immune system. Antiretroviral therapy (ART) can prevent the onset of symptomatic HIV infection and AIDS.

Baseline
An initial measurement used as the basis for future comparison. For people infected with HIV, baseline testing includes CD4 count, viral load (HIV RNA), and resistance testing. Baseline test results are used to guide HIV treatment choices and monitor effectiveness of antiretroviral therapy (ART).
CD4 Count
Also known as: CD4 Cell Count, CD4 T Lymphocyte Count
A laboratory test that measures the number of CD4 T lymphocytes (CD4 cells) in a sample of blood. In people with HIV, the CD4 count is the most important laboratory indicator of immune function and the strongest predictor of HIV progression. The CD4 count is one of the factors used to determine when to start antiretroviral therapy (ART). The CD4 count is also used to monitor response to ART.

CD4 Percentage
Also known as: CD4 Cell Percentage, CD4 T Lymphocyte Percentage
Percentage of white blood cells that are CD4 T lymphocytes (CD4 cells). In certain cases, such as during acute HIV infection or HIV infection in children younger than 5 years of age, CD4 percentage is used rather than CD4 count to assess HIV progression or response to antiretroviral therapy (ART).

Centers for Disease Control and Prevention (CDC)
A federal agency that protects the health and safety of people at home and abroad through health promotion; prevention and control of disease, injury, and disability; and preparedness for new health threats.

Centers for Disease Control and Prevention-National Prevention Information Network (CDC-NPIN)
Also known as: National Prevention Information Network
A service of the Centers for Disease Control and Prevention (CDC) that disseminates information on HIV/AIDS, viral hepatitis, other sexually transmitted diseases, and tuberculosis (TB). Information is available via the Web, phone, e-mail, and postal mail.

Centers for Medicare and Medicaid Services (CMS)
Also known as: Health Care Financing Administration
A federal agency that administers the Medicare program and monitors the Medicaid programs offered by each state, including the Children's Health Insurance Program.

Central Nervous System (CNS)
The part of the nervous system that is made up of the brain and spinal cord. The central nervous system (CNS) serves as the main processing center for the entire nervous system and coordinates all body functions. HIV infection or use of some antiretroviral (ARV) drugs can cause damage to the CNS.

Chemoprevention
Also known as: Chemoprophylaxis
Use of specific drugs, vitamins, or other substances to reverse, suppress, or prevent a disease.

Chlamydia
A common sexually transmitted infection caused by the bacterium Chlamydia trachomatis. Chlamydia often has mild or no symptoms, but if left untreated, it can lead to serious complications, including infertility. Chlamydia may increase the risk of HIV transmission.

Class-Sparing Regimen
An antiretroviral (ARV) drug regimen that purposefully excludes all ARV drugs from a specific drug class. Class-sparing regimens are used to save specific ARV drugs for future use in case a regimen needs to be changed because of toxicity or drug resistance. A class-sparing regimen may also be used to avoid adverse effects associated with a specific drug class.
Clinical Progression
Advance of disease that can be measured by observable and diagnosable signs or symptoms. For example, HIV progression can be measured by change in CD4 count.

Clinical Trial
A research study that determines whether a new drug (or other intervention) is both safe and effective for humans. There are two main types of clinical trials: interventional trials and observational trials.

ClinicalTrials.gov
An online, searchable database of up-to-date information on thousands of federally and privately supported clinical trials for a wide range of diseases and conditions, including HIV infection. The site provides information about a trial's purpose, who may participate, study site locations, and contact information. ClinicalTrials.gov is managed by the federal government.

Cohort
A group of individuals with certain characteristics in common, such as age or disease risk factor. For example, participants for a clinical trial may be recruited from a particular cohort, such as women of child-bearing age, children under 5 years old, or males with high blood pressure.

Coinfection
When a person has two or more infections at the same time. For example, a person infected with HIV may be coinfected with hepatitis C (HCV) or tuberculosis (TB) or both.

Communicable Disease
An infectious disease that is contagious.

Community-Based Organization (CBO)
A public or private nonprofit organization that provides services to local community members of an identifiable group, such as people with HIV.

Co-morbidity
Also known as: Co-morbid Condition
When a person has two or more diseases or conditions at the same time. For example, a person with high blood pressure may also have heart disease.

Condom
Also known as: Prophylactic
A product used during sex (including vaginal, anal, or oral sex) to prevent the transmission of sexually transmitted infections, such as HIV, and/or the likelihood of pregnancy. The male condom is a thin rubber cover that fits over a man’s erect penis. The female condom is a polyurethane pouch that fits inside the vagina.

Data Triangulation
Also known as: Triangulation
The mixing of data or methods so that diverse viewpoints or standpoints cast light upon a subject. The mixing of data types, known as data triangulation, is often thought to help in validating the claims that might arise from an initial pilot study. The mixing of methodologies, e.g. mixing the use of survey data with interviews is a more profound form of triangulation.
Efficacy
Effectiveness of a drug or other medical intervention. Drugs are tested for efficacy to ensure they produce the desired effect on the disease or condition being treated.

Eligibility Criteria
Also known as: Exclusion/Inclusion Criteria, Inclusion/Exclusion Criteria
Factors used to determine whether a person is eligible (inclusion criteria) or not eligible (exclusion criteria) to participate in a clinical trial. Eligibility criteria may include disease type and stage, other medical conditions, previous treatment history, age, and gender.

Elite Controllers
A very small subset of people infected with HIV who are able to maintain suppressed viral loads for years without antiretroviral (ARV) drugs. Although antiretroviral therapy (ART) may be theoretically beneficial for elite controllers, there is no clinical data supporting therapy for this group.

Endemic
When a disease occurs frequently and at a predictable rate in a specific location or population.

Epidemic
A widespread outbreak of a disease in a large number of individuals over a particular period of time either in a given area or among a specific group of people.

Epidemiology
The study of the distribution, causes, and clinical characteristics of disease or health status in a population.

False Negative
A negative test result that incorrectly indicates that the condition being tested for is not present when, in fact, the condition is actually present. For example, a false negative HIV test indicates a person does not have HIV when, in fact, the person is infected with HIV.

False Positive
A positive test result that incorrectly indicates that the condition being tested for is present when, in fact, the condition is actually not present. For example, a false positive HIV test indicates a person has HIV when, in fact, the person is not infected with HIV.

Hepatitis
Inflammation of the liver, usually from a viral infection. The most common hepatitis infections are hepatitis A, hepatitis B, and hepatitis C. Hepatitis may also be due to autoimmune disease, alcohol, medications, or toxic agents. Symptoms of hepatitis, if any, can include loss of appetite, nausea and vomiting, and jaundice. Hepatitis can lead to liver damage, liver failure, or cancer. Hepatitis is also often used to refer to the group of viral infections that affect the liver (hepatitis A, B, C, D, and E).

Hepatitis B Virus (HBV) Infection
Infection with the hepatitis B virus (HBV). HBV can be transmitted through blood, semen, or other body fluids during sex or injection-drug use. Because HIV and HBV share the same modes of transmission, people infected with HIV are often
also coinfected with HBV. HBV infection progresses more rapidly in people coinfected with HIV than in people infected with HBV alone.

**Hepatitis C Virus (HCV) Infection**
Infection with the hepatitis C virus (HCV). HCV is usually transmitted through blood and rarely through other body fluids, such as semen. HCV infection progresses more rapidly in people co-infected with HIV than in people infected with HCV alone.

**High Impact Prevention**
An approach that prioritizes prevention activities based on their effectiveness, cost, coverage, feasibility and scalability, in order to have the greatest possible impact with available resources. New biomedical tools such as pre-exposure prophylaxis (PrEP) for MSM and heterosexual men and women, along with expanded testing, treatment and linkage to care, could have an important impact on infection rates, if used strategically and in combination with other proven prevention strategies.

**HIV Prevention Trials Network (HPTN)**
A federally funded, worldwide clinical trials network that develops and tests the safety and efficacy of primarily non-vaccine interventions designed to prevent the transmission of HIV.

**HIV Progression**
The course of HIV infection. HIV is a chronic infection that progresses in four stages: acute HIV infection, asymptomatic HIV infection, symptomatic HIV infection, and AIDS. Antiretroviral therapy (ART) is designed to delay or stop the progression of HIV infection.

**HIV Vaccine Trials Network (HVTN)**
A federally funded international clinical trials network that works towards finding an effective and safe HIV vaccine. HIV Vaccine Trials Network (HVTN) conducts clinical trials on preventive HIV vaccines and educates community members on the general science of HIV/AIDS vaccines and associated research methods.

**HIV-1**
One of the two types of HIV, the virus that causes AIDS. AIDS is the most advanced stage of HIV infection. HIV-1 is transmitted through direct contact with HIV-infected body fluids, such as blood, semen, and genital secretions, or from an HIV-infected mother to her child during pregnancy, delivery, or breastfeeding (through breast milk). HIV-1 is responsible for the majority of HIV infections worldwide. In the United States, unless otherwise noted, the term “HIV” primarily refers to HIV-1.

**HIV-2**
One of the two types of HIV, the virus that causes AIDS. AIDS is the most advanced stage of HIV infection. HIV-2 infection is endemic to West Africa. Like HIV-1, HIV-2 is transmitted through direct contact with HIV-infected body fluids, such as blood, semen, and genital secretions, or from an HIV-infected mother to her child during pregnancy, delivery, or breastfeeding (through breast milk). HIV-2 infection generally takes longer to progress to symptomatic HIV/AIDS and has a lower mortality rate than HIV-1 infection.

**Latent HIV Reservoir**
Resting CD4 cells (or other cells) that are infected with HIV but not actively producing HIV. Latent HIV reservoirs are established during the earliest stage of HIV infection. Although antiretroviral therapy (ART) can reduce the level of HIV
in the blood to an undetectable level, latent reservoirs of HIV continue to survive. When a latently infected cell is reactivated, the cell begins to produce HIV again. For this reason, ART cannot cure HIV infection.

**LGBTQ**
Acronym for lesbian, gay, bisexual, transgender, and ‘questioning’.

**Microbicide**
A drug, chemical, or other substance used to kill microorganisms. Increasingly, the term is used specifically for substances that prevent or reduce the transmission of sexually transmitted infections, such as HIV.

**Microbicide Trials Network (MTN)**
A federally funded clinical trials network. Many Micobicide Trials Network (MTN) trials focus on evaluating microbicides and other promising HIV prevention approaches.

**Morbidity**
Disease state or symptom. Morbidity rate is a measure of the frequency of occurrence of disease among a defined population during a specified time period.

**Mortality**
The state of being mortal (subject to death). Mortality rate is a measure of the frequency of occurrence of death among a defined population during a specified time period.

**MSM**
Acronym for men who have sex with men.

**MSMW**
Acronym for men who have sex with men and women.

**Multicenter AIDS Cohort Study (MACS)**
Started in 1984, the study involves collection of biological specimens and medical and behavioral data on MSM (men who have sex with men) in order to study the natural and treated history of HIV. The Multicenter AIDS Cohort Study (MACS) has significantly contributed to the understanding of HIV, AIDS, and the effects of antiretroviral therapy (ART).

**National Institute of Allergy and Infectious Diseases (NIAID)**
A federal agency that supports basic and applied research to prevent, diagnose, and treat infectious and immune-mediated illnesses, including HIV/AIDS and other sexually transmitted infections. The Institute also supports medical research studies on tuberculosis (TB), malaria, autoimmune disorders, asthma, allergies, and illnesses from potential bioterrorism agents.

**National Institutes of Health (NIH)**
A federal agency that is the largest source of funding for medical research in the world. The National Institutes of Health (NIH) is made up of several institutions, each with a specific research focus, such as a particular disease or body system.

**Opportunistic Infection (OI)**
An infection that occurs more frequently or is more severe in people with weakened immune systems, such as people with HIV or people receiving chemotherapy, than in people with healthy immune systems.
**People Living with HIV/AIDS (PLWHA)**
Also known as: People Living with AIDS, People Living with HIV
Infants, children, adolescents, and adults infected with HIV/AIDS.

**Randomized Trial**
A type of clinical trial in which participants are assigned by chance (randomized) to treatment and control groups, or among various treatment groups. Randomization produces groups that are similar overall in terms of general characteristics, such as age or gender, and other factors that might affect the disease or condition being studied. Having groups that are as similar as possible at the start of a clinical trial allows researchers to conclude with a certain level of confidence whether one treatment is better than another at the end of the trial.

**Rapid Test**
A type of HIV antibody test used to screen for HIV infection. A rapid HIV antibody test can detect HIV antibodies in blood or oral fluid in less than 30 minutes. A positive rapid HIV antibody test must be confirmed by a second, different antibody test (a positive Western blot) for a person to be definitively diagnosed with HIV infection.

**Replicate**
To produce a copy or duplicate. The HIV life cycle describes the 7-step process by which HIV replicates.

**Resistance Testing**
Also known as: Resistance Assay
Laboratory testing to identify which, if any, antiretroviral (ARV) drugs will not be effective against a person's specific strain of HIV. Resistance testing is done using a sample of blood. There are two types of resistance testing: genotypic and phenotypic. Resistance testing is used to guide selection of an HIV regimen when initiating or changing antiretroviral therapy (ART).

**Retrospective Study**
A type of medical research study. Retrospective studies look back in time to compare a group of people with a particular disease or condition to a group of people who do not have the disease or condition. Researchers study the medical and lifestyle histories of the people in each group to learn what factors may be associated with the disease or condition.

**Ryan White HIV/AIDS Program**
Also known as: the CARE Act
The largest federally funded program providing HIV-related services to low-income, uninsured, and underinsured people with HIV/AIDS. The program's services are available in all 50 states and U.S. territories.

**Sero-conversion**
When an HIV-infected person converts from HIV negative to HIV positive by blood testing. Shortly after infection with HIV, the body begins to produce HIV antibodies. It takes the body a while to produce enough antibodies to be detected by an HIV antibody test—usually 10 to 14 days but sometimes up to 6 months. When HIV antibodies in the blood reach a detectable level, the HIV-infected person sero-converts. In other words, the person’s antibody test goes from HIV negative to HIV positive.

**Sero-prevalence**
The overall occurrence of a disease or condition within a defined population at one time, as measured by blood tests (serologic tests).
Sero-status
The state of either having or not having detectable antibodies against a specific antigen, as measured by a blood test (serologic test). For example, HIV seropositive means that a person has detectable antibodies to HIV; seronegative means that a person does not have detectable HIV antibodies.

Set Point
Also known as: Viral Set Point
The viral load (HIV RNA) that the body settles at within a few weeks to months after infection with HIV. Immediately after infection, HIV multiplies rapidly and a person’s viral load is typically very high. After a few weeks to months, this rapid replication of HIV declines and the person's viral load drops to its set point.

Sexual Transmission
Transmission of HIV, or other sexually transmitted infection, from one individual to another as the result of sexual contact.

Sexually Transmitted Infection (STI)
Also known as: Sexually Transmitted Disease
An infectious disease that spreads from person to person during sexual contact. Sexually transmitted infections, such as syphilis, HIV infection, and gonorrhea, are caused by bacteria, parasites, and viruses.

Simian Immunodeficiency Virus (SIV)
An HIV-like virus that can infect monkeys and apes and can cause a disease similar to AIDS. Because HIV and simian immunodeficiency virus (SIV) are closely related viruses, researchers study SIV as a way to learn more about HIV. However, SIV cannot infect humans, and HIV cannot infect monkeys.

Substance Abuse and Mental Health Services Administration (SAMHSA)
The lead federal agency for reducing the impact of substance abuse and mental illness in the United States. The Substance Abuse and Mental Health Services Administration (SAMHSA) has a Web site that focuses specifically on behavioral health and HIV/AIDS.

Superinfection
When a person who is already infected with HIV becomes infected with a second, different strain of HIV. Superinfection may cause HIV to advance more rapidly. Superinfection can also complicate treatment if the newly acquired strain of HIV is resistant to antiretroviral (ARV) drugs in the person’s current HIV treatment regimen.

Symptomatic HIV Infection
Stage of HIV infection during which signs or symptoms of the infection begin to appear. The onset of symptoms signals the transition from asymptomatic HIV infection to full blown AIDS.

Syphilis
An infectious disease caused by the bacterium *Treponema pallidum*, which is typically transmitted through direct contact with a syphilis sore, usually during vaginal or oral sex. Syphilis can also be transmitted from an infected mother to her child during pregnancy. Syphilis sores occur mainly on the genitals, anus, and rectum, but also on the lips and mouth. Genital sores (chancres) caused by syphilis increase the risk of sexual transmission of HIV.
Testosterone
A type of sex hormone. Testosterone is necessary for developing and maintaining certain male sex characteristics, and it helps maintain muscle mass and bone density. Testosterone deficiency is common with HIV and may result in a decrease in muscle mass, an increase in body fat, or erectile dysfunction.

T Lymphocyte
Also known as: T Cell
A type of lymphocyte. There are two major types of T lymphocytes: CD8 cells (cytotoxic T lymphocytes) and CD4 cells (helper T lymphocytes); both T cell types are essential for a healthy immune system. HIV infects and destroys CD4 cells, gradually destroying the immune system.

Therapeutic HIV Vaccine
Also known as: HIV Therapeutic Vaccine
A vaccine to slow the progression of HIV infection or delay the onset of AIDS. To date, no therapeutic HIV vaccine exists, but research is underway.

Toxicity
Also known as: Drug Toxicity
The extent to which a drug causes adverse effects. Drug toxicity is one of the factors considered when selecting antiretroviral (ARV) drugs to include in an HIV treatment regimen.

Transgender man
A transgender man is a female-to-male (FtM) person. A transgender man is assigned female at birth, but identifies as male. A transgender male is someone whose gender identity is male, but who does not necessarily change himself physically.

Transgender woman
A trans woman is a male-to-female (MTF) transgender person with a female gender identity.

Transmitted Resistance
When a person becomes infected with a strain of HIV that is already resistant to certain antiretroviral (ARV) drugs.

Treatment Failure
When an antiretroviral (ARV) regimen is unable to control HIV infection. Treatment failure can be clinical failure, immunologic failure, virologic failure, or any combination of the three. Factors that can contribute to treatment failure include drug resistance, drug toxicity, or poor treatment adherence.

True Negative
A negative test result that correctly indicates that the condition being tested for is not present. For example, a true negative HIV test correctly indicates that a person is not infected with HIV.

True Positive
A positive test result that correctly indicates that the condition being tested for is present. For example, a true positive HIV test correctly indicates that a person is infected with HIV.
Tuberculosis (TB)
An infection caused by the bacteria *Mycobacterium tuberculosis* and *Mycobacterium bovis*. Tuberculosis (TB), also referred to as *Mycobacterium* infection, is spread when a person with an active infection (TB disease) coughs, sneezes, speaks, or sings, and then a person nearby breathes in the bacteria. TB usually affects the lungs, but it can also affect other parts of the body, such as the kidneys, spine, and brain. There are two forms of TB: latent TB infection and TB disease. In people with HIV, TB is considered an AIDS-defining condition.

Tuberculosis Disease
The active form of tuberculosis (TB) infection. During TB disease, the bacteria multiply, become active, and make the person sick. A person with TB disease of the lungs can spread TB to others. TB disease primarily affects the lungs, but it can also affect other parts of the body, such as the kidneys, spine, and brain, and it can be fatal. Symptoms include a bad cough that lasts 3 weeks or longer, chest pain, coughing up blood or sputum, weakness, fatigue, loss of appetite, weight loss, fever, chills, and sweating at night. In people with HIV, TB disease is an AIDS-defining condition.

Wellness
It is a dynamic process that requires conditions necessary for the achievement of physical, emotional and social wellbeing…a deliberate, self-directed journey toward a healthy life…learning to make healthier lifestyle choices that enable…achievement of full potential. A harmonious blend of the following nine domains of wellness can result in improved health outcomes: social, spiritual, emotional, environmental, financial, intellectual, mental, physical and sexual.

Western Blot
A type of antibody test used to confirm a positive result on an HIV screening test. (The initial screening test is usually an enzyme-linked immunosorbent assay [ELISA] or, less often, a viral load test). The immune system responds to HIV infection by producing HIV antibodies. A Western blot can detect HIV antibodies in the blood, oral fluid, or urine.

White Blood Cell
A type of cell also known as a leukocyte found in blood and lymph. White blood cells are key components of the immune system and help fight infection and disease. Examples of white blood cells include lymphocytes, neutrophils, eosinophils, macrophages, and mast cells.

Window Period
The time period from infection with HIV until the body produces enough HIV antibodies to be detected by an HIV antibody test. This generally takes 2 to 8 weeks, but in some people it can take up to 6 months. During the window period, a person can have a negative result on an HIV antibody test despite being infected with HIV.
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Appendix A

Review of Literature and Bibliography
Literature Review

A literature review was completed to provide theoretical framework for this MSM HIV Healthcare and Wellness Project and Exploratory Study. Specifically the literature review helped to:

a. Provide a framework for understanding and examining the current state of the epidemic in Broward County as it pertains to gay, bisexual men who have sex with men living with HIV in South Florida.

b. Provide Broward County health officials with published data to guide its future work in strengthening and improving access to treatment and prevention education services for MSM living with HIV in the county.

c. Provide a reference document that can be used for identifying scientific evidence, program “best practices” and culturally relevant materials.

2. Methodology

The literature review focused on HIV among men who have sex with men in South Florida, the socio-sexual-cultural context of those at risk for HIV, behavioral dynamics and barriers to effective engagement in care and treatment services for men living with HIV. The goal of the literature review was to identify relevant literature for use in the developing program interventions and models.

Various sources were used to identify resources including:

(1) PubMed searches. The PubMed search used key words such as “HIV,” “South Florida,” “gay,” “substance abuse,” “men who have sex with men,” and “behaviors.”

(2) Internet. The PubMed search was expanded, using the same terms and words, to search the internet and thereby identify additional sources and relevant studies.

(3) Bibliographies. Citations contained in reviewed articles and related sources were also reviewed and included in the final bibliography.

2. Findings

350 articles/abstracts were reviewed, from which 117 were selected for inclusion in the bibliography.

3.1 HIV in South Florida (General)

The South has the highest HIV-related mortality and morbidity rates in the USA. The high levels of poverty, HIV-related stigma, and STDs found in the South likely contribute to greater HIV incidence and mortality. In

addition, holding at least one incorrect transmission belief was associated with being younger, heavy alcohol use, being depressed, not having seen a physician in the past 12 months and not knowing one’s HIV status. Debunking them could have HIV prevention value.²

South Florida has unique challenges arising from its migrant and immigrant populations. At least one researcher recommends that interventions be created to target adult recent Latino immigrants based on research of that cohort showing a tendency to engage in alcohol consumption, sex under the influence of alcohol, and sex with multiple partners without using condoms.³

Interventions also should be culturally sensitive, according to another researcher. For example, one team of researcher shed light on normally hidden cultural health behaviors that can impact HIV transmission. The team suggested that medical care must be delivered in a culturally competent, culturally sensitive manner, with open dialogue between physician and patient regarding health beliefs and practices.

3.2 HIV, Men, Clubs and Bathhouses

Several studies now have reported high rates of sexual risk-taking and HIV infection among young men who have sex with men (MSM). One study has concluded that adolescent boys and young men who have sex with men and use methamphetamine seems to be at high risk for human immunodeficiency virus. Thus, the authors recommend that prevention programs among this age group should address issues like housing, polydrug use, and educational needs.⁴

HIV prevention messaging has been shown to reduce or delay high-risk sexual behaviors in young men who have sex with men (YMSM). In one study, the authors examined 6 venues in which YMSM are exposed to, pay attention to, and access HIV prevention information: the Internet, bars/dance clubs, print media, clinics/doctor's offices, community centers/agencies, and educational classes. Data were drawn from a community-based sample of 481 racially and ethnically diverse YMSM from New York City. Significant differences in exposure to HIV prevention messaging venues emerged with respect to age, race/ethnicity, and sexual orientation. Attention paid to HIV prevention messages in various venues differed by age and sexual orientation. Across all venues, multivariate modeling indicated YMSM were more likely to access HIV messaging from the same venues at which they paid attention, with some variability explained by person characteristics (age and perceived family socioeconomic status). This suggests that the one-size-fits-all approach does not hold true, and

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both the venue and person characteristics must be considered when generating and disseminating HIV prevention messaging.\textsuperscript{5}

Those conclusions are reinforced by another group of researcher who recommend that efforts targeted toward highly sexually active HIV-negative/unknown status men might be best positioned online and in gay bars/clubs, whereas those tailored for highly sexually active HIV-positive men may consider targeting the Internet and peers/sexual networks.\textsuperscript{6}

3.3 HIV and GRINDR

Mobile phone social networking applications such as GRINDR are potential tools for recruitment of men who have sex with men (MSM) for HIV prevention research. In one study, demographics and sexual risk behaviors of men recruited through GRINDR and through traditional media were compared. GRINDR participants were younger (mean age 31 vs. 42, $p < 0.0001$), more White identified (44 vs. 30 \%, $p < 0.01$), and had more sex partners in the previous 14 days (1.88 vs. 1.10, $p < 0.05$) than other recruits. Email responses were less successful for enrollment than phone calls (5 vs. 50 \%). This approach resulted in successful recruitment of younger and more educated, White identified MSM.\textsuperscript{7}

Similarly, another team of researchers has found that regular internet usage occurred more often with males, Caucasians, those who were employed, had higher income, and were more educated. Higher levels of education and income >$10,000 predicted regular usage when controlling for race, employment, and gender. Cell phone ownership was associated with being Caucasian, employed, more educated, and salary >$10,000. Employment was the only predictor of owning a cell phone when controlling for income, race, and education. Individuals who were <40 years of age, employed, and more educated were more likely to know how to text message. Employment and post-high school education predicted knowledge of text messaging, when controlling for age. Disparities among internet, cell phone, and text messaging usage exist among HIV-infected individuals.

These studies suggest a need for further research on alternatives to location-based social networking applications to reach non-white males.

4. Summary

This literature review supports the implementation of targeted interventions to address population-specific barriers to care and treatment: One size does not fit all.


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11. Picuriste/injectionist use among Haitian immigrants in Miami-Dade County, Florida: implications for HIV-related theory.


13. HIV prevention and transmission myths among heterosexually active adults in low-income areas of South Florida.


14. How do the sexual behaviors of foreign-born Hispanic men who have sex with men differ by relationship status?


15. Migration, neighborhoods, and networks: approaches to understanding how urban environmental conditions affect syndemic adverse health outcomes among gay, bisexual and other men who have sex with men.


16. Statewide estimation of racial/ethnic populations of men who have sex with men in the U.S.


18. HIV seropositivity and correlates of infection among heterosexually active adults in high-risk areas in South Florida.

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21. Crystal methamphetamine use and sexual risk behaviors among HIV-positive and HIV-negative men who have sex with men in South Florida.


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26. Drug use and Hispanic men who have sex with men in South Florida: implications for intervention development.


27. Mental health in HIV seronegative and seropositive IDUs in South Florida.


29. The relationship of depressive symptoms, self-esteem, and sexual behaviors in a predominantly Hispanic sample of men who have sex with men.


30. The feasibility of modified directly observed therapy for HIV-seropositive African American substance users.


31. Healthy lifestyles and health-related quality of life among men living with HIV infection.


32. Knowledge and attitudes toward HIV/AIDS and risky sexual behaviors among Caribbean African American female adolescents.


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2. HIV risk and substance use in men who have sex with men surveyed in bathhouses, bars/clubs, and on Craigslist.org: venue of recruitment matters.

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8. HIV risk associated with gay bathhouses and sex clubs: findings from 2 seattle surveys of factors related to HIV and sexually transmitted infections.


9. Targeting HIV prevention messaging to a new generation of gay, bisexual, and other young men who have sex with men.


10. Factors associated with HIV-testing history among Black men who have sex with men (BMSM) in Los Angeles County.


11. HIV status differences in venues where highly sexually active gay and bisexual men meet sex partners: results from a pilot study.


12. Condom use, disclosure, and risk for unprotected sex in HIV-negative midlife and older men who have sex with men.


18. The role of bathhouses and sex clubs in HIV transmission: findings from a mathematic model.
19. Perceived importance of five different health issues for gay and bisexual men: implications for new directions in health education and prevention.


20. How "community" matters for how people interact with information: mixed methods study of young men who have sex with other men.


21. Determinants of recent HIV infection among Seattle-area men who have sex with men.


22. Internet-based methods may reach higher-risk men who have sex with men not reached through venue-based sampling.


23. HIV testing in gay sex clubs.

24. Examining differences in types and location of recruitment venues for young males and females from urban neighborhoods: findings from a multi-site HIV prevention study.


26. Correlates of current transactional sex among a sample of female exotic dancers in Baltimore, MD.


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28. Using the internet in pursuit of public sexual encounters: is frequency of use associated with risk behavior among MSM?


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36. Methamphetamine use patterns among urban Black men who have sex with men.


37. Sex partner meeting venues and out-of-state sex partners among men who have sex with men with early syphilis in Connecticut.


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1. Mobile phone text messaging for promoting adherence to antiretroviral therapy in patients with HIV infection.


2. Tailored text messaging intervention for HIV adherence: a proof-of-concept study.


4. Text messaging reduces HIV risk behaviors among methamphetamine-using men who have sex with men.


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7. Enhancing retention of an Internet-based cohort study of men who have sex with men (MSM) via text messaging: randomized controlled trial.


8. Effect of Text Messaging to Deter Early Resumption of Sexual Activity after Male Circumcision for HIV Prevention: A Randomized Controlled Trial.


10. Adolescents' perceptions of a mobile cell phone text messaging-enhanced intervention and development of a mobile cell phone-based HIV prevention intervention.


11. Following the trail of an HIV-prevention Web site enhanced for mobile cell phone text messaging delivery.


12. The cellular generation and a new risk environment: implications for texting-based sexual health promotion interventions among minority young men who have sex with men.


13. Text messaging for enhancement of testing and treatment for tuberculosis, human immunodeficiency virus, and syphilis: a survey of attitudes toward cellular phones and healthcare.

14. **Scope and effectiveness of mobile phone messaging for HIV/AIDS care: a systematic review.**


15. **Two-way text messaging for health behavior change among human immunodeficiency virus-positive individuals.**


16. **Text messaging for HIV prevention with young Black men: formative research and campaign development.**


17. **Feasibility of interactive text message response (ITR) as a novel, real-time measure of adherence to antiretroviral therapy for HIV+ youth.**


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19. **Putting prevention in their pockets: developing mobile phone-based HIV interventions for black men who have sex with men.**

20. Receptivity of African American adolescents to an HIV-prevention curriculum enhanced by text messaging.

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24. Recent advances (2011-2012) in technology-delivered interventions for people living with HIV.

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26. Are smokers with HIV using information and communication technology? Implications for behavioral interventions.


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29. Preliminary Evidence for Feasibility, Use, and Acceptability of Individualized Texting for Adherence Building for Antiretroviral Adherence and Substance Use Assessment among HIV-Infected Methamphetamine Users.


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33. Emerging technologies for HIV prevention for MSM: what we have learned, and ways forward.

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34. Technical Implementation of a Multi-Component, Text Message-Based Intervention for Persons Living with HIV.

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36. Beyond reminders: a conceptual framework for using short message service to promote
prevention and improve healthcare quality and clinical outcomes for people living with HIV.


37. Mobile health use in low- and high-income countries: an overview of the peer-reviewed literature.


40. Acceptability of Mobile Phone Technology for Medication Adherence Interventions among HIV-Positive Patients at an Urban Clinic.


41. Can you hear me now? Limited use of technology among an urban HIV-infected cohort.


42. Interventions using new digital media to improve adolescent sexual health: a systematic
43. Current trends in Internet- and cell phone-based HIV prevention and intervention programs.


44. The birds, the bees, and the Bible: single African American mothers' perceptions of a faith-based sexuality education program.


**HIV and Grindr**

1. Epidemiology, sexual risk behavior, and HIV prevention practices of men who have sex with men using GRINDR in Los Angeles, California.


2. Patterns of Lifetime and Recent HIV Testing Among Men Who Have Sex with Men in New York City Who Use Grindr.


3. Use of the location-based social networking application GRINDR as a recruitment
tool in rectal microbicide development research.

Appendix B

Client Assessment Survey
Client Needs Assessment Survey

The information gathered from this survey will be used in planning and improving HIV services and programs in Broward County. Please respond to each of the following questions or statements by checking the appropriate boxes and or filling in the blanks. It is important that you answer each of the questions and the information you provide will remain anonymous.

1. You are: (Check all boxes that apply)
   - A person living with HIV
   - A person living with AIDS
   - A person caring for a person living with HIV/AIDS

2. Your age: (Check one box)
   - 17 or younger
   - 18 – 24
   - 25 – 34
   - 35 – 44
   - 45 – 54
   - 55 – 64
   - 65 & older

3. Your Gender: (Check one box)
   - Male
   - Female
   - Transgender
   - Male – Female
   - Female – Male

4. How do you identify yourself? (Check one box)
   - Heterosexual
   - Gay Male
   - Bisexual
   - Lesbian
   - Man who has sex with men
   - Other (specify)

5. a. Your primary racial/ethnic background? (Check one box)
   - Black or African American (non-Hispanic)
   - White (non-Hispanic)
   - Hispanic or Latino(a)
   - Asian
   - Native Hawaiian/Pacific Islander
   - American Indian or Alaska Native
   - Other (specify)

   b. Where were you born? (Check one box)
   - United States
   - South America
   - Asia
   - Central America
   - Caribbean
   - Africa
   - Other (specify)

   c. Would interpreter services be of help to you? (Check one box)
   - Yes
   - No
   - None Needed
   If yes, what is your primary language?
   - Spanish
   - ASL (American Sign Language)
   - Other (specify) _______________

6. a. Where in DC do you live? (Check one box)
   - Fort Lauderdale
   - Hollywood
   - Wilton Manors
   - Other ______

   b. What is your zipcode? ______

7. a. What is your housing status? (Check one box)
   - Rent/Own
   - Homeless
   - Shelter
   - Living with Relatives/friends
   - AIDS Group/Assisted Housing
   - Residential Treatment/Group Home

   b. Do you currently need help finding housing or paying your rent? (Check one box)
   - Yes
8. a. Have you ever been in prison (Check one box)
   □ Yes
   □ No

8. b. If yes, were you released from prison in the last year? (Check one box)
   □ Yes
   □ No
   □ Not Applicable

8. c. Did you receive discharge planning prior to your release from prison? (Check one box)
   □ Yes
   □ No
   □ Not Applicable

9. a. What is your current primary employment status? (Check one box)
   □ Full-Time
   □ Part-time
   □ Volunteering
   □ Looking for work
   □ Unable to work
   □ Working under the table
   □ Other (specify)

9. b. What is your total household yearly income which includes your income? (Check one box)
   □ None
   □ $10,000 or less
   □ $10,001 – 20,000
   □ $20,001 – 30,000
   □ $30,001 – 40,000
   □ $40,000+

10. a. How many persons including yourself live in your household? (Check one box)
    □ 1
    □ 2
    □ 3
    □ 4
    □ 5+
    □ None

10. b. How many children live in your household? (Check one box)
    □ 1
    □ 2
    □ 3
    □ 4
    □ 5+
    □ None

11. Which financial benefits do you currently receive? (Check all boxes that apply)
    □ None
    □ SSI
    □ SSDI
    □ Pension
    □ TANF
    □ Social Security (Retirement)
    □ Unemployment
    □ Veteran (VA)
    □ Ryan White
    □ Don’t Know

12. Which medical benefits do you currently receive? (Check all boxes that apply)
    □ Medicaid
    □ Medicare
    □ Ryan White
    □ Veterans (VA)
    □ Private Insurance (Specify)
    □ Other (Specify)
    □ None

Would you like to receive information about applying for health insurance coverage?
   □ Yes  □ No
13. In the last six months have you been treated for a sexually transmitted disease other than HIV? (Check one box)
   - Yes
   - No
   - Don’t Know

14. a. How did you become HIV positive?
   - Having unprotected heterosexual sex with an HIV positive infected person
   - Sharing injection drug needles
   - A male having unprotected sex with an HIV-positive man
   - Other (Specify) ____________________

14. b. How long ago did you first test positive for HIV? (Check One Box)
   - 1 year or less
   - 1 – 3 years
   - 3 – 5 years
   - 5 – 10 years
   - 10 – 15 years
   - 15+ years

14. c. When did you first see a doctor for HIV/AIDS? (Check one box)
   - Immediately (In the hospital or health clinic where tested)
   - Within 30 days of diagnosis
   - Within 6 months of diagnosis
   - 12 months or more after diagnosis (specify)
   - Not applicable

14. d. Are you taking HIV/AIDS medicine (antiretrovirals)? (Check one box)
   - Yes
   - No
   - Don’t Know
   - If yes, How long after your HIV/AIDS diagnosis did you start HIV/AIDS medicine?

14. e. Have you ever been diagnosed with AIDS? (Check one box)
   - Yes
   - No
   - I don’t know
   - If yes, How long ago?
   - Within 30 days
   - Within 6 months
   - 12 months or more after diagnosis (specify)
   - Not applicable

14. f. In the last year, how many times have you visited your doctor? (Check one Box)
   - One
   - Two
   - Three
   - Four or More
   - Not at all

14. g. In the last year, how many times did you not see your HIV/AIDS nurse practitioner, physician’s assistant, or doctor because you felt that you could not afford it? (Check one Box)
   - One
   - Two
   - Three
   - Four or More
   - Not at all

14. h. In the last six months you HIV medical care included. (Check all boxes that apply.)
   - Taking HIV meds
   - T-cell tests
   - Viral Load tests
   - Scheduled appointments with medical staff
   - None of the above
15. In the last six months, has your doctor talk to you about any of the following? (Check all boxes that apply)
   - Your medical treat or dental care
   - Taking HIV meds
   - Practicing safer sex
   - HIV risk reduction education/counseling
   - Substance abuse
   - Mental health
   - None of the above
   - I don’t have a primary medical doctor

16. Your most recent Viral Load was: (Check one box)
   - Undetectable
   - Detectable
   - Don’t Know

17. Your most recent T-cell (CD4) count was:
   (Check one box)
   - 200 or under
   - 201-350
   - Above 350
   - Don’t know

18. a. In the last six months, have you been taking?
   (Check all boxes that apply)
   - Multiple HIV meds (anti-retrovirals)
   - Meds such as Bactrim, Zithromax, and Fluconazole to prevent infections
   - Meds to prevent current infections (such as Hepatitis, Thrush, Tuberculosis, Syphilis, pneumonia)
   - Meds for your nerves (mental health meds)
   - Meds for conditions such as diabetes, high blood pressure, and cholesterol
   - No meds taken
   - Don’t know

   If your doctor has not prescribed HIV medicines for you
   SKIP to question #19

18. b. If you take HIV medicine, in the last six months, have you received HIV-medicines through an AIDS Drug Assistance Program (ADAP) (Check one box)
   - Yes
   - No

18. c. If you take HIV meds, where do you usually pick up your prescribed HIV/AIDS meds?
   (Check one box)
   - From my doctor/clinic
   - Through an organization
   - From my local pharmacy
   - Through mail order

18. d. If you take HIV meds how long does the prescription that your doctor gives you for your HIV/AIDS last? (Check one box)
   - 30 day supply (current month)
   - 60 day supply (current month + 1 refill)
   - 90 day supplie (current month + 2 refills)
   - Greater than 90 day supply

19. In the last six months has you case manager helped you get any of these services?
   (Check one box)
   - Medical or dental treatment
   - Housing
   - Treatment adherence counseling
   - Mental health counseling
   - Substance abuse counseling
   - HIV risk reduction education/counseling
   - Ryan White services
   - ADAP
   - SSI/SSDI
   - Other supportive services (such as food, emergency, financial assistance)
   - I don’t have a case manager
   - None of the above

20. a. Have you ever felt so anxious or worried that you had trouble doing anything for 2 weeks or more? (Check one box)
   - Yes in the last 12 months
   - Yes in the last 5 years
   - Yes in my life
20. b. Have you ever felt so depressed or sad that you had trouble doing anything for two weeks or more? (Check one box)
   ☐ Never
   ☐ Yes in the last 12 months
   ☐ Yes in the last 5 years
   ☐ Yes in my life
   ☐ Never

21. Have you ever thought or has anyone ever told you that you might have had a problem with drugs or alcohol? (Check one box)
   ☐ Yes in the last 12 months
   ☐ Yes in the last 5 years
   ☐ Yes in my life
   ☐ Never

Questions 22a, 22b, and 22c are for WOMEN ONLY.

22. a. Are you pregnant?
   ☐ Yes
   ☐ No
   ☐ Don’t Know
   ☐ Not Applicable

22. b. Are you currently receiving prenatal care? (Check one box)
   a. Yes
   b. No
   c. Don’t Know
   d. Not Applicable

22. c. Has your doctor ever prescribed AZT to prevent the transmission of HIV to your baby? (Check one box)
   ☐ Yes
   ☐ No
   ☐ Don’t Know
   ☐ Not Applicable

23. In the last six months did you Receive or Need, But did not receive any of the services below? (Check one box for each service)

<table>
<thead>
<tr>
<th>Received Services</th>
<th>Needed Services but did NOT Receive</th>
<th>Did NOT need or Receive Service</th>
</tr>
</thead>
</table>

Core Services

a. Primary Medical Care
b. AIDS Drug Assistance
c. Dental Care
d. Mental Health Services
e. Case Management
f. Substance Abuse Services – Outpatient

Supportive Services

a. Child Care Services
b. Emergency Financial Assistance
c. Food Bank, Home Delivered Meals
d. Safe Sex Counseling

 e. Housing Services

 f. Legal Services

 g. Transportation Services

 h. Job Placement and/or Training Services

 i. Other (please, specify) _____________________________________________________

24. a. Do you know that there is a formal complaint (grievance) process for you to use when you have problems with the services you are receiving and/or when you can’t get the services you need but are not receiving?

☐ Yes ☐ No

24. b. If you know about the complaint process, have you ever used it to get help with the services you are getting it to get help finding services you need but couldn’t get? (Check one box)

☐ Yes ☐ No ☐ Unaware of complaint process

24. c. If you ever used the complaint process, were you satisfied with the results? (Check one box)

☐ Yes

☐ No

☐ Never used the process

25. In the last 6 months how often did you... (Check one box for each question)

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Most of the Time</th>
<th>Sometimes</th>
<th>Not Much of the Time</th>
<th>Never</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Have a hard time getting the services you needed?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Have a provider take too long to return your call?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>c. Have to wait too long for an appointment?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. Miss a scheduled appointment with a doctor?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Have trouble telling your case manager what you needed?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f. Have trouble getting transportation to your appointments?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. Have trouble getting child care for you appointments</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>h. Have trouble getting appointments at night?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>i. Have trouble getting appointments on the weekend?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
j. Have a service provider who was not good at working with people with your background? □ □ □ □ □ □ □
k. Have a hard time getting the services you needed? □ □ □ □ □ □ □
l. Have a provider take too long to return your call? □ □ □ □ □ □ □

Comments: ______________________________________________________________

____________________________________________________________________________

___________________________________________________________________________

26. In the last 6 months, how often did you... (Check one box for each question)

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Most of the Time</th>
<th>Sometimes</th>
<th>Not Much of the Time</th>
<th>Never</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Have sex (anal or vaginal) without a condom?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Have sex (anal or vaginal) without discussing HIV status?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Have sex (anal or vaginal) without a condom with an HIV-negative person?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Have sex (anal or vaginal) without a condom with an HIV-positive person?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. Have sex (anal or vaginal) without a condom while drunk or high?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

27. In the past 6 months, how often did you... (Check one box for each question)

<table>
<thead>
<tr>
<th></th>
<th>Several Times A Week</th>
<th>Once or twice a Week</th>
<th>Once or Twice a Month</th>
<th>Less Than Once A Month</th>
<th>Never</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Participate in an HIV support group?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b. Participate in any other support groups?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c. Attend a religious or faith-affiliated service?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d. Get together with other people?</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e. Participate in online chat rooms, Facebook</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>f. Go on a date?</td>
<td>□</td>
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<tr>
<td>g. Visit and/or talk with family and/or friends?</td>
<td>□</td>
<td>□</td>
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<tr>
<td>h. Want social support but could not get it?</td>
<td>□</td>
<td>□</td>
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</tbody>
</table>
28. In the last 6 months, how often you have. (Check one box for each question)

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Most of the Time</th>
<th>Sometimes</th>
<th>Not Much of the Time</th>
<th>Never</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Someone you could count on to share your feelings with or help you solve a problem?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Someone to take you to the doctor if needed?</td>
<td></td>
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<tr>
<td>c. Someone who would let you stay with them if you had no place to stay?</td>
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<tr>
<td>d. Someone to help you with money to pay rent to buy food, or to meet other basic needed?</td>
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<tr>
<td>e. Someone who showed you love and affection?</td>
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<tr>
<td>f. Someone to spend time and have fun with?</td>
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</tr>
<tr>
<td>g. Support from your family and friends when you needed it?</td>
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</tr>
</tbody>
</table>

29. Please indicate how much you agree or disagree with each statement (Check one box for each statement)

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I think less of myself because I have HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. I worry that if people knew I have HIV/AIDS they would think less of me</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>c. I would be very upset if people found out about my sexual orientation</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>d. I think that people who matter to me believe that my sexual orientation is immoral or against God’s will</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>e. I always discuss my HIV status with my sexual partners.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>f. I always tell my sexual partners the truth about my HIV status</td>
<td></td>
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<tr>
<td>g. I think that it would bother me to have sex with someone who is HIV negative</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>h. I feel that all HIV positive people eventually get AIDS</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>i. I feel that there is no need to reveal my own status to a partner who practices unsafe sex, because he/she is probably infected</td>
<td></td>
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</tr>
</tbody>
</table>
j. I already have HIV/AIDS so having unsafe sex won't hurt me

k. I feel that because I have HIV/AIDS it is difficult to form lasting relationships

l. I don’t believe that HIV/AIDS meds really work

Comments: ____________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

30. When was the last time you SKIPPED or MISSED taking any HIV/AIDS meds as prescribed? (Check one box)

☐ Within the last 3 days
☐ Within the last week
☐ Within the last month
☐ More than a month ago
☐ Never skipped or missed HIV meds
☐ Not applicable
If your doctor has not prescribed HIV/AIDS meds for you to take OR if you have not skipped or missed a dose in the past month. DO NOT ANSWER THIS QUESTION.

31. In the past month, how often have you skipped or missed taking you HIV meds because you...

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Forgot them?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. Had too many polls to take?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>c. Wanted to avoid the side effects?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>d. Did not want others to notice you taking medication?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>e. Felt sick or ill?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f. Felt too depressed or overwhelmed?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. Ran out of pills?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>h. Felt good, so figured you didn’t need them?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>i. Didn’t have a way to pay for them?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments about this SURVEY (Give Question # if applicable)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Appendix C

POZ Sexual Health Survey
POZ Survey: Under the Covers

POZ believes everybody—regardless of their HIV status—should enjoy sex to the fullest. So, how’s your sex life lately? Has it changed since you became HIV positive? Please take our confidential survey and let POZ know if and how having HIV has affected your sex life.

1. How many sexual partners have you had in the past year?
   - Zero
   - 1
   - 2-3
   - 4-6
   - 7-9
   - 10 or more

2. How frequently do you usually have sex?
   - More than once a week
   - Once a week
   - A few times a week
   - A few times a year
   - Never

3. Have you had more or less sex since your diagnosis?
   - More
   - Less
   - About the same

4. When you are having sex, do you think about your HIV status?
   - Always
   - Sometimes
   - Never

5. Do you disclose you have HIV before a new sexual encounter?
   - Always
   - Sometimes
   - Never

6. Has having HIV changes your sexual confidence?
   - Yes, I’m more confident
   - Yes, I am less confident
   - No change

7. Have you ever been rejected by a potential sexual partner because you have HIV?
   - Yes
   - No

8. Do you use online dating or hookup sites?
   - Often
   - Sometimes
   - Rarely
   - Never

9. Do you disclose your HIV status online?
   - Always
   - Sometimes
   - Never

10. Do you prefer to have sex with someone who is:
    - HIV positive
    - HIV negative
    - It doesn’t matter
11. What is your current relationship status?
Single   In a committed, monogamous relationship   In an open relationship

12. What year were you born?__________________

13. What is your gender?
Male   Female   Transgender   Other

14. What is your sexual orientation?
Straight   Bisexual   Gay/Lesbian   Other

15. What is your ethnicity? (Check all that apply)
American Indian/Alaskan Native   Arab/Middle Eastern   Asian   Black/African-American
Hispanic/Latino   Native Hawaii/Asian Pacific Islander   White   Other

16. What is your zip code?__________________
Appendix D

Informant Interview Schedules
Broward Informant Interview – Unknown HIV Sero-status

Date________________

Age___________ RACE/Ethnicity__________________________ M F M/F F/M

Sexual ID/Orientation____________ Position____________________________

1. What are three key factors, in your opinion, that contribute to the spread of HIV infection among men who have sex with men in this community?

In your opinion, what could contribute to limiting the influence of these three factors and improving prevention practices in the MSM and Transgender populations?

What two factors serve as barriers to improving prevention practices among MSM and Transgender populations?

What two factors, in your opinion, contribute to the utilization of prevention practices among men who have sex with men and transgender women?
2. In your opinion, what three factors/beliefs contribute to decision making processes about risk of HIV infection/HIV transmission for men who have sex with men, and how do these three factors/beliefs impact prevention practices?

What three steps could prevention focused agencies/programs take to improve HIV prevention practices among men who have sex with men and transgender women in this community?

3. What socio-cultural, economic, political, spiritual and environmental barriers contribute to the spread of HIV in this community? In your opinion, what three steps can be taken by HIV prevention agencies/services to impact them?
Broward Informant Interview – Known HIV Sero-status

Date__________________

Age___________ RACE/Ethnicity__________________________ M F M/F F/M

Sexual ID/Orientation______________ Position__________________________

1. What are the three key factors, in your opinion, that contribute to the spread of HIV infection among men who have sex with men and transgender women in this community?

In your opinion, what could contribute to limiting these three factors and improving utilization of HIV healthcare services and health seeking behaviors in the MSM and Transgender population?

What two factors serve as barriers to participation in HIV healthcare services and health seeking behaviors among MSM and transgender women?

What two factors could contribute to the improved utilization of care and treatment services?
2. In your opinion, what three factors/beliefs contribute to decision making processes about participating in medical services and maintaining a good relationship with a clinical service provider for men who are living with HIV and transgender women, and how do these three factors/beliefs impact utilization of care services?

What three steps could care and treatment focused agencies/programs take to improve participation and retention in HIV medical services for men who have sex with men and transgender women in this community?

3. What socio-cultural, economic, political, spiritual and environmental barriers contribute to the dropping out of HIV related care and treatment services for men in this community? In your opinion, what three steps can be taken by HIV care and treatment agencies/services to improve engagement and retention in care?
Appendix E

How to find a Support Group
HIV 101: How Do I Find HIV Support Groups Near Me?

Everyone has questions when they find out they are positive

Each state has its own toll-free HIV and AIDS hotline, and Project Inform has the full list at ProjectInform.org/hotlines. If you call Project Inform’s HIV Health InfoLine, which is (800) 822-7422, you can talk to nonjudgmental people (in English and Spanish) who will listen to you, share their experiences, offer you accurate information about HIV, and help you navigate health care obstacles and talk to doctors about your concerns.

There are a myriad of support groups, and trying to choose the right one can feel overwhelming. There are more than enough options out there—clinic-based support groups, faith-based support groups, private support groups, online support groups—so you can find one made up of people who share your values, needs, or communication styles. On About.com, HIV specialist Dennis Sifris, MD, and HIV educator James Myhre suggest you consider five things in your search for an HIV support group:

- Is this group able to provide the confidentiality I need to express myself fully and freely?
- Can I speak to this group without fear of embarrassment or judgment?
- Do I require a certain expertise or advice, and, if so, can this group provide me that?
- Does this group provide the kind of support I need to deal with my immediate issues?
- What about the other group members? What has the group experience done for them?

Adapted from HIV Plus March/April 2014
APPENDIX F

Health and Wellness Imperative
Institutionalizing a Health and Wellness Approach

Institutionalizing a Wellness Approach—adapted from the Black Women’s Health Imperative

Wellness is more than the absence of illness; it is a dynamic process and requires the conditions necessary for the achievement of physical, emotional and social well-being. The Imperative envisions a world in which the health is not determined by race or ethnicity, gender, socio-economic status or religious affiliation. As a leading authority on health issues, we aim to work with communities and individuals in a movement toward wellness – the deliberate, self-directed journey towards becoming aware of and learning to make healthier lifestyle choices that enable all persons to achieve their full potential.

We define Wellness as a conscience and deliberate process that encompasses seven different yet interrelated dimensions that are needed to achieve improved health outcomes: Social, Physical, Emotional, Sexual, Intellectual, Environmental and Financial. Through the harmonious balance of these seven components included in our wellness approach, we believe that this can result in achieving health equity.

- **Social Wellness** - the ability to respect oneself and others; interact with one another in a positive, healthy way; have meaningful relationships; and establish support systems that include family, friends and community.

- **Emotional wellness** is not an end stage but a continual process of self-care, change and growth in all areas of one’s life. Achieving emotional wellness means being able to take care of not only one’s emotional health, but also one’s physical, mental and spiritual health. An emotionally well individual is aware of personal limitations, is able to enjoy life, manage feelings and deal with difficulties. S/he is self-aware and self-accepting while remaining flexible and open to personal development in all areas of wellness.

- **Intellectual wellness** encourages curiosity, creativity, problem solving and lifelong learning through engagement in stimulating mental activities. An intellectually well individual uses available resources to expand knowledge and improve skills, while expanding potential for sharing with others.

- **Physical wellness** is not only the absence of disease, dysfunction and infirmity, but embodies cardiovascular flexibility and strength through regular, physical activity. It encourages knowledge about food and nutrition and discourages the use of tobacco, drugs and excessive alcohol consumption.
• **Sexual Wellness** requires having a healthy and respectful approach to sexuality and sexual relationships where sexual rights of all individuals are respected, protected and fulfilled. A sexually well individual possesses personal awareness and self-acceptance of physical body, self-image and sexuality. Sexual wellness means individuals are able to seek pleasurable, responsible and safe sexual experiences that are free of coercion, discrimination, and violence.

• **Environmental Wellness involves being aware of**, taking responsibility for and leading a lifestyle that is respectful of one’s environment. Being emotionally well requires choosing to live in ways that do not negatively affect nature and that help to protect the world around us. It enhances our personal health and that of our communities.

• **Financial Wellness** is not about being wealthy, but instead it is a state of well-being in which one has an understanding of your financial situation and feeling in control over your current finances and financial future. It is an intricate balance of being comfortable with where your money comes from and how you handle finances.