

Michigan 2010- 2013
Comprehensive Plan for HIV Prevention

Michigan HIV/AIDS Council
and
HIV/AIDS Prevention and Intervention Section
Division of Health, Wellness and Disease Control
Michigan Department of Community Health

Table of Contents

Introduction.....	3
Epidemiological Profile.....	4
<i>The State of African Americans and HIV in Michigan</i>	
Prioritized Populations, Prevention Needs and Interventions.....	6
<i>Categories of Need</i>	
<i>Prevention Intervention Definitions</i>	
<i>Needs Addressed by Intervention Types</i>	
<i>General Characteristics of Interventions that Work</i>	
HIV-positive persons: Prevention Needs and Strategies.....	12
Men Who Have Sex with Men: Prevention Needs and Strategies.....	15
<i>African American Men Who Have Sex with Men</i>	
Injection Drug Users: Prevention Needs and Strategies.....	19
High Risk Heterosexuals: Prevention Needs and Strategies.....	23
<i>Commercial Sex Workers</i>	
Transgender Persons.....	26
Integration of Services and Referrals.....	27
Capacity Development Needs.....	29
Supplemental Local Data.....	30
Appendix.....	32
Acknowledgements.....	35
References.....	36

Introduction

Michigan's Comprehensive Plan for HIV Prevention identifies priority populations, their HIV prevention needs and recommendations for intervention strategies best suited to meet those needs. It is the product of a close collaboration between the Michigan HIV/AIDS Council (MHAC) and the Michigan Department of Community Health (MDCH). MHAC membership includes persons living with HIV/AIDS, representatives of affected communities, local public health, community-based organizations, stakeholders and individuals with relevant expertise. Representatives from each of these areas played a role in the development of this *Plan*.

MDCH will use this *Plan* in determining program and resource allocation decisions associated with the support of HIV prevention efforts throughout the state. MHAC is responsible for sustaining the *Plan* by advising MDCH on associated implementation activities, monitoring compliance with the *Plan*, and advancing effective HIV/AIDS policy.

Epidemiological Profile

This section should be considered a summary of the impact of the epidemic in Michigan. A comprehensive *Statewide Epidemiologic Profile* is prepared and updated biannually by MDCH. More detailed information can be obtained in this profile, available at http://www.michigan.gov/mdch/0,1607,7-132-2944_5320_5331-36307--,00.html.

In Michigan it is estimated that 18,200 people are currently infected with HIV (MDCH 2009b, 1). As of January 2008 14,341 individuals were aware of their infection, and had been reported to the MDCH (MDCH 2008, 1-3). Between 2003 and 2007, the number and rate of new diagnoses remained stable at an average of 892 new HIV diagnoses (8.8 per 100,000) occurring each year (MDCH 2009a, 1).

Male-male sex is the predominant mode of transmission for all males infected with HIV. The Quarterly HIV/AIDS Analysis from July 1, 2009 shows that men who have sex with men (MSM), including those who are also injecting drug users (IDU), make up 53% of all HIV/AIDS cases with a known mode of transmission. This is about the same as what was observed in 2006 (51%). Seventy-five percent of cases of white individuals are MSM, while 50% of black cases are MSM (MDCH 2009b, 3).

Of all reported HIV/AIDS cases 17% are IDU, including MSM/IDU (Ibid., 1). Between 2003 and 2007, the number of new diagnoses among IDU decreased by an average of 9% per year, whereas the number of new diagnoses among other risk groups have remained stable (MDCH, 2009a, 4). Decreases among IDU have been noted in four consecutive trend reports.

Heterosexual cases remained level at 18% from 2003- 2007 (MDCH 2009a, 4). The heterosexual category includes males and females categorized as “high-risk” heterosexuals (persons who knew they had one or more partners that were an IDU, bisexual for females, a recipient of HIV infected blood, or a person infected with HIV) as well as females who reported sex with males of unknown risk/HIV status as their only risk.

Among men in all racial groups, male-male sex is the predominant mode of exposure. For women of all racial groups, heterosexual sex is the predominant mode of exposure. IDU is still a concern for both sexes. Although the number of cases among IDUs has declined substantially since 1998, IDU is still a concern for both sexes (MDCH, 2009a, 2).

HIV disease is distributed disproportionately in Michigan. Most HIV/AIDS cases continue to be diagnosed in Southeast Michigan (St. Clair, Macomb, Lapeer, Oakland, Wayne and Monroe Counties), where 44% of the state’s population lives, and where two-thirds (66%) of all persons currently living with HIV in Michigan reside (MDCH 2008, 3-13). HIV positive residents of this area continue to be predominately MSM, black, and ages 25- 49 years old at time of diagnosis (MDCH 2008, 4-8, 4-10, and 4-31).

HIV disproportionately impacts people of color in Michigan. Black persons are the most disproportionately impacted. African American communities are further discussed below.

Hispanic males have the third highest rate (231/100,000) and the fifth highest estimated number of cases (MDCH 2008, 3-81). They also make up 4% of reported cases among men (MDCH 2009b, 4). Hispanic females have the sixth highest rate (78/100,000) (MDCH 2008, 3-81). Four percent of reported cases in females are Hispanic (MDCH 2009b, 4).

Michigan is home to the largest Arab community in North American, with approximately 300,000 Arab immigrants living in the Detroit Metropolitan area. Arabs are not a federally recognized racial/ethnic group so HIV/AIDS surveillance data specific to this population is not readily available. However, beginning in 2001 and at the request of an Arabic community-based organization, a question was added to Michigan's HIV/AIDS Case Report Form to identify Arabic ethnicity. According to the 2008 Profile of HIV/AIDS in Michigan, there are 54 persons of Arabic descent living in Michigan with HIV. Seventy-six percent are male; and 69% of this population has progressed to AIDS (MDCH 2008, 3-69).

The State of African Americans and HIV in Michigan

African Americans make up 14% of Michigan's population and 59% of reported HIV cases (MDCH 2009b, 1). The rate of HIV infection is 8.5 times higher in the black population than in the white population (MDCH 2008, 3-46). Black persons have the highest estimated prevalence with 10,740 cases and a rate of 587/100,000 (MDCH 2009b, 1). These statistics reveal that meeting the HIV prevention needs of black communities from a culturally appropriate and community-centered standpoint presents an opportunity for improvement and must be a priority.

In the state of Michigan black females have the second highest rate (320/100,000) and the third highest estimated number (3,080) of persons living with HIV/AIDS (MDCH 2009b, 1). They account for 74% of reported cases of HIV among all females (Ibid., 3). Thirty-six percent of black females were infected through high-risk heterosexual transmission; an additional 24% are presumed heterosexual cases (Ibid.). Twenty-one percent were infected through injection drug use (Ibid.). Two percent were infected via perinatal transmission (Ibid.).

Black males have both the highest rate (885 per 100,000) and the highest estimated number (7,660) of HIV/AIDS cases (MDCH 2009b, 1). Black males account for 55% of reported cases among all males (Ibid., 3). Of reported cases for black males, MSM (including MSM/IDU) make up 59% (Ibid.). Twelve percent of black men were infected through injection drug use (Ibid). A reported 6% acquired the infection heterosexually, although this increases to 21% if presumed heterosexual cases are included (Ibid.).

Prioritized Populations, Prevention Needs and Interventions

The Prevention Plan Workgroup (PPW) used an evidence-based, data-driven process to prioritize populations, identify prevention needs and match them to interventions. Each step was voted on by the PPW, and then presented to and voted on by the full body of MHAC. The Appendix on page 32 summarizes the work of the PPW.

Through the evidence-based process four populations were prioritized and are listed below by rank:

1. HIV-positive persons

HIV-infected individuals who are at risk of transmitting HIV, or contracting sexually transmitted diseases, hepatitis C or B as a result of continued unprotected sex and/or sharing of drug use paraphernalia.

2. Men who have sex with men (MSM)

Includes all men having sexual contact with other men, regardless of self-identification. Men who have sex with both men and women (i.e., behaviorally bisexual men) and MSM who are also injecting drug users (i.e., MSM/IDU) are included in this category.

3. Injection drug users (IDU)

Includes persons who inject drugs by needle into a vein, under the skin or into muscle.

4. High risk heterosexuals (HRH)

Individuals who are at increased risk for becoming infected with HIV by virtue of opposite-gender sexual contact. This includes:

- a. Sex partners of HIV-positive persons
- b. Sex partners of injection drug users
- c. Female sex partners of men who have sex with men
- d. Individuals with a sexually transmitted infection
- e. Commercial sex workers
- f. Individuals who provide sex for drugs/money

The PPW used Michigan-specific to determine the HIV prevention needs for the prioritized populations. The prevention needs were categorized according to the definitions of needs on the following page. The identified needs were then matched to the prevention interventions defined on pages 8 and 9.

The chart on page 10 shows the needs that are addressed by each intervention type. This chart was devised by the PPW to guide their discussions about which intervention types best met the prevention needs of the prioritized populations.

Categories of Need

In the context of HIV prevention, a “need” refers to a psychosocial or environmental factor that influences an individual’s behavior. Needs are sometimes referred to as “determinants of risk.” Addressing HIV prevention needs assists an individual initiating or sustaining behavior that will reduce their risk for transmission and/or acquisition of HIV.

A need is not an intervention. Often “needs” are articulated in terms of interventions: “Population X needs street outreach.” While street outreach may be an appropriate strategy for addressing the prevention needs of population X, the true prevention need may be for accurate knowledge of HIV transmission modes.

In Michigan, needs are grouped into five broad categories: knowledge, persuasion, skills, access and supportive norms. A person may have one prevention need or several. Often needs must be addressed incrementally. For example, trying to build someone’s skills to use a condom will be less likely to succeed as a prevention strategy unless that person also understands and accepts that condoms are an effective method for preventing transmission/acquisition of HIV.

Below each category of need is explained in further detail:

Knowledge: Individuals have a knowledge-related need when they have inadequate or incorrect information about HIV (e.g., routes of transmission).

Persuasion: Individuals have a persuasion-related need when they have accurate and complete knowledge about HIV but do not or cannot act on that knowledge. Persuasion-related needs often refer to how someone feels about behaviors (e.g., I hate using condoms, they just don’t feel good).

Skills: Individuals have skills-related needs when they are unable to discuss or implement risk reduction strategies (e.g., I don’t know how to talk to my partner about safer sex).

Access: Individuals have access related needs when they have difficulty obtaining materials, tools and/or services. Access refers to the practical matter of obtaining materials (brochures, syringes), or supportive services (HIV counseling and testing). Access also encompasses the cultural, linguistic, and developmental competence of prevention materials, tools and services.

Supportive Norms: Individuals have the need for more supportive community norms when an individual is unable to initiate or sustain safer behaviors because other people in their community do not value those behaviors.

HIV Prevention Intervention Definitions

- **Counseling, Testing and Referral:** An interactive process whereby clients are assisted in identifying the specific behaviors and context of those behaviors which place them at increased risk for acquiring or transmitting HIV. The process also assists a client in identifying and committing to specific strategies designed to reduce the risk for HIV transmission or acquisition. Also includes test decision counseling, antibody testing and result delivery and referral to supportive services.
- **Partner Services:** Elicitation of sex and needle sharing partners of HIV infected individuals and notification of those partners of their exposure; followed by offering of HIV prevention services, including HIV counseling, testing, and referral.
- **Individual Level Prevention Counseling:** Multi-session health education and risk reduction counseling provided to one individual at a time. The focus of this intervention is to assess risk reduction needs of clients and assist them in making plans for individual behavior change. This intervention must include risk assessment and development of a risk reduction plan. Can also assist clients in obtaining referrals to other prevention services in clinical and community settings.
- **Prevention Case Management:** An intensive and ongoing individual level intervention targeting clients with multiple, complex problems and risk reduction needs. This intervention can target HIV+ individuals or HIV- clients at high risk for HIV and is intended for persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV acquisition or transmission. Provides intensive, ongoing, individualized prevention counseling, support, and referral assistance.
- **Skills Building Workshop:** An intervention this is provided to a small group that focuses on helping participants develop or enhance specific skills to engage in risk reduction practices. It must include client demonstration of skill by all participants. Examples of skills building topics include condom use, safer needle use, negotiation skills, etc.
- **Informational Session:** One-time, information only, group presentation covering topics such as HIV/AIDS, viral hepatitis or sexually transmitted diseases. Information may include definitions, statistics, trends, transmission, prevention, disease symptoms and progression, and testing. Although the presenter may demonstrate a skill (e.g., how to put on a condom), this intervention does NOT include a skills building component because clients do not practice the skill.
- **Outreach:** HIV/AIDS educational intervention conducted face-to-face with clients outside more traditional institutional settings, in their own neighborhoods or other areas where they socialize or congregate. Outreach must include verbal exchange of information between provider and client. Materials distribution alone does not constitute outreach.

- **Community¹ Level Interventions:** Interventions that seek to change the attitudes, norms, and behaviors of entire communities. These approaches recognize that local values, norms, and behavior patterns have a significant effect on shaping an individual's attitudes and behaviors. Community level interventions may include several components. For example, the MPowerment intervention includes formal and informal outreach, skills building workshops, and small media campaigns.
- **Structural Interventions:** This intervention aims to modify social, economic and political systems, and may affect legislation, media, health care and the market place. Structural interventions can directly alter the physical environments in which people live, work, play, and have sex, to help reduce risk. Changing a paraphernalia law to allow access to sterile syringes is an example of a structural intervention.
- **Health Communications:** Use of communication strategies to inform and influence individual and community decisions that enhance health. Effective strategies combine theories, frameworks and approaches from behavioral sciences, communication, social marketing and health education. Health Communications are typically delivered through a variety of media outlets. Examples include billboards, radio and television public service announcements.

¹ The term community has multiple meanings. This document reflects the work of the Prevention Plan Workgroup (PPW) and consequently their use of the term. In the course of their work, the term was used to refer to groups of individuals that share risk behaviors or serostatus (i.e., HIV-positive persons).

Needs Addressed by Intervention Types

Intervention type	Delivery Level	Primary Impact Level	Needs Addressed by Interventions				
			Knowledge	Skills	Persuasion	Supportive Norms	Access
Counseling, Testing and Referral Services	Individual	Individual	P ²		P		P ³
Individual Level Prevention Counseling	Individual	Individual		s	P		s
Prevention Case Management	Individual	Individual		s	s		P
Information Session	Group	Individual	P				
Skills Building Workshop	Group	Individual		P	s	s	
Structural Interventions	Community	Community/ Individual			s	s	P
Outreach	Individual	Individual/ Community	s				P
Partner Services	Individual	Individual	P		s		P
Health Communications	Individual/ Community	Individual/ Community	P		s	P	
Community Level Intervention	Community	Community/ Individual	s		s	P	

P= Primary need
s= Secondary need

² For counseling, testing and referral and partner services the primary knowledge need addressed is knowledge of HIV serostatus, although basic HIV information may also be provided.

³ For counseling, testing and referrals and partner services the primary access need addressed is linkage to care services for individuals who test HIV-positive.

General Characteristics of Interventions that Work

To be most effective, all prevention interventions must be tailored to the needs of the targeted community and to the capacities of service providers. A diverse and sustained effort is required for ongoing quality HIV prevention. An inclusive approach to prevention maintains a balanced mix of interventions and strategies to address the multifaceted and shifting needs of priority populations.

Below is a compilation of traits that support the effectiveness of interventions for priority populations

- **Include input from the targeted audience.** Members of the targeted audience should participate in the design, implementation and monitoring of interventions.
- **Responsive to a specific need.** Interventions should be implemented that address identified HIV prevention needs.
- **Provided in a culturally competent manner.** The intervention should be linguistically, culturally and developmentally appropriate for the targeted audience.
- **Target a defined audience with clear goals.**
- **Based on behavioral and social science.** With limited resources, funded interventions must be grounded in theory and practice that is known to work.
- **Include quality monitoring, evaluation and mid-course correction.** These are necessary to determine whether key intervention elements are being achieved as planned and are having the expected effect on the target population. Analysis of monitoring and evaluation should be used to correct problem areas.
- **Apply sufficient resources to implement intervention effectively.** To allow for achievement of program goals and the sufficient level of quality assurance and evaluation the program must be adequately funded.

These traits should not be thought of as an exhaustive list of principles essential to developing and running a prevention program. HIV prevention interventions can be strengthened by the use of local data to inform the development and implementation of prevention activities⁴.

⁴ See page 30.

HIV-Positive Persons

Prevention Needs and Interventions

A statewide needs assessment found that a large number of HIV-positive persons noted that since learning of their HIV infection they had experienced challenges with practicing safer sex and disclosing to their sexual partners. Fifty-seven percent of HIV-positive participants reported that telling sex partners about their HIV status had been a challenge (MDCH 2001, 8). Of those currently in relationships, 23% did not know the status of their partner.

In the statewide needs assessment, 48% of respondents reported that they struggled with practicing and maintaining safer sex. Just over 50% indicated they had unprotected sex with someone who knew that the respondent was positive (Ibid., 6). Thirty-nine percent reported that they had unprotected anal or vaginal sex with someone whose HIV status they did not know. Although a significant proportion had engaged in unprotected anal and vaginal sex since learning of their infection, most believed that they have not infected anyone. Sixty-nine percent of HIV-positive persons participating in the needs assessment agreed that counseling and support to help practice safer sex is or would be helpful (Ibid., 9).

The Supplement to HIV/AIDS Surveillance (SHAS) project interviewed HIV-positive persons receiving care services at five Detroit locations. SHAS found that of the MSM respondents who had sex with a steady partner in the last 12 months, 30% had unprotected receptive anal sex and 28% had unprotected insertive anal sex (MDCH 2004, 46). Of the MSM respondents who had sex with a man other than a steady partner, 24% had unprotected receptive and 24% reported unprotected insertive anal sex (Ibid., 46).

Of the heterosexual HIV-positive women interviewed for SHAS who reported sex with a man in the last 12 months, 31% had unprotected sex with a steady male partner and 30% had unprotected sex with an other than steady partner (Ibid., 44). Of the HIV-positive heterosexual men who had sex with steady female partners and those who had sex with other female partners, 22% reported unprotected vaginal sex (Ibid). These data suggest that some HIV-positive persons lack the ability to negotiate safer sex.

HIV-positive persons also indicated that their partners could benefit from counseling and support. As noted above, more than half of the needs assessment participants indicated that they struggled with telling sex partners that they were living with HIV. These points suggest that there are not norms that support HIV-positive persons in disclosing their status or asking partners their HIV status.

To address these needs MHAC recommends **multi-session individual level prevention counseling, skills building workshops, partner services, prevention case management and community level interventions.**

Community level interventions should work to reduce the stigma, including internalized stigma, of HIV and encourage communication about HIV status within sexual relationships. Workshops should focus on developing skills in the following areas:

- Communication, including the disclosure of status to and asking the status of sexual partners
- Negotiation of safer sex
- Safer sex skills

When asked what services were or would be helpful, information about safer sex ranked the highest (MDCH 2001, 9). To address this need MHAC recommends **informational sessions**.

Overarching Recommendations for Interventions

In the statewide needs assessment, 96% of respondents indicated that opportunities to socialize with other HIV positive people would be useful and 62% ranked this as the most useful service (Ibid.). To respond to this, MHAC recommends that all programs targeting HIV- positive persons include social networking opportunities and the provision of internal and/or external referrals to psychosocial support groups. Memorandums of agreement should be in place to ensure referrals are available for all participants.

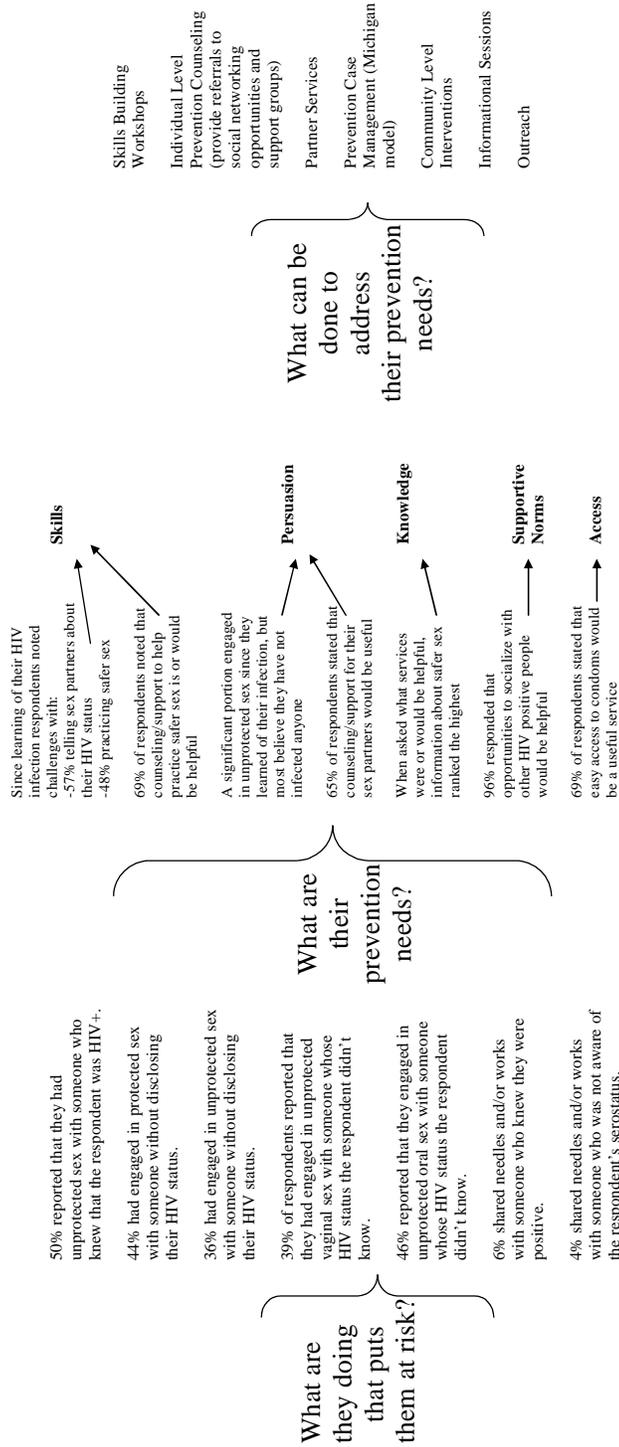
Sixty-nine percent of respondents stated that easy access to condoms would be a useful service. To address this need MHAC recommends that all prevention interventions provided to HIV-positive persons make condoms freely available to clients.

All interventions should include an anti-stigma component. Reducing the stigma (internal and external) faced by individuals living with HIV may assist them in accessing programs that address ongoing risk of STD acquisition, HIV transmission and disclosure of status.

Gap Analysis Recommendations

The prevention needs and matched interventions listed above were compared to the Community Resource Inventory of prevention services provided in 2008. This comparison revealed that current services do not fully address these prevention needs and that the provision of community level interventions, prevention case management and individual level prevention counseling should be increased from 2008 levels.

HIV - Positive Persons



Men Who Have Sex with Men (MSM)

Prevention Needs and Interventions

Many MSM lack access to HIV testing. In a statewide survey on HIV-related attitudes and behaviors of MSM, 23% of participants had never been tested (Lapinski-LaFaive 2004c, 28). Young men and men of color were more likely to have never been tested. The Community Intervention Trial for Youth study (CITY), which focused on young MSM in the Detroit metropolitan area, found that 14% of MSM who have had unprotected anal sex have never been tested (Cottrill 2009).

Most MSM do not think they are at risk for HIV. Of the MSM participating in the statewide survey, 80% thought they had a low or no chance that they would become infected (Lapinski-LaFaive 2004c, 30). The survey revealed that 54% of respondents had not used a condom during their last sexual encounter and 30% never used condoms for anal sex (Ibid., 13 & 21). Of those who had been tested for HIV, only 18% thought they may have been exposed to HIV through sex, 10% worried about transmitting HIV to others and 7% thought they had a health problem related to HIV (Ibid., 29).

To meet these needs MHAC recommends **counseling, testing and referral** services and **individual level prevention counseling. Outreach** and **informational sessions** should be used as recruitment strategies into these interventions.

MSM interviewed for the CITY study revealed a lack of supportive social norms for risk reduction behaviors. Many young MSM have negative attitudes about condom use. The CITY study found that respondents who had unprotected anal sex with main or non-main partners reported higher negative peer norms toward condom use than those who did not report unprotected anal sex (Cottrill 2009). Forty-one percent of respondents who had unprotected anal sex in the last 3 months reported being high during the encounter (Ibid.). The statewide survey showed that respondents who expected negative outcomes associated with asking partners to use condoms were less likely to use condoms when compared to respondents who did not expect negative outcomes (Lapinski-LaFaive 2004c, 26 & 27). The report concluded that prevention efforts that seek to encourage condom use should acknowledge and work to counteract the perception that condoms interfere with pleasure and intimacy (Ibid, 34).

The statewide MSM survey also suggested there are not social norms supporting open communication between sex partners. Many MSM reported that they do not talk about HIV with casual or steady partners (Ibid, iv). MSM stated that they did not ask their partner's status or disclose their own.

To address these needs MHAC recommends **community level interventions** combined with **health communications**. Social norms that promote the following behaviors should be considered when implementing these interventions:

- Avoiding sex when drunk or high
- Using condoms for anal sex

The specific social norms addressed should be determined through local data, as multiple norms may affect these behaviors.

MSM do not have all of the skills they need to protect themselves from HIV. The statewide MSM survey showed that respondents indicated challenges not only with using condoms related to their feelings and negative expectations, but also with using condoms in the context of the sexual encounter (Ibid., 26). As noted above, MSM reported that they do not talk with partners about HIV. These data indicate a lack of skills to negotiate and communicate with sex partners about condom use and other risk reduction strategies.

To address these needs MHAC recommends **skills building workshops, health communications and counseling, testing and referral** services. Health communications should be used in the context of social marketing methods. Skills addressed through these interventions should include:

- Communication and negotiation with sex partners
- Risk reduction strategies (in contrast to risk elimination)
- Condom use

African American MSM (AAMSM) & Young African American MSM (YAAMSM)

Prevention Needs and Interventions

There are a variety of social norms influencing behaviors of AAMSM that do not support HIV risk reduction. A statewide study that examined the HIV related needs and risk perceptions of AAMSM concluded that bi- and homosexuality remain highly stigmatized in the African American community (Lapinski-LaFaive and Simpson 2005, 18). AAMSM reported that communicating about homosexuality was not normalized, particularly within families (Ibid.). One consequence of this stigma is that MSM choose not to disclose bi- or homosexual behaviors (Ibid., 19).

National data offers further insight into this issue. AAMSM who report that their parents disapprove of their sexuality also report high rates of sexual risk taking (Miller 2009). Family and community rejection are associated with mental health problems (e.g., depression) and sexual risk behaviors (Ibid.). These points, in addition to the Michigan-specific data, indicate that AAMSM and YAAMSM lack social norms and structures that support their lives as MSM and safer sexual practices.

To address these needs MHAC recommends **structural interventions, prevention case management, community level interventions and health communications**. Structural and community level interventions should work to increase acceptance of AAMSM and be aimed at AAMSM, YAAMSM and African American communities as a whole. Structural interventions may also focus on school systems, advocating for the use of comprehensive sex education curriculums inclusive of the sexual behaviors of MSM. Prevention case management programs should have memorandums of agreement with mental health and other applicable prevention services that are skilled and experienced in providing services to AAMSM including youth. Health communications may be used as part of social marketing campaigns to fight homophobia on a community level.

Overarching Recommendations for MSM Interventions

Interventions targeting AAMSM and YAAMSM must have strong linkages to mental health and counseling services for survivors of sexual assault. National data suggest that a large percentage of AAMSM experience childhood sexual abuse (Fields et. al.). Childhood sexual abuse has been linked to higher rates of IDU, unprotected receptive anal sex, sex work and sexually transmitted diseases (Ibid.). Interviews with 21 Michigan stakeholders, including staff and providers from community based organizations, health care, state and local health departments showed that their ability to serve YAAMSM could be enhanced by skills building trainings that address working with survivors of sexual abuse and domestic violence (McNall 2009). MHAC recommends that trainings addressing these issues be made available to all providers working with YAAMSM.

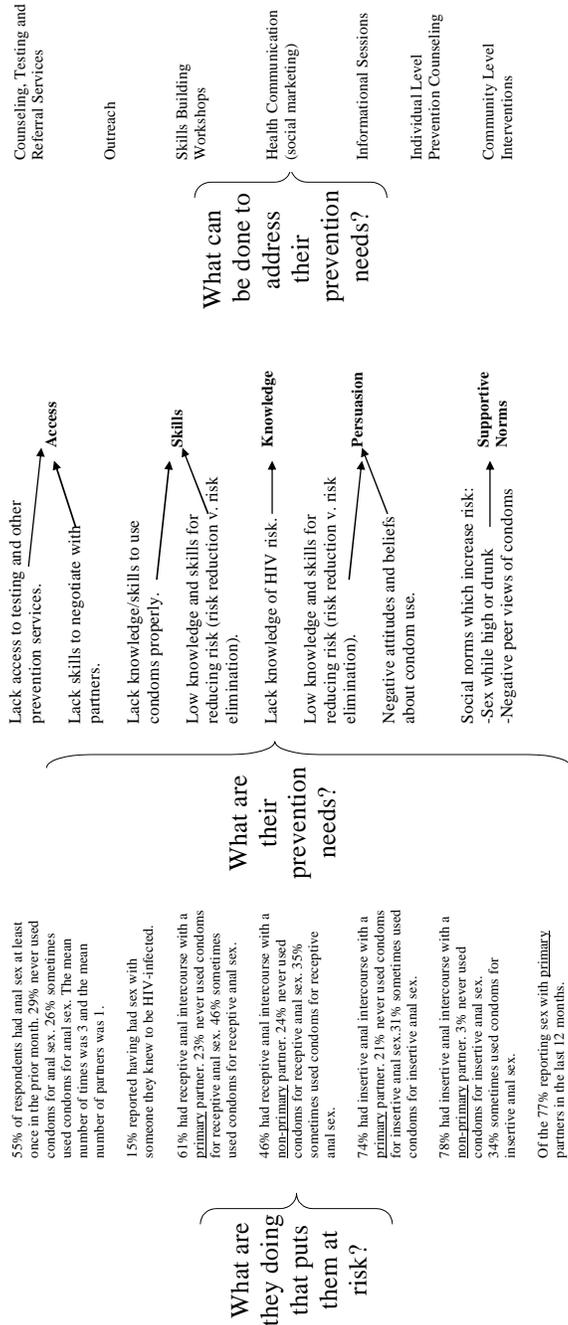
All interventions targeting MSM should have components that address homophobia. These components may be directed at decreasing internalized homophobia (within skills building workshops) or homophobia in the general community (through community level interventions).

Interventions should also address issues related to education and employment. Prevention providers should build relationships with and facilitate referrals to programs that offer free or low-cost education, job training and other related services.

Gap Analysis Recommendations

The prevention needs and matched interventions listed above for MSM were compared to the Community Resource Inventory of prevention services provided in 2008. This comparison revealed that current services do not fully address the prevention needs of MSM. MHAC recommends increasing efforts to provide counseling, testing and referral, prevention case management services and skills building workshops to address these gaps. Additionally MHAC recommends an increase in structural and community level interventions aimed at reducing homophobia and stigma in the general community and increasing supportive norms for using condoms for anal sex.

Men Who Have Sex with Men



Injection drug users (IDU)

Prevention Needs and Interventions

Many IDU lack access to sterile syringes and injection equipment. Of the IDU interviewed for the HIV Testing Survey, 32% reported sharing needles and 37% reported sharing injection equipment (Lapinski-LaFaive and Simpson 2004b, 15). Among Detroit IDU who participated in National HIV Behavioral Surveillance (NHBS) interviews, 22.6% reported sharing needles and 46% reported sharing equipment in the last 12 months (Reznar 2009b). These IDU obtained needles from multiple sources, including friends, relatives and drug dealers. The HIV/AIDS and Health Related Needs among IDU in Michigan report describes the difficulties IDU have in obtaining new syringes and works, particularly from pharmacies (Lapinski-LaFaive and Simpson 2004b, 20). NHBS interviews revealed that IDU who had gotten free needles were more likely to use sterile needles (Reznar 2009b). Taken together, these data show that IDU would benefit from increased access to sterile needles and injection equipment.

To address this need MHAC recommends **structural interventions** that concentrate on the following three areas:

- Changing state and local paraphernalia laws/ordinances to allow the purchase and possession of syringes and works without a prescription.
- Educating physicians and pharmacists in order to expand prescription and over-the-counter availability of syringes.
- Expanding syringe exchange, including increasing the number of syringe exchange programs (SEP), the number of services provided at SEP, and the amount of funding and capacity development opportunities available for programs.

Some IDU lack the skills to reduce their risk for HIV. Needs assessment found that many IDU did not clean their syringes according to the Centers for Disease Control and Prevention guidelines although they identify using new or sterile syringes as important and state that they are concerned about reusing syringes (Lapinski-LaFaive and Simpson 2004b, 18). IDU identified addiction and accompanying drug sickness as conditions that lead to sharing injection equipment (Ibid, 20). In addition to risks directly associated with injecting, IDU also have prevention needs arising from their sexual behaviors. Forty-two percent of the IDU interviewed sold or bought sex, and some respondents indicated that their attempts to use condoms were sometimes hindered by their partners (Ibid., 6).

To address these needs MHAC recommends **skills building workshops**. Workshops should focus on developing skills in the following areas:

- Accessing and using sterile equipment
- Cleaning syringes
- Reducing sexual risks
- Drug use management

There are a variety of social norms influencing behaviors of IDU that do not support HIV risk reduction. There is some evidence that there are not social norms supporting open communication about HIV and HCV status among IDU. In the NHBS interviews, 57% of IDU who shared syringes and equipment did not know the other persons' HIV status, and 63% did not know the other persons' HCV status (Reznar 2009b). Ninety percent of the sharing partners were identified as sexual partners, friends and acquaintances. This suggests that social norms do not support the idea that it is important to tell or ask other IDU their HIV and HCV status.

IDU interviewed for the statewide IDU needs assessment also made statements that reveal a lack of supportive social norms for risk reduction behaviors. Some IDU reported that friends used their syringes without permission (Lapinski-La Faive and Simpson 2004b, 20). Several interviewees indicated that accessing treatment programs made it difficult to reduce their risks because of the drug activity within the facility (Ibid.). These data illustrate the lack of supportive norms to reduce injection related risks.

To address these needs MHAC recommends **community level interventions**. IDU reported that they trust and talk to other injectors; therefore MHAC recommends the use of peers in community level interventions (Ibid., 23). Norms that promote the following behaviors should be considered when implementing these interventions:

- Knowing and disclosing HIV and HCV status with injecting and sexual partners
- Avoiding sharing equipment and needles

Community level interventions targeting administration, staff and clients of drug treatment facilities should focus on creating a safe atmosphere so that participants feel comfortable reporting the sale or use of drugs at the facility.

The relatively high levels of knowledge and self-efficacy IDU report do not translate into reduced risk behaviors. The HIV/AIDS and Health Related Needs among IDU in Michigan report concluded that ongoing risk behavior is the result of complex psychosocial factors (Ibid., 26). In addition, participating IDU identified the importance of and their need for mental health services, including counseling (Ibid., 23).

To address these needs MHAC recommends **counseling, testing and referral** services. Referrals should be provided to additional counseling and mental health services as indicated. In areas where mental health or counseling services are not available to or culturally appropriate for IDU, MHAC recommends **individual level prevention counseling**.

Overarching Recommendations for Interventions

MHAC recommends that viral hepatitis prevention be included in all interventions for IDU. Injecting drugs is the primary mode of transmission for hepatitis C. Studies show that within 5 years of beginning to inject, 60% to 80% of IDU are infected with HCV (CDC 2001). It is estimated that 50% to 90% of IDU with HIV also have HCV infection (CDC 2005). HIV/HCV co-infection accelerates progression of HCV disease and increases hepatitis C morbidity and mortality with end-stage liver disease being the leading cause of death in co-infected populations (Taylor).

IDU are also at risk for hepatitis B virus through the sharing of needles and drug-preparation equipment. In addition, outbreaks of hepatitis A infection have been reported among IDUs; such outbreaks are believed to occur through both percutaneous and fecal-oral routes (CDC).

MHAC recommends that all interventions for IDU acknowledge the sexual risks of IDU, addressing the needs of heterosexuals, MSM, transgender persons and other sexual minorities. MSM who inject drugs make up 28% of reported IDU cases in Michigan (MDCH 2009b, 2). Studies have shown that transgender persons have high rates of HIV, and some are at risk through injection drug, hormone and silicone use (Herbst et. al. 2007). Intervention materials, role plays and data collection forms should not assume participants are heterosexual or that they identify as male or female. SEP should provide needles in a variety of gauges to meet the needs of persons who inject hormones and silicone.

MHAC suggests that pre-test counseling for IDU incorporate an overdose prevention discussion. The findings of one study suggest that young injectors at highest risk for overdosing are also those at highest risk for HIV infection (Ochoa 2001, 458).

Gap Analysis Recommendations

The prevention needs and matched interventions listed above for IDU were compared to the Community Resource Inventory of prevention services provided in 2008. This comparison revealed that current services do not fully address these prevention needs. These gaps can be addressed through increased emphasis on skills building workshops, structural and community level interventions including the use of peer-led prevention services, when appropriate (e.g. secondary syringe exchange). MHAC also recommends using HIV prevention funds to integrate hepatitis C screening into HIV testing for IDU.

Injection Drug Users

32% reported sharing needles during the 12 months prior to the interview.

31% sometimes used a needle previously used by another person.

37% sometimes used the same croaker, cotton, rinse water or other equipment with other people while shooting up.

85% injected drugs in the week prior to the interview. Respondents on average reported injecting 2-3 times a day, seven days a week.

17% stated that they sometimes or never used a new needle when they injected.

58% indicated that they had not used a condom the last time they had sex.

42% reported that they have exchanged sex for drugs or money.

HIV+ IDU

15% reported ever injecting drugs;

12% reported injecting within the last 12 months.

75% reported ever sharing needles or

syringes.

45% reported sharing needles or

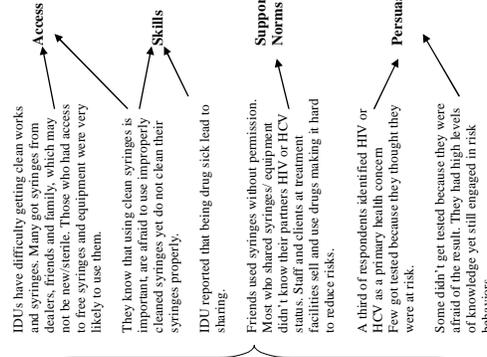
syringes within the last 12 months.

69% reported ever sharing croakers,

cottons, or rinse water.

What are they doing that puts them at risk?

What are their prevention needs?



High Risk Heterosexuals (HRH)

Prevention Needs and Interventions

Many heterosexuals,⁵ including HRH, do not know their HIV status. Data from the National HIV Behavioral Surveillance (NHBS) interviews of heterosexuals in Detroit showed that 38% of men, 29% of women and 51% of youth had never been tested for HIV (Reznar 2009a). Of the respondents, 68% reported a health care visit in the past 12 months, but only a 31% of them were offered an HIV test at that visit (Ibid.).

Some HRH accessing sexually transmitted disease (STD) clinics do not perceive themselves to be at risk and do not test for HIV. Of the HRH who participated in the HIV Testing Survey (HITS) and had not been tested in the prior year, 60% thought it was unlikely they had been exposed to HIV through sex (MDCH 2002, 9). All of these individuals were seeking care at an STD clinic.

To address these needs MHAC recommends **counseling, testing and referral** services and **structural interventions**. Structural interventions should focus on making HIV testing a standard of care in health care settings and providing appropriate referrals into care and prevention services.

Many HRH do not think they are at risk for HIV though they engage in risky behaviors or live in high prevalence areas. HITS revealed that 46% of males and 36% of females never used condoms with primary sex partners for vaginal sex (MDCH 2002, 30). Twenty percent of males and 46% of females never used condoms for vaginal sex with other sex partners.

To address these needs MHAC recommends **outreach, individual level prevention counseling**, and **community level interventions**. Individual level prevention counseling should be provided in venues that already reach HRH (e.g., at syringe exchange programs for partners of IDU, at infectious disease clinics for partners of HIV-positive persons with repeat STD). Community level interventions should include a health communication component. Health communications campaigns should target HRH and other heterosexuals to raise awareness of HIV risks and promote the importance of testing.

Commercial Sex Workers (CSW)

Prevention Needs and Interventions

Sixty-two percent of CSW interviewed in a statewide needs assessment reported that they never used risk reduction strategies with their primary partners (Lapinski-LaFaive and Simpson 2004a, 5). The same assessment showed that 60% did not talk to their primary partners about HIV.

⁵ The National HIV Behavioral Surveillance project, interviewed 777 heterosexuals living in census tracts of the Detroit metropolitan area with high rates of heterosexually transmitted HIV. Because these individuals were not identified as HRH according to the definition on page 7, they are referred to as heterosexuals in this section.

To address these needs MHAC recommends **individual level prevention counseling** and **community level interventions**. Community level interventions targeting CSW should concentrate on changing norms to support using risk reduction strategies with primary partners.

CSW had additional HIV prevention needs tied to drug use. Many participants said that they had begun selling sex due to their drug use and continued to sell sex because of their drug habit (Lapinski-LaFaive and Simpson 2004a, 9). When asked to describe their biggest worries or problems few of the participants mentioned their drug use. However, CSW stated that they had considered quitting sex work or had quit in the past but continued with or returned to sex work because they needed money for drugs and did not have the skills to do other jobs (Ibid., 9 & 10).

To address these needs MHAC recommends **individual level prevention counseling**, **community level interventions** and **structural interventions**. Individual level prevention counseling should be used to explore ambivalence about reduction or elimination of drug use, and ways to reduce risks through harm reduction strategies. Community level interventions should focus on changing norms around drug use. Structural interventions should be directed at strengthening referrals to:

- Education
- Job training
- Substance use disorder treatment

Some CSW lack the knowledge and skills to reduce their risk for HIV. Many CSW reported performing visual inspections of clients' genitalia to determine if they had an STD (Ibid., 13). A number also mentioned cleaning themselves after sex to avoid HIV. A significant portion of participants reported that they were most likely to be able to successfully negotiate use of condoms or other risk reduction strategies with clients when they were not drug sick (Ibid., 16). As noted above, CSW sold sex to support drug habits, which may reveal a lack of drug use management skills.

To address these needs MHAC recommends **informational sessions** and **skills building workshops**. Informational sessions should include information on effective risk reduction strategies for CSW. Workshops should build skills in:

- Negotiation of safer sex
- Drug use management

Gap Analysis and Recommendations

The prevention needs and matched interventions listed above for HRH were compared to the Community Resource Inventory of prevention services provided in 2008. This comparison revealed that current services do not fully address these prevention needs. MHAC recommends that to address these gaps that the provision of individual level prevention counseling, structural interventions, and community level interventions be increased.

High Risk Heterosexuals

46% of male STD clients never use a condom for vaginal sex with their primary partner.

Of the 12% who have anal sex, 31% never use a condom. 30% of female STD clients never use condoms for vaginal sex & 50% never use condoms for anal sex.

62% of STD clients tested for HIV, with 24% tested because they thought they were exposed through sex.

60% of STD clients not tested for HIV though it unlikely they had been exposed through sex.

71% of women, 60% of men and 49% of youth in areas with high prevalence of heterosexually transmitted HIV tested for HIV. Of those who had health care visit in the last 12 months, 31% offered an HIV test.

62% of CSW do not use risk reduction strategies with their primary partners.

60% of CSW never talked with primary partners about HIV; although 98% had been tested for HIV.

25% of CSW inject drugs, & 42% of IDU sell sex.

39% of CSW use crack, while almost all use alcohol or other drugs. Many initiated & continued to sell sex because of a drug habit; however, most did not see drug use as a salient health concern & unwilling to stop.

Many CSW most likely to negotiate risk reduction strategies with clients when they were not drug sick.

Many CSW use visual inspection of clients to assess disease status & use cleaning after sex as a risk reduction strategy.

Many respondents stated that they did not feel like they had the skills to do other jobs.

What are they doing that puts them at risk?

Many clients at STD clinics do not perceive themselves to be at risk for HIV and do not test for HIV. Many heterosexuals—especially youth—are not tested for HIV and do not know their HIV status. Most heterosexuals are not offered testing at other health care visits.

CSW do not use risk reduction strategies with primary partners, mentioning intimacy and a way to distinguish between their work partners and their primary partners as a reason.

CSW do not talk with their primary partners about HIV, although many know their own status as they have been tested. They do not view their partners as people who would put them at risk for HIV.

Almost all CSW use some form of drugs. They mention their financial needs from drug use as a reason for selling sex. They indicate they are less successful at negotiation risk reduction with clients when they are drug sick.

Many CSW lack full knowledge about HIV prevention strategies.

Many CSW indicate lack of skills to do jobs other than sex work.

What are their prevention needs?

Counseling, Testing and Referral Services

Individual Level Prevention Counseling

Community Level Intervention/Health Communications

Outreach

Structural Intervention to increase HIV testing as a standard of care in health care setting

CSW

Individual Level Prevention Counseling

Community Level Interventions

Skills Building Workshops

Information Sessions

Structural Interventions to increase access to substance abuse treatment & education/job training

What can be done to address their prevention needs?

Knowledge

Persuasion

Access

Knowledge

Persuasion

Supportive Norms

Skills

Knowledge

Persuasion

Supportive Norms

Skills

Access

Knowledge

Skills

Transgender Persons

The impact of HIV on transgender⁶ persons was an important concern of the Prevention Plan Workgroup as this plan was developed. Although there was anecdotal information about transgender persons and HIV in Michigan, there were no Michigan-specific data available to MHAC.

National data shows that transgender persons are at risk for HIV. A meta-analysis of studies examining HIV prevalence and risk behaviors found that transgender persons are at risk for HIV due to sexual behaviors, injection drug, hormone and silicone use (Herbst 2007). This analysis found that the average prevalence rate for male to female transgender women was 27.7% from four studies that reported rates of laboratory confirmed HIV infections (Ibid., 8). One study that provided HIV tests to female to male transgender men was included in this analysis. It reported a two percent prevalence rate among female to male transgender men (Ibid., 8).

Transgender persons may identify as, and use services for, any of the prioritized populations. While they should be provided services in congruence with their self-identified gender and risk behaviors, transgender persons may have prevention needs that are not addressed by interventions aimed at the prioritized populations. These needs may best be determined at the local level and addressed through interventions explicitly designed for transgender persons.

MHAC recommends that all statewide needs assessments collect data on gender identity and expression, even when they are not specifically targeted to transgender communities. It is vital that data collection methods be improved to better capture and understand the complexities among these diverse communities.

Furthermore, MHAC recommends that providers seek out opportunities to learn from (and build skills to better serve) transgender persons.

⁶ Transgender is an umbrella term used to describe people whose gender identity or gender expression differs from that usually associated with their sex as assigned at birth. Individuals who “fit” this definition may or may not self-identify as transgender.

Integration of Services and Referrals

Individuals who are at increased risk for HIV are often at risk for other diseases and have psychosocial, physical and spiritual needs that cannot be met through HIV prevention interventions. HIV prevention providers need to be familiar with the myriad issues that affect their clients and prepared to provide additional services or make referrals to external programs.

Integrating services maximizes the opportunity that providers have to impact the health of at-risk populations. Providers should assess the services they are currently providing and work on reducing inefficiencies in parallel service delivery systems. To promote the integration of services, MHAC recommends that all providers:

- Provide integrated prevention messages. Intervention curricula and materials should address HIV, sexually transmitted diseases (STD), viral hepatitis and tuberculosis (TB) as appropriate for target populations
- Use risk assessment tools that inquire about risk behaviors for HIV, STD, viral hepatitis, TB, substance use and mental health disorders
- Seek out cross-training opportunities
- Address barriers to services identified through local needs assessments

In addition to the efforts of individual HIV prevention providers to promote integration of services within organizations, opportunities should be sought to enhance the integration of HIV prevention services into existing care, prevention and supportive services.

Particular opportunities may exist in these areas:

- Making HIV testing a standard of care in health care and sexually transmitted disease clinics
- Incorporating HIV prevention messages and services into family planning, substance use disorder and mental health services
- Enhancing the cultural competence of substance use and mental health treatment providers to serve MSM, HIV-positive and transgender persons, and individuals who do not want to or cannot stop using drugs

Referrals play an equally important role in meeting the complex needs of clients. Providers should develop partnerships with agencies to support referrals that address clients' prioritized needs. Partnerships between providers should be formalized in memorandums of agreement that clearly outline the roles and responsibilities of each partner.

Referrals should comply with the MDCH Prevention Referral Guidelines, which can be found at www.mihivnews.com. The guidelines outline the active role of prevention staff in ensuring clients receive appropriate services:

Referral is the process by which a client's immediate needs for care, prevention and supportive services are assessed and prioritized. Clients are provided with assistance (e.g., setting up appointments, providing transportation) in accessing referral services. Referral also includes reasonable follow-up efforts necessary to

facilitate initial contact with prevention, care and psychosocial services and to solicit clients' feedback on satisfaction with services (MDCH 2007, 2).

Providers should maintain a referral resource guide that contains the essential information about referral partners. At a minimum, providers should be able to facilitate referrals for the following services:

- Partner services
- HIV-specific medical care
- Primary medical care
- STD testing and treatment
- Hepatitis screening
- Hepatitis A and B vaccination
- Mental health services
- Substance use disorder treatment
- Domestic violence and sexual assault counseling and related services
- TB testing and treatment
- Syringe exchange
- Case management

Capacity Development Needs

In light of the HIV prevention needs of the four prioritized populations, the service gaps identified through the Community Resource Inventory analysis, and the aforementioned emphasis on integration and effective referrals, the following areas were identified as priorities for capacity development for providers working with these populations.

- Collecting, analyzing and applying local level data, including identifying prevention needs of local (sub)populations.
- Matching prevention needs to and selecting evidence-based interventions. This includes examining provider capacity, and determining length and intensity of intervention.
- Implementing and evaluating prevention activities, including evidence-based interventions, recruitment and retention strategies.
- Using technologies (e.g., web-based and cell phone applications) to recruit and serve target populations especially MSM who seek sex via these mechanisms.
- Using health communications as part of prevention activities. Emphasizing how to craft effective messages aimed at particular (sub)populations.
- Providing prevention services for HIV-positive persons and their partners by medical providers and other care providers.
- Providing culturally competent and developmentally appropriate services for young MSM including young African American MSM and MSM who are living with HIV.
- Working with and facilitating referrals for MSM who are survivors of sexual abuse and/or domestic violence.
- Integrating harm reduction strategies (including syringe access) into traditional substance use disorder treatment modalities.
- Integrating viral hepatitis information and services into programs serving IDU.
- Providing effective hepatitis C counseling, testing and referral services.
- Incorporating broader harm reduction practices into services for IDU (e.g., overdose prevention and intervention).
- Understanding and incorporating intervention elements to address the impact of alcohol and other drug use on sexual risk behaviors.
- Developing a diversified funding base to support comprehensive prevention portfolios and agency sustainability.

A Note on Using this Plan and the Need for Supplemental Local Data

This plan was deliberately devised to provide an overview of prevention needs and recommended strategies for the four prioritized behavioral groups at a statewide level. It does NOT provide a detailed prescription of which specific intervention models should be provided to individual subpopulations within the behavioral groups.

The prioritized populations described in the plan encompass numerous subpopulations that have distinct prevention needs that may be reflected in or missing from this macro level analysis. This approach was intentional, as MHAC was cognizant that there was no feasible way to include all of the richness and diversity of local (sub)populations and their needs in one plan. Therefore the population sections do not include all of the data needed to select or create an effective intervention for a specific subpopulation in a particular community.

MHAC encourages readers to use this plan as a beginning point. Local data must be used to complement, expand, and narrow down the recommendations in this plan. The following sections can be used as maps to guide readers as they delve into the risk behaviors and prevention needs of their community members.

The flow charts following each population section provide a framework for thinking about the types of data that should be considered when doing local assessments:

- What is the population doing to put themselves at risk for acquiring or transmitting HIV?
- What are their prevention needs?
- Which categories do the needs fall into (access, skills, persuasion, supportive norms or knowledge)?
- Which interventions address these needs?

Local needs assessments can be done through a variety of mechanisms, including:

- Surveys
- Interviews
- Observation
- Focus Groups

While local needs assessment can and should include input from agency staff and other service providers, agencies should prioritize seeking input directly from at-risk individuals in their service area.

Local data about risk populations can also be gathered from other sources:

- County level epidemiological data
- Care or prevention service data
- Risk assessment forms

The importance of local data cannot be overstated. In order to select and implement effective interventions local data must be used along side the broad recommendations of this plan. Specifically MHAC encourages the use of local data to:

- Inform the choice of interventions (e.g., individual or group level, single or multi-session, location, integration opportunities)
- Determine effective recruitment and retention strategies
- Adapt evidence-based interventions

MHAC encourages all providers to seek training and support to increase their capacity to gather, analyze and apply local data to inform program planning.

Appendix

This plan is the product of five two-day meetings of the Prevention Plan Workgroup (PPW). The PPW consisted of members from MHAC's Comprehensive Plan and Needs Assessment Committees and MHAC advisors. Below is a brief description of the objectives and products from these meetings.

October 29 and 30, 2008

Meeting Objectives:

1. Practice four steps of community planning: needs assessment, priority setting, resource inventory and gap analysis.
2. Try three different priority setting models.
3. Choose a priority setting model.
4. Identify the populations to be used in the priority setting process.
5. Develop guiding principles for successful prevention planning.

Meeting products:

Priority setting model

- Create a list of populations
- Decide which data will be used for priority setting
- Discuss how to interpret data for each population
- Decide if data should be weighed and determine weights
- Conduct individual scoring of data
- Facilitated discussion to share initial scores
- Opportunity to adjust scores
- Total scores

Identified populations

- MSM
- HRH
- HIV+
- IDU

MHAC voted and approved this work at the November 13, 2008 meeting.

January 22 and 23, 2009

Meeting Objectives:

1. Review community planning and priority-setting basics.
2. Practice using the population priority setting model.
3. Review epidemiology 101.
4. Select the types of data to be used for priority setting.
5. Develop a method for how these data will be scored.
6. Decide what weights, if any, should be applied to those data

Meeting Products:

Data types and weights

Reported HIV/AIDS cases	- ⁷
Population Size	-
Disproportionate impact	1.8
Estimated HIV/AIDS Prevalence	1.3
Incidence Trends	1.9
Prevalence of risk behaviors	1.3

MHAC voted and approved this work at the March 19, 2009 meeting.

March 11 and 12, 2009

Meeting Objectives:

1. Use data to determine population priorities.
2. Discuss the epidemic for subpopulations within each of the broad population categories.

Meeting Products:

Prioritization Scores

	MSM	IDU	HRH
Reported HIV/AIDS cases	96	54	56
Population Size	57	73	89
Disproportionate impact	201.6	144	70.2
Estimated HIV/AIDS Prevalence	136.5	78	71.5
Incidence Trends	184.3	74.1	131.1
Prevalence of risk behaviors	136.5	123.5	126.1
Total	811.9	546.6	543.9

MHAC voted and approved this work at the March 19, 2009 meeting.

⁷ Reported HIV/AIDS cases and Population Size were weighted at the same level, and therefore, were counted at their scored level.

April 30 and May 1, 2009

Meeting Objectives:

1. Discuss findings from the web survey evaluating the process.
2. Review the taxonomy of population needs and intervention types.
3. Identify prevention needs and recommend interventions for each population.
4. Develop recommendations about needs assessment and service integration.

Meeting Products:

Population prevention needs matched to interventions. Flow sheets summarizing this work are shown on pages 14, 18, 22, 25.

MHAC voted and approved this work at the May 14, 2009 meeting.

June 4 and 5, 2009

Meeting Objectives:

1. Review draft sections of the Comprehensive Plan describing population needs and interventions.
2. Identify intervention gaps and develop recommendations.
3. Identify priority data needs to be pursued in the future.
4. Clarify next steps for the comprehensive plan, application and concurrence.

Meeting Products:

Prioritized subpopulations to consider for future state-supported needs assessments

HIV+	MSM	IDU	HRH
African American	Youth	African American	African American
Youth	Older	Youth	Youth
Transgender persons	Bisexual men	Newer injectors	Commercial sex workers
Newly diagnosed	Transgender persons	Transgender persons	Female partners of MSM

Due to the time sensitivity of this step in the process and because the MHAC was not scheduled to meet until September 17, 2009, the MHAC Executive Committee acted on behalf of the full council to approve this work. The intervention gaps and developed recommendations were approved by the Executive Committee via a conference call on the June 19, 2009 so that the *Plan* could be drafted.

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