

## CHAPTER 3: PRIORITIZATION OF TARGET POPULATIONS

### Population Priority Setting Process

#### Priority Populations for 2005-2009

Population priority setting was accomplished by considering CDC's mandated population of persons living with HIV/AIDS (PLWHA); size of at-risk populations; measurement of the percentage of HIV morbidity (i.e., HIV/AIDS incidence or prevalence); and prevalence of risky behaviors in the population.

In March of 2003, DHEC staff distributed and reviewed the *South Carolina's Epidemiologic Profile* with the Community Planning Group. The Needs Assessment Committee reviewed the Epi-Profile and other data, then presented the recommendations for changing the priority order of populations at the July 2003 CPG meeting. The recommendations were ratified and the following seven priority populations were selected and defined by transmission risk\*, gender, age, race/ethnicity, and HIV status:

- 1) Persons living with HIV/AIDS
- 2) African American Men who have Sex with Men, Ages 15-44
- 3) African American Women who have Sex with Men, Ages 15-44
- 4) African American Men who have Sex with Women, Ages 15-44
- 5) White Men who have Sex with Men, Ages 15-44
- 6) Injection Drug Users, Ages 20-44
- 7) Hispanics/Latinos.

For a detailed description of the priority setting process and the literature reviews for identifying recommended types of interventions for each priority population, please review the archived 2005 – 2009 S.C. HIV Prevention Plan, Chapter 4, at the DHEC web site: [http://www.scdhec.gov/health/disease/stdhiv/sc\\_hiv\\_prevention\\_plan.htm](http://www.scdhec.gov/health/disease/stdhiv/sc_hiv_prevention_plan.htm).

#### Priority Populations for 2010-2014

In February 2009, DHEC staff distributed and reviewed the *South Carolina's Epidemiologic Profile* (with data through 2007) with the HPC. The Prevention Committee reviewed the Epi Profile and other supplemental data, re-examined the priority populations for 2004-9, and then presented their recommendations for the 2010 priority order of populations at the June 2009 HPC meeting. The recommendations ratified by the HPC were to reaffirm the seven priority populations as previously ranked and noted above.

\*NOTE: HIV epi risk data presented in the following sections for each population has been calculated from those persons reporting an HIV risk.

**POPULATION #1  
PERSONS LIVING WITH HIV/AIDS**

Size of Population: 14,696

As of December 31, 2007, there were 14,696 persons reported to be living with HIV, including AIDS, in South Carolina. The growing number of persons living with HIV/AIDS (PLWHA) challenges both prevention and care service systems. Prevention needs are essential to address the sexual and substance use risk behaviors among some PLWHA. The need is increasing for continual supportive services at the individual, group and community levels to assist PLWHA in their personal health care and behavior change. Adherence to drug regimens reduces the viral load of the person living with HIV/AIDS, thus reducing the likelihood of HIV transmission if risk behaviors are engaged in. As people live longer and longer with HIV/AIDS, the need will certainly increase for prevention programs to adapt to meet the needs of the aging population who may otherwise “burnout” on previous or current prevention interventions.

**Subpopulations of Concern:**

- AAMSM and WMSM
- AAMSW and AAWSM
- IDU

**Needs Assessment Findings:**

- High incidence of unprotected sex
- High incidence of STD/history of STDs
- Misinformation & lack of knowledge about HIV risky behaviors & transmission
- Multiple sexual partners
- Non-injection drug/substance use
- Lack of drug treatment programs and/or access to such
- High incidence of commercial sex work
- Low SES (education, income & employment)
- Inadequate support services for PLWH/A
- Frustration, hopelessness & resignation
- Mental health issues
- Limited access to & utilization of health & social services (health insurance, adherence & compliance, transportation, etc.).
- Social stigma, discrimination & phobias
- Little or no follow-up care or linkages to needed services
- Inadequate outreach services
- Unmet necessary needs (shelter, food, etc.)
- Low sensitivity, empathy and confidentiality by health care providers

## **POPULATION #2**

### **AFRICAN AMERICAN MEN WHO HAVE SEX WITH MEN, AGES 15 - 44**

Estimated Size: Minimum of 24,515 men

African American men who have sex with men (AAMSM) comprise 24% of the reported PLWHA in South Carolina. Among those recently diagnosed with HIV/AIDS in South Carolina, AAMSM comprise 33% of the cases. There are significant prevention challenges related to AAMSM in South Carolina, similar to other southeastern states. Few programs are targeted toward this population. Access to the population is difficult due to secrecy of the activity, denial of AAMSM engaging in same sex activities and the double stigmas of racism and homophobia. Many AAMSM often identify themselves as heterosexual. Thus, there is not a defined open “community” to focus needs assessments, target information or provide support. Further, the lack of family and religious institution support of sexuality issues reduces the population’s access to preventive health services. There is too little information on proven effective interventions for this population, particularly in rural areas. Culturally reflective staff, including peers, are often not available to deliver the interventions.

#### **Subpopulations Of Concern:**

- HIV negative partners of PLWHA
- Youth and young adults (<25)
- Incarcerated
- Substance users
- HIV infected
- Bisexual
- Transgenders
- Sex workers
- MSM who do not identify as MSM

#### **Needs Assessment Findings:**

- Unified gay community
- Financial and generation gap within community
- Apathy about HIV/AIDS
- Lack of accessible social, cultural & health information /resources
- Lack of alternative non-bar meeting/gathering places
- High incidence of drug use
- High incidence of unprotected sex
- High incidence of closeted (down-low) sexual behaviors
- High incidence of unknown HIV status, and unwillingness to be tested, and/or lack of awareness of benefits of testing/testing sites
- Misinformation & lack of knowledge about HIV risky behaviors and transmission
- Multiple sexual partners
- Non-injection drug use
- Prevalence of societal discrimination & stigma related to race, sexual orientation & economic status
- High incidence of STD/history of STDs

**POPULATION #3**  
**AFRICAN AMERICAN WOMEN WHO HAVE SEX WITH MEN, AGES 15 - 44**

Estimated Size: 284,437 women

African American women who have sex with men comprise 21% of the PLWHA in South Carolina. Among recently reported cases during 2006-2007, African American heterosexual women accounted for 20% of the total cases. This trend is similar across southern states where joblessness, substance abuse, teenage pregnancy, STDs inadequate schools, minimal access to health care and low incomes contribute to the increasing rates of HIV among this population. In addition, African American women are frequently unknowingly placed at risk by their male sexual partners who are more likely to be HIV infected through male-to-male sex and substance use. Women are often in power imbalanced relationships and perceive themselves as “victims” which creates significant challenges for prevention.

**Subpopulations of Concern:**

- HIV negative partners of PLWHA
- Youth and young adults (<25)
- Incarcerated
- Substance users
- HIV infected
- Sex workers
- Pregnant women

**Needs Assessment Findings:**

- High incidence of unprotected sex
- High incidence of STD/history of STD’s
- Misinformation & lack of knowledge about HIV risky behaviors and transmission
- Multiple sexual relationships
- High incidence of commercial sex work
- Low SES (education, income and employment)
- Non-injection drug use
- Inadequate health, social and support services (transportation, health insurance, child care).

**POPULATION: #4**  
**AFRICAN AMERICAN MEN WHO HAVE SEX WITH WOMEN, AGES 15 - 44**

Estimated Size: 262,924 men

African American men who have sex with women comprise approximately 13% of PLWHA and of the more recently diagnosed cases in South Carolina. Many local HIV providers believe the proportion of African American men reporting heterosexual transmission is inflated due to stigma of male to male sex. However, it is recognized that many of these men have sex with women and as the number of African American women infected with HIV grows, the heterosexual risk to men will also grow. Additionally, many important programs developed by and for the African American community often focus more on women. African American men have fewer services provided specifically to meet their needs.

**Subpopulations of Concern:**

- HIV negative partners of PLWHA
- Men older than 25 years
- Incarcerated
- Substance users
- HIV infected

**Needs Assessment:**

- High incidence of unprotected sex
- High incidence of STD/history of STD's
- Misinformation & lack of knowledge about HIV risky behaviors and transmission
- Multiple sexual partners
- Non-injection drug use
- High incidence of commercial sex work
- Low SES (education, income and employment)
- Inadequate health, social and support services (transportation, health insurance, child care, etc.).
- Apathy to HIV status

## **POPULATION #5**

### **WHITE MEN WHO HAVE SEX WITH MEN, AGES 15 - 44**

Estimated Size: Minimum of 16,698 men

White men who have sex with men (WMSM) comprise approximately 16% of PLWHA and 15% of the more recently diagnosed cases in South Carolina. Men who have sex with men (MSM) continue to remain a significantly affected population with HIV, regardless of age, race/ethnicity and residence. The largest proportion of reported PLWHA in the state are men who have sex with men. The level of new HIV cases appears to be declining among white MSM. However, further assessments need to occur to determine if testing patterns have changed (particularly among young men under 25 years) or if there are other factors to confirm if “incident” cases are truly declining. Most white MSM live in the more urban counties and may have more sense of community than exists with African American MSM, reducing some of the prevention barriers. Most white MSM infected with HIV are older than 25 years of age. Increases in very high risk behaviors among young MSM living in other areas of the country, however, is cause for concern among young MSM in South Carolina.

#### **Subpopulations of Concern:**

- HIV negative partners of PLWHA
- Youth and young adults (<25)
- Substance users
- HIV infected
- Sex workers
- Older adults (>44)
- Internet “cruisers”

#### **Needs Assessment:**

- Unified gay community
- Generation gap within community
- Apathy about HIV/AIDS
- Lack of alternative non-bar meeting/gathering places
- High incidence of drug use
- High incidence of commercial sex
- Prevalence of societal discrimination & stigma relating to race, sexual orientation & economic status
- High incidence of unprotected sex
- Language and cultural barriers for subsets of the community
- High incidence of STD/history of STD’s
- Misinformation & lack of knowledge about HIV risky behaviors and transmission
- Multiple sexual partners
- Non-injection drug use
- Misconceptions about HIV/AIDS antiretroviral drugs & therapy

## **POPULATION #6 INJECTION DRUG USERS, AGES 20 - 44**

Estimated Size: 8,000 (All races/genders)

Injecting drug users (IDUs) comprise approximately 18% of PLWHA and 9% of the more recently diagnosed cases in South Carolina. There is an apparent decline in the number of new HIV infections reported among both men and women due to injecting drug use (IDU). Among the newly diagnosed cases of HIV/AIDS with injecting drug use as a risk factor, 32% are African American men compared to 22% who are white men. African American women account for 21% of recent cases due to injecting drug use; white women account for 20%. The majority (92%) of recently diagnosed IDU cases are among persons 25 and above. The urban areas have more persons living with HIV due to injecting use. Due to legal barriers, South Carolina does not have needle exchange programs, which limits effective prevention efforts for this population. Other barriers include South Carolina's legal policy of reporting pregnant substance users (including IDUs) for prosecution which may deter women from seeking early and regular prenatal care.

### **Subpopulations of Concern:**

- HIV negative partners of PLWHA
- Persons older than 25 years
- Incarcerated
- Substance users
- HIV infected
- Sex workers
- Homeless
- Pregnant women

### **Needs Assessment:**

- Co-existence of HIV infection and substance use
- Lack of availability and access to drug treatment
- Inadequate linkage and/or follow-up services
- Non-integration of physical and psychosocial needs of patients
- Non-integration of HIV/AIDS & drug treatment services/programs
- Non-expansive nature of drug treatment services
- Non-gender specific drug treatment programs

## **POPULATION #7 HISPANIC OR LATINO/A**

### **Estimated Size: 168,920**

Two percent of the total persons living with HIV infection are Hispanics, who comprise about 3.8% of the state's population (2007 estimates). While the general population has grown 15.1% in the period from 1990 to 2000, the Hispanic Population grew from 30,500 to 95,076 in the same period, a 211.71% growth. The US Census reports this number could double to 190,152 by 2010. Most of this increase can be attributed to high levels of migration due to economic opportunities in agriculture, construction and food industries, as well as high Hispanic birth rates. This rapid growth has considerable implications for the health status of this medically underserved population. This growth has surpassed the ability of health care providers to provide adequate services to this group of people. Meeting the health care needs of Hispanics requires an understanding of their social, cultural, economic, and physical environments.

Hispanics in South Carolina face many barriers to health care and HIV education including language, lack of transportation, geographic inaccessibility, and financial constraints. Similarly, substance abuse, health risk behaviors (e.g. smoking, unhealthy dietary practices), and the occupational hazards of migrant work add to the risk of disability and chronic illness. At the same time, health care providers face certain barriers that make it difficult to offer adequate services to the Hispanic community such as shortages of bilingual and bicultural health care providers, and trained interpreters, at health care centers. As a result of these barriers, Hispanics are limited as to the quality and quantity of health care information they receive.

### **Subpopulations of Concern:**

- HIV negative partners of PLWHA
- Farmworkers (Latino/a)
- Migrant farmworkers (Latino)
- Sex workers (Latina)

### **Needs Assessment:**

- Language and cultural barriers
- Low SES (education, income, employment)
- Transportation barriers
- Lack of health insurance
- Limited or no target-population specific programming and outreach

## **Populations of Special Interest**

In addition to the Priority Populations noted above, it is important to note several populations of special interest. The populations noted below do not have specific epidemiologic data to make them a priority population; however, there are factors that make them either populations for special consideration or emerging populations.

### **STD Clinic Patients**

Patients who present at the health department's STD clinics are coming due to onset or worsening of symptoms and/or fear of infection. These individuals have engaged in unprotected sex or have otherwise been exposed. Additionally, those diagnosed with an STD are at higher risk of becoming HIV infected. HIV testing and prevention efforts must be targeted to these clinic patients. Once STD symptoms subside, persons may not follow-up on return visits for treatment and follow-up or testing. Reaching these individuals as they present for services should be considered a top priority. This must also include persons who present at the clinic as a result of a disease investigation referral.

### **Partners of Persons Living with HIV/AIDS (PLWHA)**

Across studies of HIV-positive MSM, women, and IDUs, between 17% and 38% report unprotected vaginal or anal intercourse (many as recently as their last sexual encounter) with partners who are HIV negative or of unknown HIV status. High-risk sexual behavior among PLWHA is not limited to interactions with casual or anonymous partners. Multiple studies have found that safer sex precautions are less likely to be adopted in relationships characterized by affection and in ongoing sexual relationships than in casual or transient partnerships. This pattern has been found not only in the case of monogamous serodiscordant male couples, but also among affectionate relationships that are not mutually exclusive and in which partners do not know each other's serostatus.

In one analysis of couples in serodiscordant relationships, 31% reported unprotected anal sex with their primary partner at least once in the past 12 months. Several studies have suggested that PLWHA go through a period of sexual abstinence as they adjust to their infection status, but later resume their sexual activity. However, one study of newly infected persons found that 11% reported unprotected insertive anal sex and 26% reported unprotected receptive anal sex with unknown-serostatus or HIV-negative partners within a 6-month period after infection. This strongly suggests a need to address risk reduction concerns of newly diagnosed persons and their partners at the earliest possible times following knowledge of one's HIV positive status. Ongoing supportive counseling and education is needed for the partners of PLWHA in addition to the continual prevention activities directly with PLWHA themselves.

### **Partners of Persons from Priority Populations, Regardless of the Partner's Race, Ethnicity, or Age**

Persons who are having sex may choose to have sex with partners who are not of the same race, ethnicity or age as themselves. While there is little data to indicate what percentage of persons infected with HIV have had partners of a different race, ethnicity or age, anecdotal reports and disease investigation follow-up have shown that these sexual encounters are occurring. While

prevention efforts should be targeted to the populations with the highest incidence and prevalence of HIV infection, consideration must be given to any sexual partner at risk, regardless of race, ethnicity or age.

### **Persons who are Incarcerated**

While the S.C. Department of Corrections tests all persons as they enter the system, there are few and insufficient efforts to reach persons who are incarcerated in city or county jails. Some prevention contractors are working with their local jails for HIV testing and prevention messages. Other jails may have placed barriers to coordinated services and/or the access to incarcerated persons. Data is needed to demonstrate the percentages of those who are interfacing with detention facilities and have HIV or had an STD. With these data, opportunities may be pursued for additional funding to work collaboratively with the incarcerated population. Partners of persons with a history of incarceration should also be considered at increased risk for HIV/STDs.

### **Transgender**

Little data exists in South Carolina regarding the transgender population. If persons have had sexual reassignment surgery, they often “disappear” into the general population. Male-to-female transgender persons who have sex with men and do not realize the alignment of their sexual and physical identities are still considered Men who have Sex with Men. With the usually disenfranchised nature of this population and the high-risk sexual and drug behaviors that have been reported in other areas of the United States, transgender persons are considered a population of interest. Historically, HIV infection rates have been high among transgender persons in large metropolitan areas. The HPC Needs Assessment Committee recommended, designed, and has implemented an 18-page survey of transgender persons 18 years and older living or a student in South Carolina. Data from this survey, distributed through social networks and via prevention and care contractors, will help guide future training, cultural competence, and prevention strategies for providers serving this population.

### **Sex Workers**

Although little data exists in South Carolina on this population, sex workers should be a priority for prevention efforts due to the high-risk behaviors that have been anecdotally reported to prevention and care service providers. While outreach efforts sometimes reach these individuals, more sustained efforts need to take place to include consideration of this population’s complete sexual networks (i.e., significant others, johns, pimps, etc.). Special interventions should be considered for anyone with an arrest and conviction for solicitation or prostitution.

### **Victims of Sexual Assault**

Gender-based violence may increase a person’s risk for HIV infection through forced or coercive sex. Forced or violent intercourse can cause abrasions and cuts that can facilitate entry of HIV through vaginal and/or anal mucosa. Forced or coerced sex limits a person’s ability to successfully negotiate HIV prevention such as condom use. In addition, sexual violence may also expose a person to STD’s, which can increase the recruitment of receptor cells (CD4 cells) possibly increasing their risk for HIV acquisition in the future.

### **Other Drug Users**

While injection drug users are certainly at high risk for HIV infection, in S.C. their numbers are generally low. Other drugs, however, are a noted area of concern for service providers who recognize the need for alcohol/other drug intervention with their clients. Use of drugs such as crack cocaine, cocaine, methamphetamine, ecstasy, and other illegal and illicit drugs are major concerns in segments of their client populations. Noninjection drugs (such as "crack" cocaine) contribute to the spread of HIV and other STDs when users trade sex for drugs or money, or when they engage in risky sexual behaviors that they might not engage in when sober.

Comprehensive HIV prevention interventions for substance abusers must provide education on how to prevent transmission through sex. Studies have documented that drug users are at risk for HIV through both drug-related and sexual behaviors, which places their partners at risk as well. Comprehensive programs must provide the information, skills, and support necessary to reduce both risks. Many successful interventions aimed at reducing sexual risk behaviors among drug users have significantly increased the practice of safer sex (e.g., using condoms, avoiding unprotected sex) among participants.

Clearly, the need for substance abuse treatment vastly exceeds the state's capacity to provide it. Effective substance abuse treatment that helps people stop using drugs not only eliminates the risk of HIV transmission from sharing contaminated syringes but, for many, reduces the risk of engaging in risky behaviors that might result in sexual transmission. For individuals who continue to use alcohol/other drugs, harm reduction approaches will help reduce the risk of HIV and STD transmission. HIV prevention and treatment, substance abuse prevention, and sexually transmitted disease treatment and prevention services must be better integrated to take advantage of the multiple opportunities for intervention--first, to help the uninfected stay that way; second, to help infected people stay healthy; and third, to help infected individuals initiate and sustain behaviors that will keep themselves safe and prevent transmission to others.

### **Older Adults**

The number of persons aged 50 years and older living with HIV/AIDS has been increasing in recent years. This increase is partly due to highly active antiretroviral therapy (HAART), which has made it possible for many persons with HIV/AIDS to live longer, and partly due to newly diagnosed infections in persons over the age of 50. With post-menopausal women not having the need for birth control and with men bombarded with messages promoting medications for erectile dysfunction, the risk of exposure to HIV/STD increases for older adults. As the US population continues to age and is living healthier longer, it is important to be aware of specific challenges faced by older Americans and to ensure that they get information and services to help protect them from infection with HIV and other STDs.

### **Youth**

The SC Youth Risk Behavior Survey, administered to in-school youth, provides information on sexual activities occurring in this population. The proportion of sexually active teens that used condoms or birth control the last time they had sex decreased in 2007 (62%) from 2005 (67%). The rate of teens that had sex before they turned 13 increased slightly in 2007 for the first time since 1993. Teen births and HIV/STD rates among youth in SC are consistently among the highest in the nation. In addition, many young people use alcohol and other drugs and are more likely to engage in high-risk behaviors, such as unprotected sex, when they are under the

influence of drugs or alcohol. Abstinence from vaginal, anal, and oral intercourse is the only 100% effective way to prevent HIV, other STDs, and pregnancy. Youth may not choose to remain abstinent, so it is vitally important to provide all youth with Comprehensive Sexual Education (CSE). CSE is age-appropriate, abstinence-based, and provides young people with the knowledge and skills to avoid teen pregnancy and infection with HIV/STDs. HIV/STD prevention education should address the needs of youth who are not engaging in sexual intercourse as well as youth who are currently sexually active. It is important to ensure that all youth are provided with effective education to protect themselves and others from infection with HIV and STDs as well as teen pregnancy.