

Rapid Assessment, Response and Evaluation

Final Report

Philadelphia

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Table of Contents

• ...Executive Summary	3
• Introduction to report	5
• Background	7
• Target Areas	9
• Methods.....	14
• Data Sources and Findings.....	15
• Recommendations/Action Plan.....	28

EXECUTIVE SUMMARY

AIDS has had a dramatic and disproportionate impact on the African American and Latino communities in Philadelphia. While representing approximately 47% of the City's population, 75% of all AIDS diagnoses in the City have been among African Americans and Latinos. AIDS case data also reveal that this disparity is most dramatic among individuals classified as heterosexual. Ninety percent of the AIDS cases attributable to heterosexual activity in Philadelphia occur among African Americans and Latinos.

In the summer of 1999, the City of Philadelphia responded to an initiative of the Office of AIDS Policy of the Department of Health and Human Services known as Rapid Assessment, Response, and Evaluation (RARE). RARE was established to assist urban areas in responding to the disproportionate impact of AIDS on African Americans and Latinos.

At the direction of the local Advisory Board brought together by the City Health Department for the RARE process, a field team was assembled and trained in the RARE methodology in August of 1999. Given the epidemiology of the epidemic in Philadelphia, the Advisory Group directed the team to focus on crack smoking women in two AIDS prevalent zip code areas—19104 and 19140. Beginning in September the field team collected data for 10 weeks through observations and interviews with community experts, community leaders, and service providers.

KEY FINDINGS

- **RISK POCKETS** Within each of the two target zip code areas the field team identified small “pockets”, where drug sales, drug use and sex exchanges flourish. These pockets are characterized by a high number of abandoned properties and neglected open spaces interspersed with occupied housing and residents interested in improving the neighborhood. This creates an environment that is avoided by many people, and where high risk behaviors thrive. Respondents from these risk pockets were unaware of the existence of HIV prevention services. Based on the data, the field team believes these “risk pockets” should be the focus of a low-threshold, saturated intervention.
- **MIXING** One of the epidemiological features of these risk pocket is the frequency of contact that occurs between individuals of different socio-economic and ethnic backgrounds, sexual orientations, geographic areas, health status, and risk behaviors. This mixing provides opportunities for viral transmission and dissemination to other areas. The mixing is fueled by the easy access to inexpensive sex. This access is created by the availability of crack cocaine.

- **STREET SCIENCE** HIV risk and prevention issues are clearly misunderstood by many of the community experts interviewed. “Street science” combines facts with more popular myths, folk wisdom, and government mistrust. There is a great need and desire for accurate, culturally sensitive information that is accessible and trusted. Based upon this finding the field team recommended the implementation of a comprehensive street level educational campaign.
- **CONDOM USE** The primary risk in these pockets is unprotected anal, oral, and vaginal sex. No community experts interviewed engaged in consistent condom use. Many had partners with whom they did not use condoms. Respondents equated partner familiarity with risk reduction. Both the low-threshold, saturated intervention and the street level education campaign are designed to address this risk factor by making condoms more accessible and their use more acceptable.

INTRODUCTION

In the Spring of 1999 President Clinton signed a bill releasing \$156 million to combat HIV and AIDS in minority communities. The Health and Human Services Department has distributed these funds through its various satellites—the Office of HIV/AIDS Policy, the National Institute on Drug Abuse, and the Centers for Disease and Prevention and Control. This legislation was the direct result of an intensive lobbying effort by the Health Committees of the Congressional Black Caucus and the Hispanic Caucus who felt that the Federal Government was not doing enough to combat the spread of the virus in African American and Latino communities. One of the critical components of this legislation was the Rapid Assessment, Response, and Evaluation process (RARE) initiated by the Office of HIV/AIDS Policy in the Department of Health & Human Services.

The RARE process and methodology has been utilized by a wide variety of non-governmental organizations in assessing various health and environmental problems and needs in many third world countries. The foundation of the process—Crisis Response Teams (CRT) are composed of traditionally trained academic researchers and “field researchers” who come from those areas that serve affected populations or are members of affected populations. These “field teams” go directly to the target populations and communities combining traditional ethnographic field research—observation, interviewing, and focus groups. In the RARE process, the cultural, the physical environment, and the social environment of the people being affected by the specific problem are assessed. Perhaps most importantly, the process is both intense and rapid. Field teams usually work from ten to twelve weeks assessing, evaluating, and observing the specific problem. At the conclusion of the process, the field team presents an “action plan” and report to the appropriate authorities.

The intent of the RARE process and methodology is to provide detailed information from people directly affected by a specific health or environmental problem. Often those most affected are “counted” or “measured” but are not included in the traditional research design and implementation. In many areas the populations most affected by the AIDS epidemic are hidden. The RARE process and methodology attempts to give visibility and voice to these hidden and avoided populations.

One of the critical components of the Government’s HIV/AIDS initiative in Minority Communities was the introduction of the RARE process and methodology to assess the impact of the epidemic in minority communities. HHS targeted cities with the largest populations affected by HIV/AIDS. To be eligible for this assistance, cities had to have populations of at least 500,000 people and at least 1500 African Americans or Hispanics living with HIV/AIDS. In addition, these two groups had to account for at least 50% of their community’s HIV/AIDS cases. Once a city qualified under these criteria, the chief elected official had to make a request that HHS dispatch a Crisis Response Team (CRT). Twenty cities were eligible for this assistance and eleven requested it, lead by Detroit, Miami, and Philadelphia. The overall goal of this application of RARE is to assist

communities in reducing HIV/AIDS morbidity and mortality among African American and Latino populations.

The RARE Advisory Group met in August, 1999 to initiate the process and identify target populations. The group decided to target two specific zip-code areas, 19104 in West Philadelphia and 19140 in North Philadelphia. These two areas had a significant number of new AIDS cases reported through March 31, 1999. Based upon AIDS case data, observations of the Advisory Group, and recent data from seroincidence studies, it was further specified that crack-smoking women would be the targeted focus of the field team's research.

The Philadelphia field team was selected by the Advisory Group and the team co-leaders were selected in consultation with the Office of HIV/AIDS Policy of HHS and the City of Philadelphia Department of Health. The field team was led by Dr. David Metzger, Director of the Opiate/AIDS Division of the Center for Studies of Addiction at the University of Pennsylvania of Pennsylvania Health System and Dr. William Eric Perkins, Senior Research Scholar with the African American Literacy & Culture Project at the University of Pennsylvania. Field team members came from a wide variety of outreach, counseling, referral, and treatment facilities and services.

Once the field team was assembled team leaders divided the field team into two sub-teams, one for North Philadelphia and one for West Philadelphia. The team was trained in August of 1999 and began its work on September 8. Data were collected through December 3, 1999. Weekly team meetings were held throughout this process to analyze data and schedule new data collection activities, developed outreach strategies, and engaged in serious deliberations about the risk behaviors and meaningful and appropriate interventions.

A report of the team's preliminary findings and proposed action plan with detailed recommendations was presented by the field team to the HIV/AIDS Advisory Board on December 20, 1999. This final report includes a detailed description of the target areas and populations, the methods used by the field team, and the team's findings. The recommendations for intervention are designed to be not only necessary but achievable and sustainable. They reflect the collective judgement of the field team and incorporate feedback from the Advisory Board. As Philadelphia moves into its third decade of the AIDS epidemic, strategies of prevention and care must remain responsive to the needs and sensitivities of those most affected.

BACKGROUND

AIDS and Race in Philadelphia

In Philadelphia, AIDS has had a disproportionate impact on African Americans and Latinos. The most recent census data indicate that Philadelphia has a total population of approximately 1,451,372. Of these, 617,065 (42.5%) are African American and 60,379 (4%) are Latino, Asian and other races.

Since the first diagnosis of AIDS in Philadelphia in 1981, through October of 1999, 12,353 individuals in the City have been diagnosed with AIDS. Of these, 7,040 (64%) were African American and 1,171 (11%) were of other races. Thus, while minorities account for 47% of the total population in Philadelphia, 75% of the diagnosed AIDS cases are among African Americans, Latinos, and other races.

The “AIDS gap” between whites and minorities is widening. Between January 1 and September 30 of 1999, 1,071 individuals were diagnosed with AIDS. Of these 733 (68%) were African American and 134 (12.6%) were of other races.

Risk Groups and Race

The disproportionate racial impact can be found in each of the three primary populations at risk for AIDS--Men who have sex with men (MSM), injection drug users (IDUs), and heterosexuals.

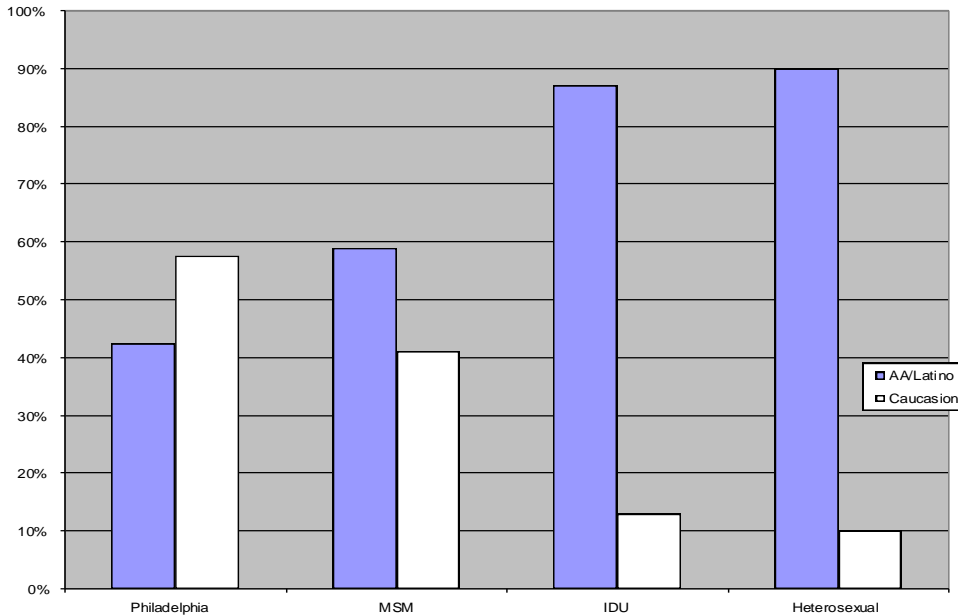
MSM: Since 1981, the beginning of the epidemic in Philadelphia, 5,157 men who have sex with men (MSMs) have been diagnosed with AIDS. Of these, 59% (3,028) were African American or Latino. Between January 1 and September 30, 1999, African Americans and Latinos accounted for 58% of MSMs diagnosed with AIDS.

IDUs: Of the 3,155 injection drug users (IDUs) diagnosed with AIDS since 1981, 2,738 (87%) were African American or Latino. During the last reporting period, covering the time between January 1 and September 30, 1999, African Americans and Latinos accounted for 87% of IDUs diagnosed with AIDS.

Heterosexual: Of the 1,577 heterosexuals diagnosed with AIDS since the beginning of the epidemic in Philadelphia, 90% (1423) were African American or Latino. Between January 1 and September 30, 1999, African Americans and Latinos accounted for 91% of heterosexuals diagnosed with AIDS.

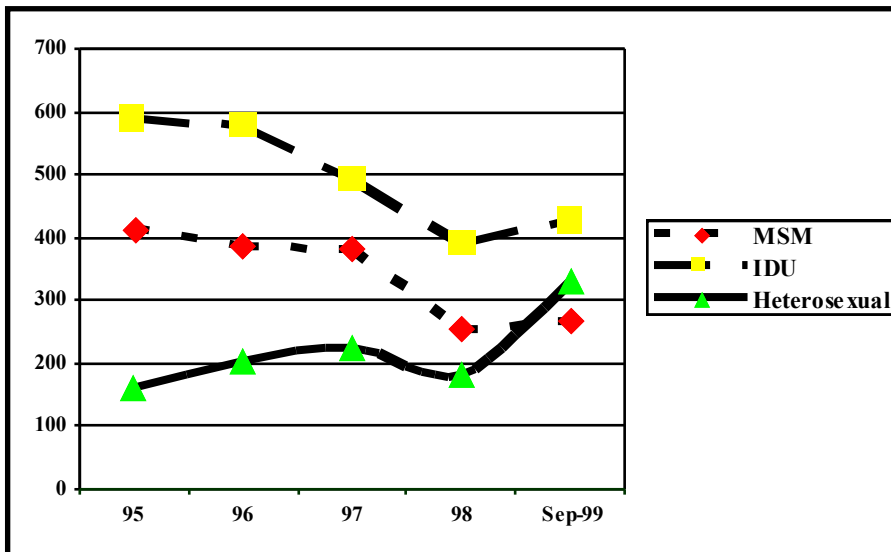
The following chart provides a graphic depiction of the relationship between AIDS diagnosis and race within risk group.

**Diagnosed AIDS cases by Race in Philadelphia:
1981 - 1999**



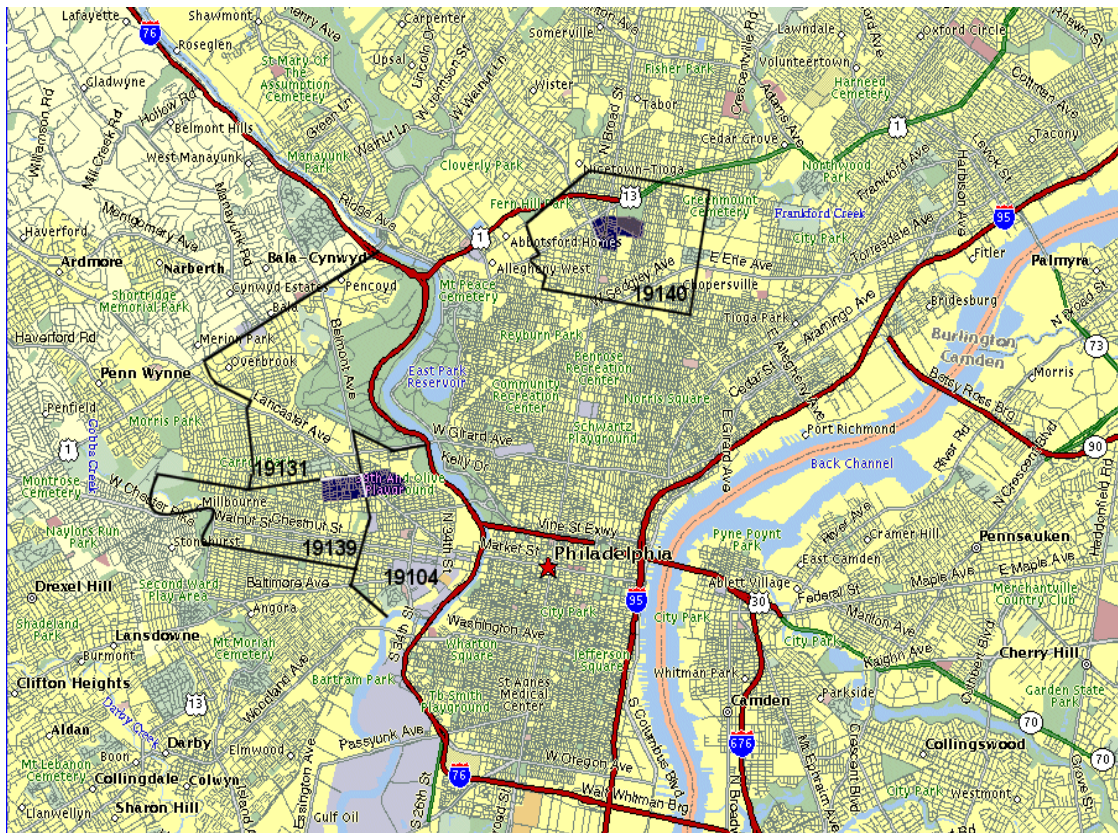
Further complicating the disproportionate impact of AIDS on African Americans and Latinos in Philadelphia, AIDS cases are growing most rapidly among heterosexuals. Data from 1999 indicate that AIDS diagnoses among heterosexuals have shown a dramatic increase and while this may reflect changes in reporting, it may also be an indication of a shift in the predominate mode of transmission.

Philadelphia AIDS diagnoses since 1995

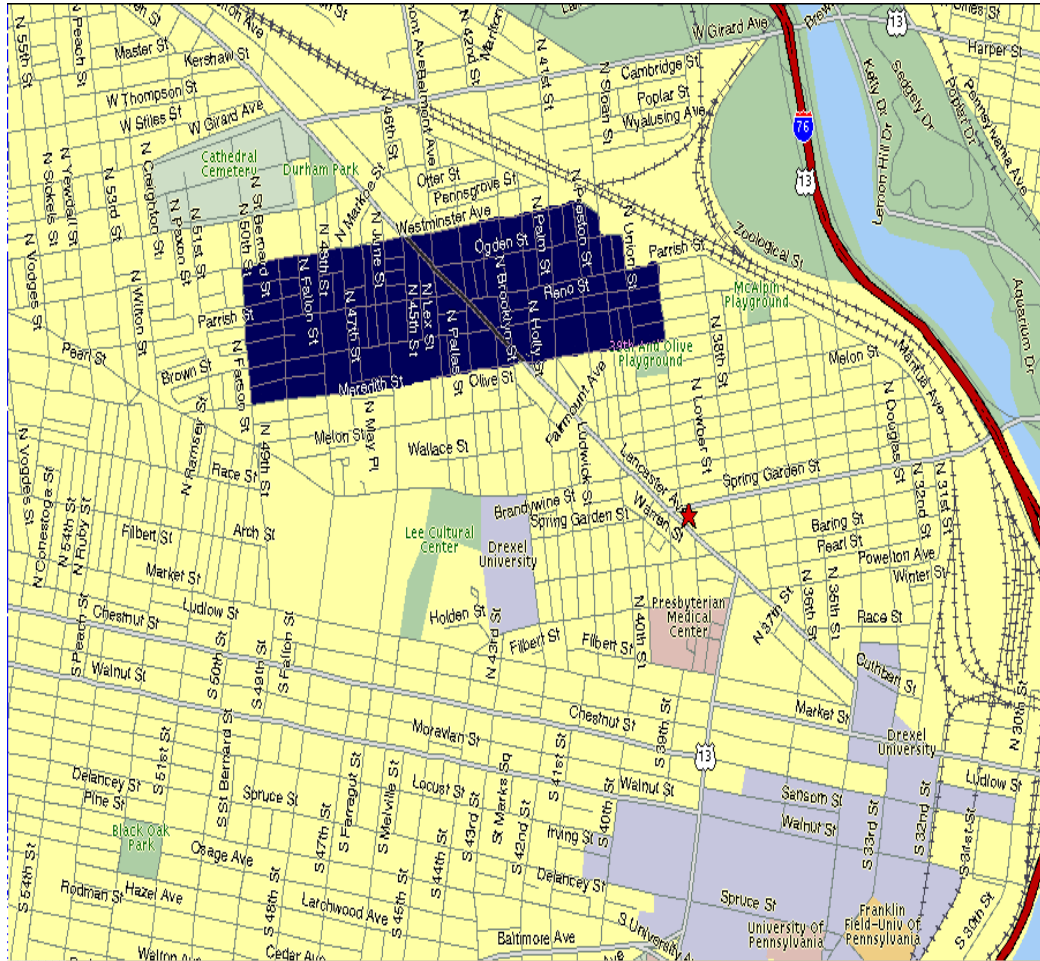


TARGET AREAS

Two zip codes 19140 and 19104 were designated as the target areas of assessment. As shown in the following map, the area of 19140 is located in North Philadelphia and zip code 19104 is located in West Philadelphia. Within each area, the team identified smaller areas in which drug sales, drug use, and sex work concentrated. Early in the process these concentrated areas were labeled “risk pockets” by the field team and are shown as the shaded areas in the following map. As can be seen the risk pocket in 19104 extended into the zip code areas of 19139 and 19131.



The Bottom: As can be seen in the following map, the West Philadelphia risk pocket is bounded by 39th Street to the East, 49th Street to the West and lies between Westmenster Avenue to the north and Merideth Street to the South. This area is known locally as “the Bottom”. The Bottom is bisected by Lancaster Avenue and is best described as an aging densely populated residential area.



Profile of the Risk Pockets

Unfortunately, the most current and complete socio-economic data for the target areas are data from the 1990 census. Despite the age of these data, the following summaries are reported to highlight the demographic characteristics of the areas and the long term nature of their current economic distress.

	The Bottom	Hunting Park
Population (1990):	19,301	18,583
Area:	1 sq. mi.	1 sq. mi.
Race:		
Black	18,736 (97%)	9,256 (49%)
White	396 (2%)	1,563 (8%)
Latino/a	80 (<1%)	7,764 (42%)
Unoccupied Housing Units:	1,578 (26%)	901 (15%)
%Employed:	79%	84%
Household Income (med):	\$13,174	\$16,430
% below poverty level	37%	36%

The Bottom, in West Philadelphia, is an area of less than one square mile in size. The vast majority (97%) of its residents are African American. Although a very high rate (26%) of the housing units were unoccupied in 1990, it is estimated that this rate has dramatically increased over the past 10 years. Thirty seven percent of the residents of this area were living below the poverty level and the median household income for this area was \$13,174 in 1990. This is slightly more than one half the median household income (\$25,176) for the City as a whole.

The Hunting Park risk pocket in North Philadelphia is characterized by a high degree of poverty, unemployment, and abandoned properties. In the 1990 census (the most recent source of socioeconomic data for the area), median household income for the three census tracts which define this risk pocket (197,198, and 203) was \$16,430, slightly more than 50% of the median household income for all of Philadelphia during the same time period. The proportion of people living below the poverty level in the year before the 1990 census was 36%. Among those in the labor force the unemployment rate was 16%. In 1989 15% of the housing units were not occupied.

METHODS

Four qualitative methods were used in the collection of data for the RARE process in Philadelphia—street interviews, formal interviews, focus groups and observation. Each is described in more detail below.

"STREET INTERVIEWS" In order to more effectively collect data from community experts and members of our primary target population--crack-smoking women-- the field team used a modified interview strategy which they termed a "street interview". This particular adaptation of RARE methodology is a synthesis of the formal, more lengthy interview with the "street intercept" method. Using mini-cassette tape recorders, field team members were able to record interviews with community experts with minimal intrusion into their activities. Interviews were often conducted while respondents were engaged in the search for potential tricks or on a "mission," (acquiring the next hit of crack-cocaine). It would not have been feasible to conduct a more formal interview in a private setting.

INDIVIDUAL INTERVIEWS Individual interviews were used to collect information from people with whom private sessions could be scheduled. These included community experts, community leaders and service providers. The interviews were conducted using a semi-structured interview format included as an Appendix. The questions were designed to document the respondents familiarity with the risk pocket, their perception of drug sales and use in the area, their understanding of HIV risk and their ideas regarding needed services. With the awareness and consent of the respondent, these interviews were tape recorded and transcribed.

FOCUS GROUPS The field team utilized focus groups to verify and elaborate on the observations of the field team and the reports from respondents interviewed individually. Focus groups were held with clients in a drug treatment program (2), with individuals receiving services from a prevention program (2), and community experts from the target areas (2). The focus groups were also tape recorded and transcribed. The focus groups used modified versions of the interview guidelines to structure the group discussion.

OBSERVATION AND ASSESSMENT Observation and assessment were ongoing activities for the RARE field team. Following an initial training in the strategies for safe and effective street outreach, team members conducted regular visits to the target areas. Team members were expected to work in small groups and carried fliers that explained the RARE process (see Appendix). Visits were scheduled to take place on various days each week throughout the 10 week data collection phase. The primary objective of this methods was to become familiar with the population and document the patterns and locations of activity in each area. Many of the street interviews described above took place during these observation visits. Team members also photographed key locations associated with risky behavior. Observations took place throughout the day and night. The field team met weekly to present findings and discuss implications for prevention.

DATA SOURCES

Three classes of respondents were targeted for data collection. These three respondent groups were labeled by the team as 1) community experts, 2) community leaders, and 3) service providers. Community experts refer to those individuals with knowledge of the target area-- residents, sex workers, drug dealers, and others encountered during street outreach activities. Community leaders refer to those individuals who are knowledgeable about the target area and who have a formal leadership role in the community—police, religious leaders, and leaders of community organizations. Service providers were program administrators and staff of agencies providing HIV prevention services to the target area.

FINDINGS

As shown in the following table, during the ten week data collection phase, the field team accumulated over 400 hours of observation, and complete 60 street interviews, 40 individual interviews and 6 focus groups.

	Experts	Leaders	Providers
Observation	200 hrs	200	50
Street Interviews	30	20	10
Individual Interviews	10	20	10
Focus Groups	4	2	

Through weekly debriefing and discussion sessions, team members synthesized observations, interview findings, and experiences. Four prevention relevant themes emerged and were reinforced by redundancies in the data. These included; 1) the observation of concentrated areas of risk, 2) the widespread lack of accurate and complete information on HIV transmission, prevention, and prevalence, 3) the high rate of “mixing” that occurs in these risk pockets, and 4) the numerous barriers to consistent condom use. Each of these four findings is described in detail below with representative excerpts from interview and focus group transcripts.

Risk Pockets

As described earlier, one of the first findings of the field team was the observation that within the targeted zip codes, small geographic areas (blocks and groups of blocks) were identified with high concentrations of individuals involved in exchange of sex for drugs or money. The most common drug in these areas was crack cocaine. These areas are also the location of numerous drug sales, indoor and out door spaces where drugs can be used, abandoned houses interspersed with occupied housing , and neglected open spaces. We have labeled these areas, risk pockets.

As reflected in this respondent's statement, sex exchanges occur around the clock in the risk pocket.

Respondent 01: Well I, I used to see them like, they'll be on the corner say Jerome Street. They'll be on the corner any time from way in the morning like eight until the next morning, you know. I used to work hours from 6:00 to 2:30 in the morning. Sometimes when I walked from the bus home, and that wasn't often, but when I did I would see that they would be on the corner doing their business. And you knew who was doing what, you know. You had your runners and what have you.

Both risk pockets have a large number of abandoned properties and neglected spaces allowing risk behaviors become embedded in the landscape.

Respondent 05: Look at the grass over there, right over there by the telephone pole and all that stuff. Man, it looks like a war zone over there. It's not supposed to be like that. That area's suppose to be a park, you know what I mean? It keeps a lot of elderly people from walking through, kids from playing, you can't play out there, they're cleaning up some hypodermic needles the other day right around the corner, cause I sweep from here all the way around by my alley way; you know what I'm trying to say? Cleaned up about three or four hypodermic needles on the ground. My children, when they come, my grandkids, they playing, riding their bicycles, they fall, might fall on one of those things, or the glass around here. You know what I'm trying to say?

As depicted in the following statement from a resident in the Hunting Park area, there are many people living in these risk pockets committed to the neighborhood and want to see things improve.

Respondent 02: hi, my name is[respondent 02], I've been in this neighborhood approximately ten years, no actually it is eleven years now. It was um, as far as I know always a um, family oriented block and I had some friends who lived here and there was always children playing 10 years ago, 20 years ago and even now. I like the block but it is rapidly deteriorating, my property value has probably decreased by ten thousand dollars because to the right of my home there are four abandoned properties, across the street from me directly there's an abandoned property, to left and across the street there's two abandoned properties but I'm not going anywhere. (laughter)

The prevalence and visibility of drug sales and sex work contributes to a sense of abandonment and loss of control.

Oh, okay. I'm from down the bottom, I'm from around the corner of 46th St.. What I know is um, they sell all kinds of drugs around there. Yeah, well I trick a lot , and um it's... it's really, really totally out of hand because they disrespect the women. And I know my brother-he did it a lot too, disrespect women and tricking' and I have seen in crackhouses, I seen people have orgies in it. And I have seen girls do guys, you know. I have seen a lot and it's it's really out of hand.

Through extensive observation and interviews the field team was able to gain an understanding of the patterns of risk in each pocket. Risk pattern refers to the interaction between location, time, type of sex exchange, and risk group. This level of detail provides an opportunity to design highly specific prevention intervention.

Hunting Park: Location of Sex Exchange by Risk Populations

	Sex Money	Sex For Crack
Local	Park Cars Abandoned Houses Hotel	Park Cars Abandoned Houses Hotel
Drive Ins	Cars Hotel	Abandoned Houses Hotels
IDUs	Park Cars Abandoned Houses Hotel	Abandoned Houses Hotel
MSM		Crack House
Bar Crowd		

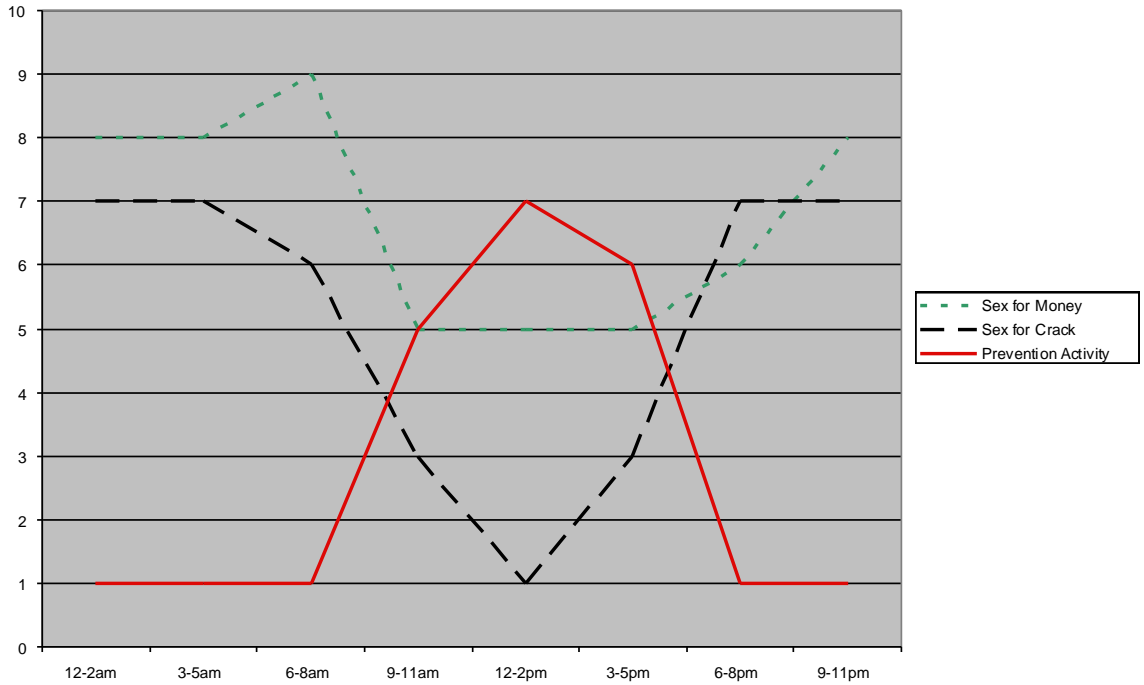
The Bottom: Location of Sex Exchange by Risk Populations

	Sex For Money	Sex For Crack
Local	Cars Abandoned Houses Crack Houses	Cars Abandoned Houses Crack Houses
Drive Ins	Cars Hotel Crack Houses	Crack Houses Hotels
IDUs	Park Cars Crack Houses Hotel	Abandoned Houses Hotel Crack Houses
MSM		Crack House
Bar Crowd	Cars Hotel Crack House	Hotel Crack House

Local: Refers to people who live in the risk pocket
 Drive Ins: Refers to people who drive to risk pocket
 IDUs: Injection drug Users
 MSM: Men who have sex with men.
 Bar Crowd: Men who frequent local bars

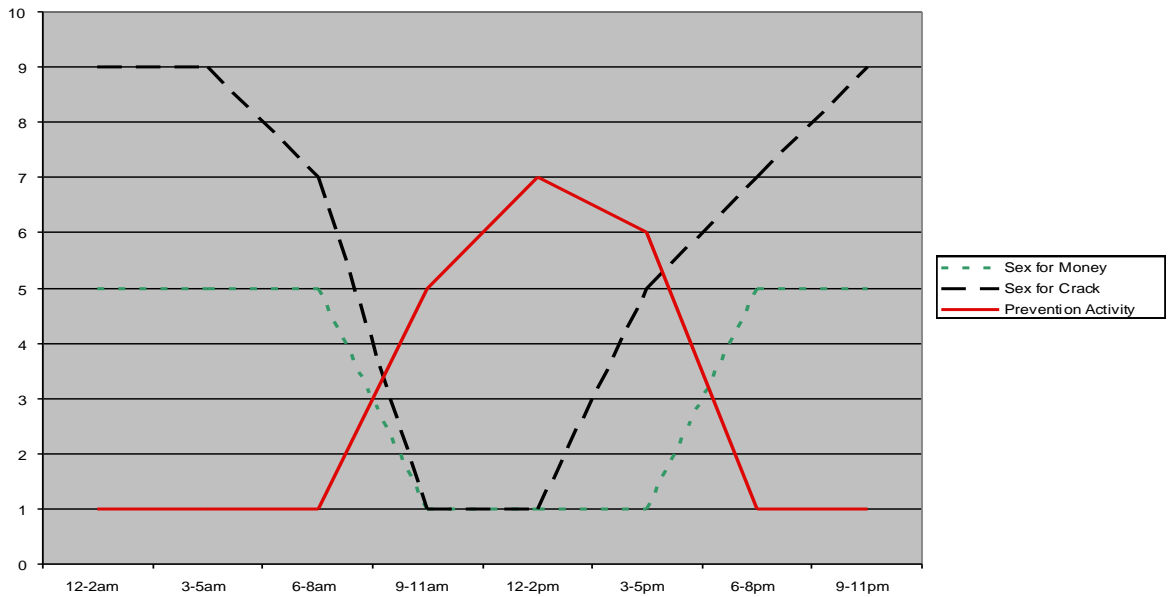
The following tables depict both the peak and down times of risk and prevention activities

Hunting Park: Daily Risk and Prevention Activity



in each risk pocket. Using an arbitrary scale of 0 to 10, in which 0 indicates no activity and 10 indicates peak activity, the charts highlight the “mismatch” between prevention activities and risk behaviors.

The Bottom: Daily Risk and Prevention Activity



Street Science: Facts, Misinformation and Mythology

HIV risk and prevention was not well understood by the community experts interviewed. Often this knowledge included a mixture of facts, misinformation, and mythology. We call this "Street Science" These community experts appeared quite interested in information and amenable to altering their perceptions when the information is delivered by trusted sources who are respected by the community. Heath Department reports and other "Official" data do not meet this test.

The following community expert (drug dealer) reveals both a level of awareness of treatments for AIDS as well as an unconventional view of the epidemiology of HIV disease.

Respondent 03: Well, come -- anybody's at risk for HIV. Not only this area, any area. It seem like to me, honestly, the more the money you got the more that AIDs shit come about. You know what I mean? Yeah, there's people off in corners that don't have the medical assessments and shit like that, the drug cocktails and all of that, to take of their AIDs or their HIV condition. But, you best believe them fucking rich people are getting that shit too 'cause they got the money so they can try and do anything they fucking want to do.

If you look at that shit on a worldwide scale, and I just was reading that Dow Jones report like a month or two ago, if I'm not mistaken, that more people with money get that shit then these ghetto people, than the people in the ghetto. Because the more people with the dough, they're liable to try any mother fucking thing, and they're trying anything and sleeping with anybody. See I'm saying ?

This female respondent reflects the desire for information that was common among the community experts interviewed.

FEMALE: *First of all, I'd have some information out there. Uh, that's a start. Prevention is uh, an ounce of prevention... a pound of cure. Something like that? You know what I'm trying to say, you know what I'm saying. That, that's it. That in itself. It takes money to get information out. And it, it takes manpower, and, you know, people willing, you now, to to put that effort forth. And that takes money.*

The following excerpt reflects the degree to which the government is perceived as an agent in the drug trade, influencing the types and availability of drugs on the street. This respondent goes on to minimize the risk associated with crack.

Male: *.... besides the fact that they what, they have more mope on the street then dope okay, and I think all the drug dealers that have the bad shit should be locked up don't lock up the ones that have the good shit lock up the nasty ass poison ass shit, and the government knows the shit 'cause they probably get the good shit in the country, they ones, they got the best scientist, the best chemist, they the one's that **(inaudible phrase)** and give us the bad shit. And why is it, hold on, why is it, okay, now check this out, why is it powder, right, back in the day there was one kind of cocaine back **(inaudible phrase)** , one powder was for everybody you can shot it, snort it or smoke it right, how come all of a sudden now, they got snorting drugs, shooting drugs, and smoking drugs and ain't no fucking such thing as that but check it out, I think the safest way to do, the safest drug in world is to smoke crack because you need baking soda **(inaudible phrase)***

In the following segment, we hear a series of common myths about HIV transmission and the role of the government in allowing the epidemic to continue.

Subj01: everybody, everybody in this whole world is, everybody, there's no... I'm saying, I think they doing it with a bug (inaudible phrase) . I think there's a bug somewhere, they give it to a bug and the bug come, like a mosquito, that's how they did it. I'm saying everyone in the whole world, it might be in the air, airborne, know what I mean. I'm saying how come some people get it and some people don't. It might be the mood the person is in, or something. You got condoms, (inaudible phrase) And bleach don't work. Why is the Health Department (inaudible word)? Why they tellin' people that I can use (inaudible word) and then you bleach them out (inaudible words). I mean, what's up with that? Why is the Health Department doin it? Why they putting out a myth, that bleach is actually gonna change (inaudible word) Airborne, if its airborne, it's safer. The works is in the air. The air has a better chance of killing the virus than bleach. The bleach ain't gonna do nothing. So why they givin' out, I mean they know they know what they doin'. Part of the concern is just like uh, just like Viet Nam, it's a plague that the government is a part of. It would never be like this; it would never got this far. You know what I mean? It ain't about the homosexual community that they credit, the homosexual community, or the drug community. It's an economic based , uh to get rid of a number of people because the welfare roles the drug programs, because it cuts the HMO the hospitalization, the whole nine yards.

Mixing

One of the defining epidemiologic features of the risk pocket is the high level of intimate interaction that takes place among individuals. This interaction often occurs among individuals from diverse geographic areas, socio-economic and ethnic backgrounds, drug use patterns and histories, sexual preferences and health status. Thus, the probability of viral transmission and spread is greatly increased.

As highlighted in the following series of quotes from respondents, the team repeatedly heard reports about people from different areas of the city and suburbs, attracted to the risk pockets by the availability of sex. As described the availability of sex attracts heterosexuals, gays, and bi-sexuals.

Intr: Who, who do you think that they talk to, like the girls? Like, what kind of guys?
Subj03: White guys, black guys, Chinese guys; all types of shit be coming through here.
Intr: Is it a drive through--
Subj03: Indian guys.
Intr: Do they walk up?
Subj03: They drive more than -- most -- a lot, 90%, 99% of them drive.

Male:... I'm an addict. I've been active in addiction for 27 years. Um, I first got into tricking because, ah, ah, well, first of all, I'm a homosexual and I had a very unsatisfactory relationship for 20 years and the last 5 of them, I was having no sex with my lover. And, um, I found that when I was out at the crack houses, that there are men in crack houses that will do just about anything for drugs, just as there are women that will do anything for the drugs. And, ah, I used to offer the dealers blow jobs when I ran out of money, and I felt I as getting one over on them because I was homosexual and they didn't know it and I was enjoying myself; or so I thought.

Female: I got friends who like, who like deal with men, but have women. I guess they call it like being bi-sexual; like having that closet life so they won't spook like, family members and their friends. Especially if like, they decide that they interested in.... That they also go both ways.....into a behavior that they didn't like when they like indulge in the other way.

*I've been a heroin addict for like, well I started 35 years ago. And from (**inaudible phrase**) when the AIDS epidemic first started in the 80's, early 80's, I was on the path and I'm a highly sexed person, and like to see the tricks out on Broad Street I'd run up and down the street, and they wouldn't help me. They, they'd get me to drive them around, they wanted a place to sit in the winter time and thaw off, so you know I was there. So you know it was like free sex with them, and (**inaudible words**) but, uh, since I been out here lately and the guys, and everything, its been like; I've seen so much stuff and I mean. I remember back in the 80's when I used go to walk ins when I was on pot or cocaine and sometimes, I be having sex with that girl that everybody talkin' about.*

do you think it's like some much like people coming in the neighborhood that don't live here like maybe looking for tricks or looking for the drugs that kind of keeping going or that...:

Subj05: yeah, where ever you go

Subj04: for real, for real okay, all it going to be the same thing right, because you know what I mean, they can always come back in here looking for trickin'

Subj05: and then you ain't got to have the one's that do come here

Subj04: the same environment people around here gonna be going ...

Intr(male): that's what we trying to find if there is more an influence with people coming in from outside the neighborhood...

Subj04: I think it's more when they still is in here

Condom Use

Condoms are not consistently used in these risk pockets. While some sex workers stated that they require condoms for all of their partners, all respondents reported some circumstances in which condoms would not be used. The decision is based foremost upon the apparent risk posed by a partner or a potential partner. Familiarity is a key factor in making the decision to use or request that a condom be used.

The follow excerpt reflects some of the disadvantages of condom use that sex workers encounter.

Sex Worker: It's to our disadvantage, okay, get that part, the lubricated ones they taste like shit, okay, that shit tastes worse then cum itself, that shit tastes nasty and you dont' have the green ones all the time, all that shit, tastes really, really, really, really nasty, nasty ass taste in your mouth but most men, it's psychological. I'm at the point where they'll take them off or they'll cum inside of it and then say, see they play games with condoms. they play games, they can cum in the condom and then snatch it off and say they didn't cum.

Intr(male): right

Subj01: that happens alot, okay, so that mean they get to cum twice. Okay, so condoms is for you and against you

The following passage highlights the inconsistency of condom use among individuals “in relationships” even when fully aware of their partners risk status.

Intr(male): without you saying no names or saying your name, do you have sex with one of the girls in the park? I mean just honest.

Subj02: very rarely

Intr(male): have you ever?

Subj02: yeah

Intr(male): when you did, did you have, did you use protection?

Subj02: um, sometimes

Intr(male): sometimes, has it been all time?

Subj02: use protection all the time, no

Intr(male): tell me your reason why that you didn't use protection.

Subj02: they few that I didn't use protect wit we were in a relationship

Intr(male): was she messin' with anybody else that you know of? In your opinion?

Subj02: yeah

Intr(male): she was and that didn't matter to you

Subj02: well, I mean you know uh, it did but apparently it didn't, you know what I mean

The following segment highlights the psychological and economic factors that influence the use of condoms.

Okay, I was all over the city at one time or another but I predominantly was around Broad and Olney, down in this neighborhood, 19139, and over round 18th, I mean Broad and Somerset, where it's very, very busy up there, and Huntington Park. I could say I was everywhere. Um, it's a terrible thing that a lot of girls do not take the time to get rubbers 'cause they, they easy access. They too busy tryin' to make that \$5 or less. And when I found out that was the going price out there today, it broke my heart because to me, your body is worth something but it's worth more than \$5, but the girls have made it such an easy thing now that it's, you know. That's the most any man wanna' give you unless he has respect for his self. Some of the girls look like zombies. Some of 'em look like skeletons. I mean some of 'em look so bad and dirty I don't even know how some men trick 'em, but that's what the limit that the women have turned themselves into- so the point that they don't mean anything to anybody, if they don't mean nothing to themselves, how could they mean anything to anybody, you know? I've seen husbands that be out there trickin' and they turn around and say 'I gotta go home to my wife. Do you have anything?' -like a girl's really gonna tell you 'yeah I got a disease, take it home to your wife.' Before you get beat up or killed, women don't be honest about it. And like I said, most of the time, they're are no condoms accessible unless, they have 'em in a ,a, you know- like a lot of times the vans come over and deliver, you know, the girls all the condoms they want or could use. And a lot of times, you run out. If you doin' a lot of business, you run out and before they come back, then what you gon' do? You ain't gon spend no dollar to buy no condom. that may mess up your drug thing . So , I seen, nowadays it's the young girls that's comin' out with the same thing. They want \$5 a hit. They still in high school, and they out here trickin' trying to get they \$5 to get their groove on. And um, I'm HIV+, and I wish to God, somebody had been there for me to explain or to let me think about it.

RECOMMENDATIONS

Recommendations for Action

Recommendation 1: A street level HIV education campaign needs to be conducted in each of the risk pockets. This campaign should highlight the risk behaviors associated with the sex-for-crack economy. It must be integrated into the risk pocket with messages delivered by community members who are respected by the target population, and use acceptable and accessible media.

Finding: This recommendation is responsive to the field team’s finding of numerous uncertainties, inaccuracies, misconceptions, and myths regarding the epidemiology of HIV. These included questions about the risks of contracting HIV from oral sex, the belief that withdrawal could prevent transmission, that the rich were at greater risk than inner-city African-Americans, and reliance on one’s steady or regular sex partners to prevent infection.

The team found serious distrust of what is perceived as official information. Messages about HIV communicated through the “official media” are held in suspicion. Although HIV was not seen as a high priority issue, the field team found substantial interest in learning more about the epidemic.

Method: Street Interviews

Sample: Community Experts and Community Leaders

Recommendation 2: Low-threshold, saturated (LTS) prevention intervention should be instituted in each “risk-pocket.” LTS interventions would be rooted in the community and have the goal of providing access to prevention related services and supplies to these risk pockets.

Finding: Many community experts were unaware of current HIV prevention initiatives and methods for accessing existing services. Prevention services and prevention supplies are typically not available during evening, night-time and week-end hours. HIV risk is a multi-dimensional problem related to a wide variety of socio-economic factors for which existing service systems are in place but do not penetrate these risk pockets.

Method: Team Observations and Street Interviews

Sample: Community Experts, Community Leaders, and, Service Providers.

Recommendation 3: Risk pockets can be found throughout the city and the RARE process should be used to assist in targeting and evaluating public health and prevention services.

Existing HIV prevention outreach workers in Philadelphia should be educated and oriented to the RARE methodology.

Finding: At this stage of the HIV epidemic in Philadelphia, a substantial amount of HIV risk appears to be concentrated in small geographic clusters. These small risk pockets increase the potential for mixing and viral transmission and can become the focus of public health intervention.

Method: Team Observations and Street Interviews

Sample: Community Experts, Community Leaders, and Service Providers

Recommendation 4: An Inter-Agency Task Force composed of appropriate representatives from agencies that have as their charge serving our target populations. Task Force representatives should come from the Housing Authority, the School District, CODAP, AAACO, Human Services, the Health Department, and the criminal justice system. Coordination of the Task Force's activities would be by the Low-Threshold, Saturated (LTS) team in each intervention zone.

Finding: Many of the field team's observations concerned the paucity of services in the two intervention zones. Traditional services, like social services or health-related services seem to have bypassed these areas. Arresting the spread of the virus in these two zones will require strong coordinated effort by the entire health, social service, and criminal justice establishment.

Method: Team Observation and comments from HIV Advisory Committee members.

Sample: Team members, service providers, and Advisory Committee members.

APPENDICES

Street Interview Guide
Community Expert

Interviewer Initials: _____ Zip: _____ Location: _____

Date: ___ / ___ / ___

1. *Introduction/Description of Rapid Assessment Project*
2. *Overview of the Interview and Reason for Recording*
3. *Reminder about Confidentiality –No Names*
4. *Expected Duration 10 minutes*
5. *Permission to begin*

- I.) Tell me how you know about this neighborhood:
- II) Are there people you know in this neighborhood who are at risk of HIV because of their drug use? What makes them at risk? Why? Where?
- III) Are there any AIDS/HIV Prevention Services in the area?
- Where are each of these located? How do people feel about these services?
- IV) If you had the power and the money, what would you do to reduce HIV risk in this area? What specific services? Where would you locate them?
- V) Do you think a drop-in center/outreach teams would be accepted?
- VI) Any additional comments? Thanks

RAPID ASSESSMENT GUIDE

Community Leader

Introduction/Description of Rapid Assessment Project

Overview of the Interview and Reason for Recording

Reminder about Confidentiality –No Names

Expected Duration 30 to 45 minutes

Permission to begin

Tell me a little about yourself

Where do you live? For how long?

Does your family live in the area?

Did you grow up here?

What's your understanding of the drug problem in this area?

What is your experience with the drug problem in this area?

Where do people usually buy? Where do people usually use?

What kinds of drugs are most common?

How does the current drug situation compare to a year ago? Five years ago?

II) Are there people you know in this neighborhood who are at risk of HIV because of their drug use?

What makes them at risk? Why? Where?

III) Are there any AIDS/HIV Prevention Services in the area?

Free list the names of those services. Ask respondent to name all of the services they can think of. Prompt by asking "Can you name any others?" until the answer is no.

Where are each of these located?

How do people feel about these services?

IV) If you had the power and the money, what would you do to reduce HIV risk in this area?

What specific services?

Where would you locate them?

Do you think a drop-in center would be helpful?

What about drug treatment?

Thank You

Interventions for HIV in African American Communities

This past June, Health and Human Service Secretary Donna Shalala announced that Philadelphia will be one of eleven cities to receive special assistance from teams of federal and local experts to help African American communities combat the spread of HIV/AIDS.

In Philadelphia, Crisis Response Teams will focus on two specific neighborhoods --the Hunting Park/Nicetown area of North Philadelphia and Mantua and Mill Creek sections of West Philadelphia. These Crisis Response Teams' goals are to assess the neighborhood's HIV intervention and prevention service needs, with the larger goal of reducing the spread of HIV and AIDS deaths. Following an eight week period of talking with people who are at highest risk of infection, local service providers, and community experts, the team will present the Mayor's office with an action plan and a set of recommendations to combat the epidemic in these neighborhoods.

This initiative is a joint effort between the US Department of Health and Human Services and the Congressional Black Caucus who have pressured the Clinton Administration to do more to fight HIV/AIDS in African American communities.

Local Contact: David Acosta, AIDS Activities Coordinating Office (215-685-5650)
William Eric Perkins, Ph.D. Crisis Response Team Co-Leader (215-898-4912)
David Metzger, Ph.D. Crisis Response Team Co-Leader (215-823-6098)

Examples of Recommended Interventions

Street-Level Education: For example, a campaign could follow the street-marketing model of hiphop record distributors, inundating each risk pocket with flyers (in the form of small cards), posters, and giveaways (key chains, tee-shirts, caps, etc..) The theme of this campaign would be “Protect Yourself, Respect Yourself.” The Staple Singers song, “Respect Yourself” would be the cornerstone of this aspect of the campaign and would be used to kick it off. The messages would be designed to counter the myths associated with the “street science” of our population. For example, that there is no risk from oral sex, that only rich, white people contract the virus, that unprotected sex with a regular partner reduces risk, or that sex with familiar people (“homeys”) held no risk.

A series of public service announcements recorded by both cultural experts and local celebrities from the designated intervention zones (for example, Patti Labelle is from West Philadelphia and the rapper, Schooly D is from the Mill Creek risk pocket). These messages, with content tailor-made to the risk pocket level, would be featured on local cable television stations and the radio, the medium of choice for our population. WDAS-FM is the radio station that virtually all of our population listens to.

These short and concise announcements would have maximum effect provided the campaign customizes the messages to the language, idiom, and geography of each intervention zone and target population.

A series of murals depicting prevention themes with messages of protecting family and community. These could be painted at selected, targeted sites in each risk pocket. One way of going about this is to have a school, university, health department collaboration in which students would submit entries in a competition. Following the selection, students from University City High School and the University of Pennsylvania (for the West Philadelphia intervention zone) and Simon Gratz High School and Temple University (for the North Philadelphia intervention zone) would paint the murals at sites frequented by the populations. This aspect of the campaign would link students to the local communities while introducing them to the wide range of sexual risk behaviors associated with the transmission of HIV.

Street fairs could be held in each intervention zone (Hunting Park in North Philadelphia and the Mill Creek Park in West Philadelphia) with information booths, counselors, local celebrities, and live broadcast

feed from local radio stations, especially WDAS-FM. This would be held in the late spring or early summer, and given the successes of street fairs in marketing hiphop, this is expected to reinforce and enhance the prevention messages.

Low Threshold Intervention:

The implementation of LTS would be the responsibility of a team of community experts and leaders from the targeted risk pockets. These teams would be coordinated by a two-member prevention worker. These teams would become integrated into the community, maintaining trusting and respectful relationships with the community experts and community leaders in each area. The support and participation of the people “on the block” is essential for the success of this intervention.

The LTS teams in each risk-pocket would become advocates for the prevention needs of the local, at-risk population — easily accessible HIV/STD counseling and testing, drug treatment, housing, syringe exchange, job training, GED preparation and testing, legal services, mental health services, child care, and counseling. These LTS teams would work non-traditional hours and be responsible for establishing and coordinating a collaborative effort with local community leaders and service providers. These outreach-worker teams would become linkages to existing services.

One of the primary goals of the outreach-member teams is to assist all sex workers in each risk pocket to have periodic testing for HIV and other STDs.

The RARE Method:

The RARE methodology is well suited to planning and evaluation of HIV prevention services. The process gives voice to those “invisible” populations at greatest risk of infection currently. Its flexibility and adaptability can be customized to the unique social, cultural, economic, and sexual characteristics of individual risk pockets.

Through an ongoing in-service training and development program, the existing network of HIV prevention outreach workers could be used to identify and respond to risk pockets.