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# EXECUTIVE SUMMARY

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In 2002, the HIV Prevention Planning Council (HPPC), San Francisco’s HIV prevention community planning group, identified a need to assess the HIV prevention efforts in two San Francisco neighborhoods – Bayview/Hunter’s Point (BVHP) and the Tenderloin. The HIV Prevention Section (HPS) of the San Francisco Department of Public Health (SFDPH) contracted with an independent research consulting firm, Harder+Company Community Research, to conduct a systems capacity assessment by neighborhood (SCAN) for each of these two communities. Harder+Company launched a participatory research project in each of these neighborhoods. The overarching research questions for the SCANS were:

- To what extent do neighborhood residents have access to HIV prevention information and services?
- What is the current capacity of each neighborhood to meet the HIV prevention needs of its residents?
- What improvements are needed to ensure that HIV prevention efforts are meeting the neighborhood needs?

A research design was developed to collect data related to community need, community assets, and community access. Based on these data, the SCANS aimed to characterize each neighborhood’s capacity to meet the HIV prevention needs of its residents. This report describes the methods and findings for the Tenderloin SCAN.

## METHODS

The SCAN was implemented using a participatory research approach. In participatory research, “knowledge is not simply *for* the people, but created *with* and *by* the people. The evaluation team also worked with a Tenderloin SCAN Community Advisory Board to help define the types of data to be collected, to assist in the design of data collection tools, and to determine who the participants should be.

Four main data collection strategies were employed for this report:

<b>Data Collection Methods</b>	
<i>Strategy</i>	<i>Details</i>
1) Neighborhood Profile	<b>Data collected from various secondary sources</b> – census data, literature and web-based information describing the Tenderloin, data on people living with AIDS, and counseling and testing data.
2) Neighborhood Residents’ Perspectives	<b>3 Focus Groups and 8 Interviews</b> – MSM drug users (n=12), recently released men (n=7) and male-to-female transgendered persons (n=15); Youth Interviews (n=8)
3) HIV Prevention Provider Perspective	<b>Input from HIV prevention providers</b> – Provider Information Forms and Interviews with Program directors (n=11).
4) Health and Social Services Inventory	<b>Review of community health and social service assets</b> – To provide a comprehensive picture of neighborhood capacity.



## LIMITATIONS

The most significant challenge to the SCAN was the limited availability of neighborhood-specific data. Additional limitations occurred specific to each data collection method and are further explained in the full report.

## NEIGHBORHOOD PROFILE

The Tenderloin, situated just west of downtown San Francisco and the Financial District, has a unique demographic composition that contrasts sharply with the demographic makeup of the city as a whole. Although its racial/ethnic composition is similar to the city's, a substantially higher proportion of Tenderloin residents are male and MTF transgendered, low-income, non-English speaking, and foreign-born non-citizens compared with the rest of the city. The Tenderloin is also home to a substantial proportion of San Francisco's Native Americans, sex workers, homeless individuals, and individuals who are at risk for incarceration or have been recently released from jail or prison. Many of the HIV cofactors that affect marginalized and underserved populations are part of the daily reality of Tenderloin residents, including homelessness, drug use (injection and non-injection), and mental health issues.

Of all San Francisco neighborhoods, the Tenderloin has perhaps the richest mix of health and social service resources, ranging from food pantries to peer support groups to shelters, all designed to meet the specific and unique needs of the different people who live and seek services there. HIV prevention programs are a key component of the health and social service system in the Tenderloin. Services available include needle exchange, counseling and testing, street outreach, support groups, one-on-one counseling, prevention case management, and referrals to other health and social services. Despite the wealth of services available, basic structural barriers, including lack of affordable housing and limited substance use and mental health treatment slots, prevent many agencies from fully meeting the needs of their clients.

The HIV- and AIDS-related needs in the Tenderloin are greater than in many other San Francisco neighborhoods. Most people living with AIDS in the Tenderloin are white (58%) and African American (20%). The rate of new HIV infections among MSM and MSM/F in this neighborhood appears to be high at 2.4% and 3.9% per year, respectively (based on counseling and testing data), compared with an estimated citywide rate of 2.2% per year for MSM and MSM/F. The HIV and AIDS trends in this neighborhood are directly related to the prevalence of the multiple cofactors mentioned earlier.

## RESULTS

The various research methods with Tenderloin residents, and HIV Prevention Providers yielded 20 salient findings which are highlighted below. Detailed explanations of each finding are given in the full report.

### Tenderloin Residents' Perspective

**Finding 1:** Participating Tenderloin residents had high levels of HIV-related knowledge.

**Finding 2:** There may be some gaps in HIV-related knowledge among Tenderloin youth.

**Finding 3:** HIV prevention information appears to be reaching high-risk Tenderloin residents.

**Finding 4:** Multiple cofactors represent barriers to acting on HIV prevention information.

**Finding 5:** To address the cofactors that affect HIV, specific changes in the health and social service system are needed: more money, more housing, better mental health services, more substance use treatment.

**Finding 6:** Different HIV prevention approaches and services work for different people, on different timetables, and in different ways.

**Finding 7:** Participating MSM drug users reported easy access to HIV prevention information and services, highlighting outreach, media messages, and peer approaches as effective.

**Finding 8:** Participating men recently released from prison or jail have been reached by prevention messages, and reported that 1) jail- and prison-based prevention should focus more on preparing individuals for accessing the service system upon release, and 2) more needle exchange services are needed.

**Finding 9:** Participating MTF persons reported easy access to HIV prevention information and services, and noted opportunities for building on the existing infrastructure to improve and expand the services.

**Finding 10:** Participating Tenderloin youth have been reached by HIV prevention messages and services through a wide range of channels, and reported that peer approaches, outreach, skits, and group discussions are the preferred services.

### HIV Prevention Providers' Perspective

**Finding 11:** Tenderloin HIV prevention providers have referral systems in place to help meet their clients' health and social service needs.

**Finding 12:** HIV prevention providers are aware of and refer clients to population-specific services when appropriate.

**Finding 13:** The efficiency and effectiveness of referrals and linkages to other services (e.g., substance use, mental health, housing, other HIV prevention services) could be improved.

**Finding 14:** In some instances, there may not be sufficient referral resources to meet substance use, mental health, and housing needs.

**Finding 15:** Collectively, Tenderloin HIV prevention programs cover all the BRPs, and there are more programs for the highest-risk BRPs.

**Finding 16:** Tenderloin providers are reaching a diverse group of subpopulations within the BRPs.

**Finding 17:** There appears to be little duplication of HIV prevention services in the Tenderloin.

**Finding 18:** There may be some duplication of CTR services.

**Finding 19:** HIV prevention outreach schedules and locations in the Tenderloin needs to be better coordinated to improve the ability of programs to reach the population.

**Finding 20:** Corroborating what neighborhood residents stated in the focus groups, providers widely agreed that immediate and life-threatening concerns, such as food and shelter, take priority over HIV prevention for residents.

## CONCLUSIONS

Using the project framework of community need, community assets, and community access, the Tenderloin SCAN resulted in the following conclusions:

- **Community Need:** There is a high level of HIV prevention need in the Tenderloin, but from the perspective of residents, more pressing issues such as homelessness, mental health and substance use take priority. Although HIV prevention information and services are readily available, HIV cofactors are not being sufficiently addressed.
- **Community Assets:** There is a strong HIV prevention presence and a wealth of health and social service agencies in the Tenderloin, all of which represent community assets. Each existing HIV prevention service appears to fill a unique niche in the landscape of HIV prevention services in the Tenderloin, resulting in the availability of a wide variety of mostly non-duplicative, population-specific HIV prevention services. HIV prevention providers have linkages in place to refer clients to additional needed services.
- **Community Access:** HIV prevention information and services are readily available and accessible to high-risk populations in the Tenderloin. In particular, CTR services and outreach need to be better coordinated to ensure appropriate access to these services. Linkages and coordination between HIV prevention and other health and social services (e.g., substance use, mental health, and housing) could be better utilized to improve access for Tenderloin residents.

In summary, the Tenderloin has a high capacity to meet HIV prevention needs in the sense that it is well-covered in terms of BRPs, subpopulations, strategies, and interventions. Its capacity to meet HIV prevention needs is limited, however, when the need falls outside the scope of what prevention providers are able to offer. For example, when lack of housing is one of the primary factors driving an individual's HIV risk, the role of the HIV prevention provider becomes more complex and is generally limited to referring a person to housing services, which may or may not result in the client finding a place to live. High-risk populations in the Tenderloin have the knowledge and skills to prevent HIV infection, due to the strong and consistent presence of HIV prevention programs in this neighborhood. For HIV prevention to be effective, a greater focus is needed on the root causes of HIV and AIDS in this neighborhood, including lack of affordable housing, poverty, drug use, mental health, incarceration, and others.

## **RECOMMENDATIONS**

The following recommendations represent a synthesis of the researchers' recommendations as well as those from the HPPC, the SCAN participants, and community members and providers who attended a community forum where the results of the SCAN were presented.

### **General Recommendations**

- Develop and implement a plan to improve linkages among HIV prevention providers and between prevention providers and health and social services (e.g., mental health, substance use) in the Tenderloin. This might include the development of a resource guide, trainings for line staff on available resources, increasing units of services for referral and follow-up, and developing a referral tracking system.
- Explore policy and structural interventions directed at changing the availability and accessibility of services for meeting basic health and social needs.
- Improve the coordination of outreach efforts in the Tenderloin. This might include developing an outreach calendar (with times, locations, target population, and goal of outreach) that includes not only HIV prevention outreach but other outreach services as well.
- Develop a neighborhood-based plan for CTR that includes strategic allocation of resources, availability of a variety of testing options (e.g., standard, rapid, Orasure), policies regarding incentives for testing, and strong linkages and referrals from HIV prevention and other programs to counseling and testing.
- Put in place a system for analyzing units of service delivered/number of clients served by neighborhood to provide information for planning purposes (e.g., planning for neighborhood-based resource allocation).
- Provide incentives for collaboration, partnerships, and coordination among HIV prevention providers.
- Examine and replicate other relevant models of collaboration and coordination (e.g., integrated services model used in HIV/AIDS care).
- Ensure that services are delivered at times and in locations that are convenient for consumers (i.e., bring the services to the consumers instead of bringing the consumers to the services).

- Utilize suggestions regarding methodology to improve future SCANs. For example, future surveys might include more open-ended knowledge questions to improve the assessment of participants' knowledge regarding HIV/AIDS.

### **Recommendations for Specific Strategies and Interventions**

- Provide Tenderloin-based culturally appropriate speed treatment and mental health services for gay men and other MSM.
- Ensure the availability of peer-delivered services and that peer educators are perceived as true peers by the population.
- Implement innovative outreach programs (e.g., street theater, musicals).
- Offer both professional and paraprofessional street and community based outreach and counseling.
- Emphasize a harm reduction model that meets people “where they’re at.”
- Offer acupuncture and other health promotion services on a drop-in basis.

## SECTION I: INTRODUCTION

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After a period of rapid decline in new HIV infections in San Francisco in the 1980s, and a stable period in the 1990s, recent years have seen an increase in new infections among men who have sex with men. In addition, African Americans continue to be disproportionately affected by HIV and AIDS. In these times, it has become increasingly important to understand how HIV prevention programs can best address the increases in new infections as well as disparities in health and health care access. There is a need to ensure that people at risk for acquiring or transmitting HIV have access to general health as well as HIV-related information and resources as part of the overall HIV prevention effort. This is particularly important in San Francisco's underserved and vulnerable communities, where many of the new HIV infections occur.

In 2002, the HIV Prevention Planning Council, San Francisco's HIV prevention community planning group, identified a need to assess the HIV prevention efforts in two San Francisco neighborhoods – Bayview/Hunter's Point and the Tenderloin. The HIV Prevention Section (HPS) of the San Francisco Department of Public Health (SFDPH) contracted with an independent research consulting firm, Harder+Company Community Research, to conduct a systems capacity assessment by neighborhood (SCAN) for each of these two communities. Harder+Company launched a participatory research project in each of these neighborhoods. The overarching research questions for the SCANS were:

- To what extent do neighborhood residents have access to HIV prevention information and services?
- What is the current capacity of each neighborhood to meet the HIV prevention needs of its residents?
- What improvements are needed to ensure that HIV prevention efforts are meeting the neighborhood needs?

To answer these questions, a three-part framework for the research was developed:

- **Community Need:** For the SCAN, community need was defined as a combination of epidemiologic need, felt need, and normative need. "Epidemiologic need" is defined as HIV/AIDS prevalence and incidence. "Felt need" is defined as how neighborhood residents experience and articulate their own need for HIV prevention services. "Normative need" is defined as how service providers and other professionals view the needs in the communities in which they provide services.
- **Community Assets:** McKnight and Kretzmann (1997) describe an approach to mapping community capacity that is based on community assets, as opposed to community problems or deficits, as is done with traditional needs assessments. Community assets were documented as part of the SCAN.
- **Community Access:** Community access is the extent to which neighborhood residents who want HIV prevention services or information can readily receive such services or information. For the purposes of the SCAN, the term "access" encompasses availability (i.e., does the service exist) and accessibility (i.e., how easy is it to use a service/get information) of HIV prevention and other health and social services in the community.

A research design was developed to collect data related to community need, community assets, and community access. Based on these data, the SCANs aimed to characterize each neighborhood's capacity to meet the HIV prevention needs of its residents. This report describes the methods and findings for the Tenderloin SCAN.

## SECTION II: METHODS

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### PARTICIPATORY RESEARCH APPROACH

The SCAN was implemented using a participatory research approach. In participatory research, “knowledge is not simply *for* the people, but created *with* and *by* the people”. Thus, it validates each person’s right to speak, regardless of such factors as socioeconomic status, class, or race” (Hurst 1995). Harder+Company convened a Tenderloin SCAN community advisory board (CAB) to help define the types of data to be collected, to assist in the design of data collection tools, and to determine who the participants should be (i.e., which providers and which neighborhood subpopulations). All Tenderloin-based HIV prevention providers were invited to participate in the CAB, and a total of seven providers attended one or more of the three CAB meetings.<sup>1</sup> After most of the data collection was completed, a community forum was held. All SCAN participants (consumers, providers, and CAB members) as well as the community at large were invited to the forum to discuss and give feedback on the findings and develop recommendations for next steps.

### METHODS AND PARTICIPANTS

#### Neighborhood Profile

The neighborhood profile consists of a general description of the Tenderloin (demographics and neighborhood characteristics), a description of community assets, and a profile of the HIV and AIDS epidemic in the neighborhood. For the neighborhood profile, the Tenderloin neighborhood boundaries were defined as: Bush Street to the north, Powell Street to the east, Market Street to the south, and Van Ness Street to the West. The following data were reviewed:

- Census data (Source: U.S. Census Bureau, Census 2000);
- Literature and web-based information describing the Tenderloin;
- Data on people living with AIDS (HIV/AIDS Statistics and Epidemiology Section, SFDPH); and
- Counseling and testing data (HIV/AIDS Statistics and Epidemiology Section, SFDPH).

#### Neighborhood Residents’ Perspective

Harder+Company conducted interviews and focus groups with four populations identified by the CAB as being at high risk for HIV in the Tenderloin:

- Male-to-female (MTF) transgendered persons (focus group);
- Men who have sex with men (MSM) and use drugs (focus group);
- Men recently released from jail or prison (focus group); and
- Youth (interviews).

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<sup>1</sup> One of the CAB meetings was an HPPC committee meeting focusing on Tenderloin issues, to which Tenderloin-based providers were invited. This meeting served as the kick-off meeting for the CAB, which met two additional times.

Although women were not prioritized as part of this SCAN, four women were included in this study. Their input is included in this report where applicable; however, the majority of data focuses on participants from the four prioritized populations.

Participant demographics appear in Exhibit 1. While the ethnic breakdown of the participants in each group seems to be fairly representative of the Tenderloin neighborhood, Latino participants were slightly over-represented, especially in the focus group with MTF transgendered persons.

### Exhibit 1 Focus Group/Interview Participant Demographics

	MSM Drug Users* (n=12)	Recently Released Men** (n=7)	MTF Transgendered Persons*** (n=15)	Youth**** (n=8)
<b>Race/Ethnicity</b>				
African American	3	2	1	-
Asian/Pacific Islander	1	-	3	1
Latino	2	1	6	1
Native American	-	-	1	-
White	3	3	1	-
Bi/Multiracial	2	1	2	2
<b>Age</b>				
15	-	-	-	2
18	-	-	-	1
20	-	-	1	-
21	-	-	-	1
23	-	-	1	-
25-29	-	-	4	-
30-39	4	4	4	-
40-49	7	3	4	-
<b>Gender</b>				
Male	12	7	-	5
Female	-	-	1	3
MTF Transgendered	-	-	13	-
Other	-	-	1	-
<b>Sexual Orientation</b>				
Heterosexual	-	4	9	3
Bisexual	2	2	2	1
Gay/lesbian	9	-	2	-
Declined	-	1	1	-
<b>Number Who Did Not Participate in Survey*</b>	1	0	1	4

\*One focus group was conducted with MSM drug users.

\*\*One focus group was conducted with recently released men.

\*\*\*One focus group was conducted with MTF transgendered persons.

\*\*\*\*Individual interviews were conducted with youth.

Note: With the exception of gender, demographic information is not available for those who did not complete the survey.

Participants were recruited through flyers posted in the Tenderloin and were screened for eligibility by phone. A cash incentive of \$20 was offered in appreciation for their time at the conclusion of the focus group or interview. Focus group and interview questions were tailored for each population. The questions focused on HIV knowledge and perceptions of the availability, accessibility, and appropriateness of HIV prevention and other health and social services. The focus group and interview protocols appear in Appendices 1 and 2. In addition, focus group and interview participants were asked to complete a brief, self-administered survey regarding their demographics, HIV-related knowledge, and risk behaviors. The survey appears in Appendix 3.

## HIV Prevention Provider Perspective

Two methods were used to document HIV prevention providers' perspective: 1) a provider information form (PIF), which asked providers to provide key information about their target populations and the services they provide (Appendix 4); and 2) in-depth telephone or in-person interviews with HIV prevention program directors (Appendix 5). All providers receiving public funds for HIV prevention located in the Tenderloin neighborhood or for whom Tenderloin residents are a primary target population were invited to participate in an interview and in the CAB, but only agencies located in the Tenderloin were asked to complete the PIF. Exhibit 2 lists all the agencies invited to participate, whether they completed the PIF and/or participated in the interview, and whether they participated in some other way.

**Exhibit 2**  
**HIV Prevention Provider Participants**

<b>Agency</b>	<b>Completed PIF/ Participated in Interview</b>	<b>Participated on the CAB</b>
API Wellness Center	X	X
Ark of Refuge		
Black Coalition on AIDS	X	X
CAL PEP	X	
Centerforce		
Continuum	X	
Forensic AIDS Project		
Glide Health Services	X	X
Larkin Street Youth Center	X	
San Francisco AIDS Foundation	X	X
Shanti	X	X
St. James Infirmary	X	
Tenderloin AIDS Resource Center	X	X
Westside Community Mental Health Center	X	X

## Health and Social Services Inventory

A review of community health and social service assets was conducted as part of providing a comprehensive picture of neighborhood capacity. A particular emphasis was placed on agencies that deliver services related to the cofactors that contribute to HIV transmission, including substance abuse, mental health, homelessness, and sexually transmitted diseases (STDs). Available services were identified through an Internet search and with assistance from the CAB and HIV prevention providers.

## LIMITATIONS

The most significant and ongoing challenge to the SCAN was the limited availability of neighborhood-specific data. Because neighborhood boundaries are somewhat arbitrary and do not line up with zip codes (which are used in collecting most HIV and AIDS data), the neighborhood profiles should be viewed with some caution. There were also problems assessing the capacity of a particular neighborhood, since providers generally target a specific population rather than a geographic area. For example, many providers in the Tenderloin target populations across the city and could not accurately estimate the proportion of resources that are devoted to Tenderloin residents exclusively. This was also true for providers who are not physically located in the Tenderloin, yet conduct outreach and other prevention services in the neighborhood. In summary, there was no accurate method for determining the proportion of any one HIV prevention contract that served the Tenderloin. This precluded any presentation of detailed findings related to HIV prevention resources allocated in the Tenderloin or interventions reaching Tenderloin populations, although some limited data on the latter are offered.

Limitations specific to the various data collection methods are as follows:

### Neighborhood Profile

- Data on people living with AIDS reflect zip code of residence at the time of diagnosis and may not accurately represent the true number or demographics of people living with AIDS currently residing in the Tenderloin.
- Counseling and testing data provide only HIV incidence rates among testers and are not necessarily generalizable to the larger population. The greater the number of testers, the more likely it is that the incidence rates reflect those of the population at large. Data on populations with low numbers of testers (e.g., transgendered persons) are more difficult to interpret.
- Neighborhood boundaries are somewhat arbitrary. For example, the South of Market (SOMA) neighborhood, was not included in this SCAN, although it is situated next to the Tenderloin. SOMA and other surrounding areas were not included because they have their own unique needs and assets, which could be explored in future SCANS.

### Focus Groups/Interviews with Neighborhood Residents

- The Tenderloin CAB selected the populations to participate in focus groups/interviews. Due to the limited number of focus groups/interviews conducted, it is not possible to generalize the findings from any one group to the population as a whole. For example,

only one focus group was conducted with MSM who use drugs and their comments are not necessarily representative of all MSM in the Tenderloin who use drugs.

- Although themes that cut across all focus groups/interviews are more generalizable to Tenderloin populations as a whole, the CAB did not prioritize women for any focus groups, and thus the findings are not necessarily applicable to women.
- The participants were asked questions regarding their HIV knowledge. Upon inspection by an HIV Prevention Section staff member, these questions were found to be written in such a way that led participants to answer a certain way, thus limiting the accuracy of the information collected from these questions. Further assessments of the Tenderloin and/or future SCANS may consider revising these questions to a more open-ended format in an attempt to improve the quality of data collected.

### **Provider Information Forms and Provider Interviews**

- It was challenging to identify which HIV prevention providers to include in the SCAN, as neighborhood boundaries are fluid and most providers do not define their target populations by neighborhood. Therefore, providers with offices based in the heart of the Tenderloin, those whose HIV prevention contracts specified they were providing a substantial proportion of their services to Tenderloin residents, and those who self-identified as providing a substantial proportion of their services to Tenderloin residents were invited to participate. As a result, providers offering limited services to Tenderloin residents and those serving primarily surrounding neighborhoods (e.g., SOMA) and not the heart of the Tenderloin were not included.
- The provider interviews were conducted primarily with program directors, and in some cases, agency executive directors, in order to get the “big picture” perspective on HIV prevention in the Tenderloin. Staff working directly with clients were not invited to participate in interviews, and thus a unique perspective on HIV prevention may have been missed.
- Information from the PIFs reflects the services offered and target population reached at the time the PIF was completed (during 2003). However, services are constantly shifting to meet needs and in response to changes in funding. Therefore, the services described in this report may not accurately reflect the current profile in 2004.

### **Health and Social Service Inventory**

- It was not possible within the scope of this project to document all health and social services available in the Tenderloin. Therefore, a general description of types of services available is presented.

## SECTION III: NEIGHBORHOOD PROFILE

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### OVERVIEW

The Tenderloin, situated just west of downtown San Francisco and the Financial District, has a unique demographic composition that contrasts sharply with the demographic makeup of the city as a whole. Although its racial/ethnic composition is similar to the city's, a substantially higher proportion of Tenderloin residents are male and MTF transgendered, low-income, non-English speaking, and foreign-born non-citizens compared with the rest of the city. The Tenderloin is also home to a substantial proportion of San Francisco's Native Americans, sex workers, homeless individuals, and individuals who are at risk for incarceration or have been recently released from jail or prison. Many of the HIV cofactors that affect marginalized and underserved populations are part of the daily reality of Tenderloin residents, including homelessness, drug use (injection and non-injection), and mental health issues.

Of all San Francisco neighborhoods, the Tenderloin has perhaps the richest mix of health and social service resources, ranging from food pantries to peer support groups to shelters, all designed to meet the specific and unique needs of the different people who live and seek services there. HIV prevention programs are a key component of the health and social service system in the Tenderloin. Services available include needle exchange, counseling and testing, street outreach, support groups, one-on-one counseling, prevention case management, and referrals to other health and social services. Despite the wealth of services available, basic structural barriers, including lack of affordable housing and limited substance use and mental health treatment slots, prevent many agencies from fully meeting the needs of their clients.

The HIV- and AIDS-related needs in the Tenderloin are greater than in many other San Francisco neighborhoods. Most people living with AIDS in the Tenderloin are white (58%) and African American (20%). The rate of new HIV infections among MSM and MSM/F in this neighborhood appears to be high at 2.4% and 3.9% per year, respectively (based on counseling and testing data), compared with an estimated citywide rate of 2.2% per year for MSM and MSM/F. The HIV and AIDS trends in this neighborhood are directly related to the prevalence of the multiple cofactors mentioned earlier.

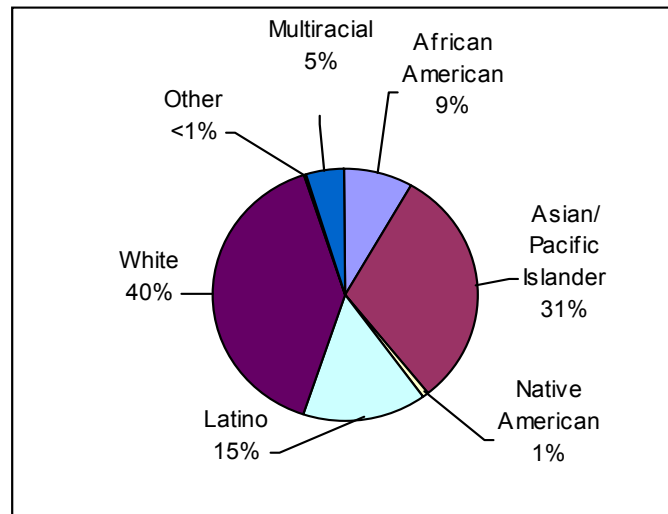
Additional data and information on the Tenderloin neighborhood can be found in the Tenderloin Collaborative Work Group Final Report (TCWG 2004).

## DEMOGRAPHICS

**Number of residents.** The Tenderloin is home to 36,589 residents, representing 4.7% of the overall San Francisco population.

**Race/ethnicity.** The racial/ethnic composition of the Tenderloin largely mirrors that of the city as a whole, with a slightly higher percentage of African Americans and Latinos, and a slightly lower percentage of whites. Together, whites and Asian/Pacific Islanders<sup>2</sup> make up nearly three quarters of Tenderloin residents. In addition, 15% are Latino, 9% are African American, less than 1% are Native American, 5% are biracial or multiracial, and less than 1% identify as another race (Exhibit 3).

**Exhibit 3**  
**Race/Ethnicity of Tenderloin Residents**



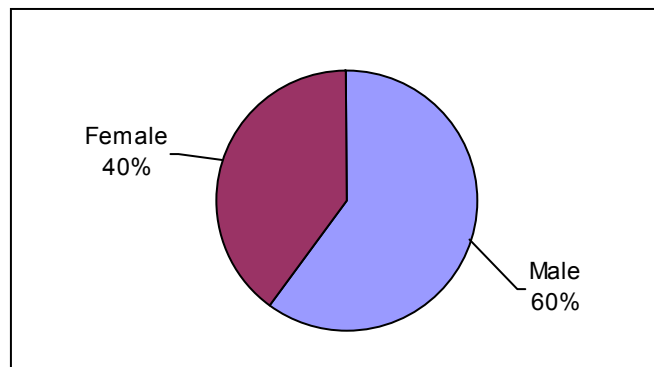
Source: 2000 census.

**Gender.** Men represent the majority (60%) of Tenderloin residents (Exhibit 4). The Tenderloin is also home to a sizeable number of MTF transgendered persons; however, the census does not allow individuals to identify as transgendered and therefore the number of transgendered residents is uncertain.

**Age.** Overall, the age distribution of the Tenderloin population mirrors the age distribution in San Francisco as a whole (Exhibit 5). However, children and youth under the age of 20 represent a smaller percentage of Tenderloin residents (11%) than in the City at large (16%).

Conversely, the percentage of residents between 20 and 29 years old is slightly higher in the Tenderloin (24%) than in San Francisco overall (19%).

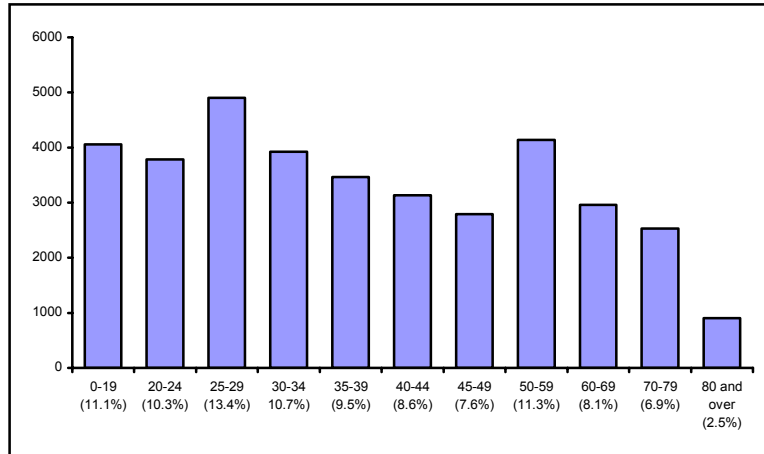
**Exhibit 4**  
**Gender of Tenderloin Residents**



Source: 2000 census.

<sup>2</sup>For comparison purposes, ethnicity categories on the demographic survey were designed to match those of the 2000 census data; therefore specifics regarding origin of API participants are not known.

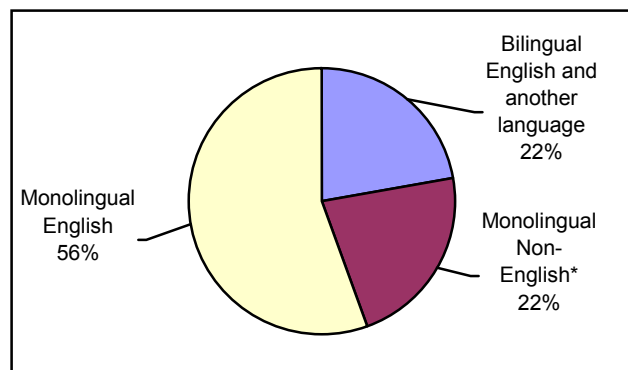
### Exhibit 5 Age of Tenderloin Residents



Source: 2000 census.

**Languages spoken.** Among the 21,099 households located in the Tenderloin, more than one-fifth (22%) are monolingual in a language other than English, nearly twice the rate for households in San Francisco as a whole (13%) (Exhibit 6). Households whose primary language is an Asian/Pacific Islander language account for nearly half (48%) of the households where a language other than English is spoken, and 60% of Asian/Pacific Islander language-speaking households are monolingual. Households where Spanish is spoken represent approximately one-quarter (24%) of non-English speaking households, and 46% of Spanish-speaking households are monolingual (Exhibit 7).

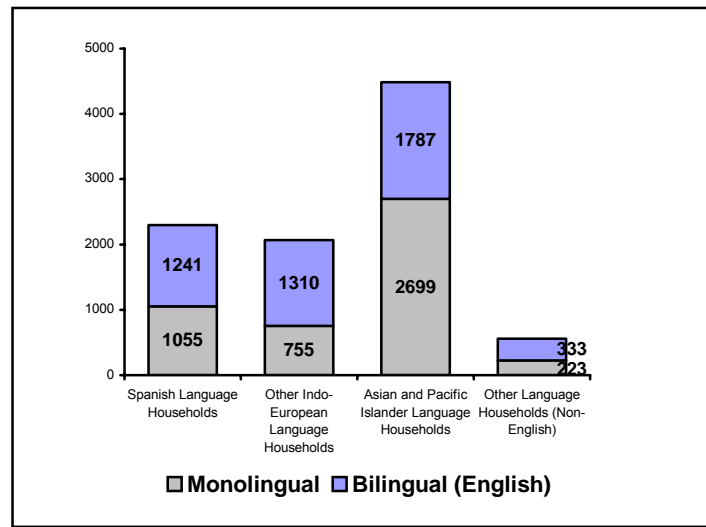
### Exhibit 6 Primary Language of Tenderloin Households



Source: 2000 census.

\* Monolingual non-English speaking households are defined as follows: the primary language spoken in the household is not English, and no member of the household over 14 years of age speaks English without at least some difficulty.

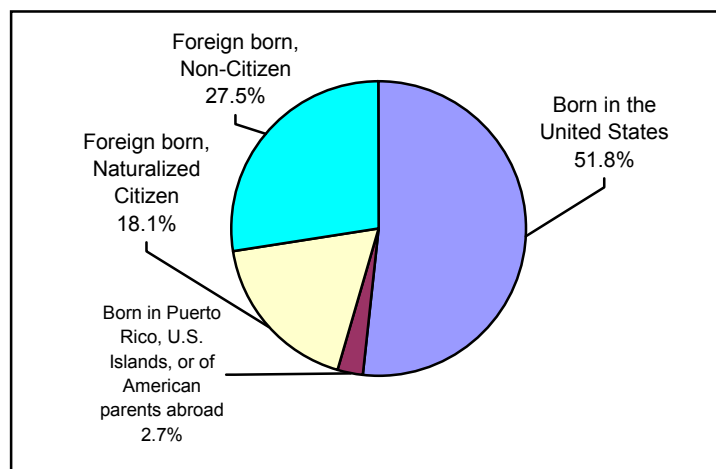
**Exhibit 7**  
**Households Where a Language Other than English Is Spoken**



Source: 2000 census.

**Country of origin and citizenship.** The Tenderloin is home to a significantly higher percentage of foreign-born non-citizens than the city as a whole; more than one-quarter (28%) of the neighborhood’s residents are non-citizens, while only 16% of the San Francisco population are foreign-born non-citizens (Exhibit 8). As the census does not record legal immigration status, it is not possible to estimate how many non-citizen residents hold temporary or permanent legal residency.

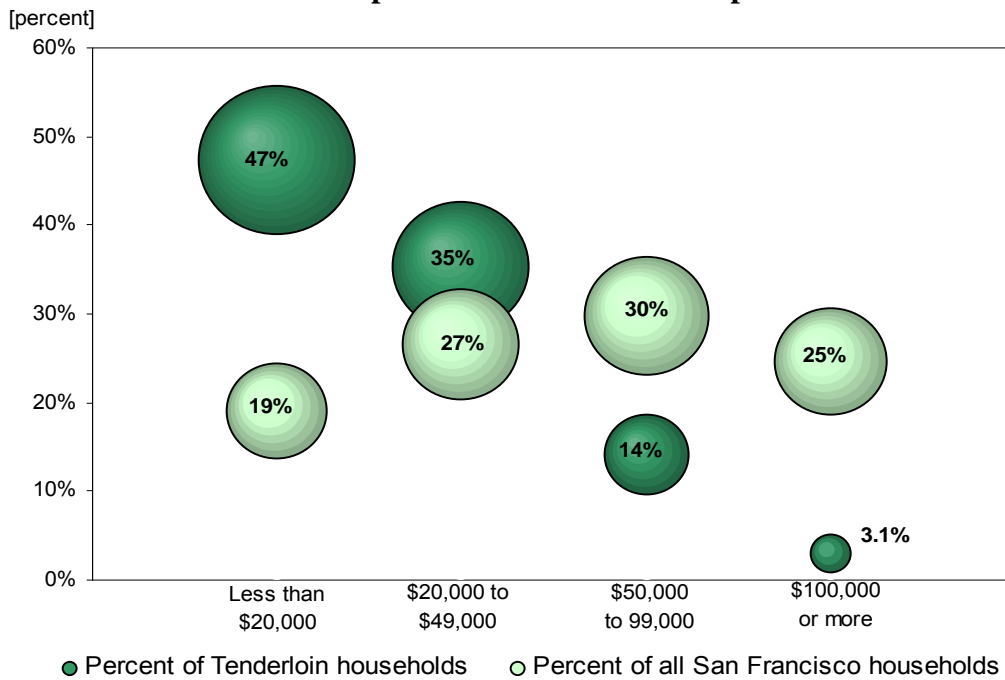
**Exhibit 8**  
**Place of Birth and Citizenship Status of Tenderloin Residents**



Source: 2000 census.

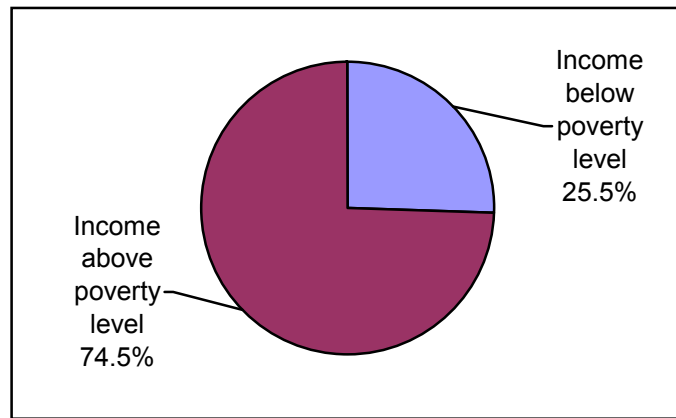
**Income and poverty.** Household income levels in the Tenderloin are significantly lower than those in the city as a whole. Nearly half (47%) of the households located in the Tenderloin have a total annual income of less than \$20,000, compared to only 19% of all San Francisco households. In contrast, households with annual incomes at or above \$100,000 represent only 3% of the Tenderloin, though households with this income level account for 25% of San Francisco as a whole (Exhibit 9). More residents of the Tenderloin (26%) are living in poverty compared with San Francisco (11%) as a whole (Exhibit 10). Both youth and adults are affected; 39% of youth, 26% of adults, and 12% of seniors in the Tenderloin live in poverty (Exhibit 11).

**Exhibit 9**  
**Household Income of Tenderloin Residents**  
**Compared to San Francisco Population**



Source: 2000 Census

**Exhibit 10**  
**Poverty Level of Tenderloin Residents**



Source: 2000 census.

**Exhibit 11**  
**Poverty Level by Age of Tenderloin Residents**

	<b>Below Poverty Level: Tenderloin (n)</b>	<b>Below Poverty Level: Tenderloin (%)</b>	<b>Below Poverty Level: San Francisco (%)</b>
Youth (0-17 Years)	1,248	38.9%	14.2%
Adults (18-64 Years)	7,278	26.2%	10.9%
Seniors (65 and over)	587	12.2%	10.5%
<b>Totals</b>	<b>9,113</b>	<b>25.5%</b>	<b>11.3%</b>

Source: 2000 census.

**Employment.** Nearly half (43%) of the residents in the Tenderloin are not in the labor force, compared to about one third (34%) of San Francisco residents. The census found a San Francisco-wide unemployment rate of 4.6%, compared with 8.2% in the Tenderloin (Exhibit 12).

**Exhibit 12**  
**Employment Status of Tenderloin Residents**

	Tenderloin (n)	Tenderloin (%)	San Francisco (%)
Employed	17,627	91.8%	95.4%
Unemployed	1,570	8.2%	4.6%
<b>Subtotal</b>	<b>19,197</b>		
Not in Labor Force	14,482	43.0%	33.7%
<b>Total</b>	<b>33,679</b>		

Source: 2000 census.

**COMMUNITY ASSETS: HEALTH AND SOCIAL SERVICES IN THE TENDERLOIN**

Internet research on available services in the Tenderloin revealed over 50 health and social service agencies serving Tenderloin residents in general or Tenderloin subpopulations. Some but not all of these agencies are located in the Tenderloin, whereas others have Tenderloin residents as clients but are located elsewhere. Briefly, the types of services available fall into the following categories:

**Non-HIV Services**

- Case management
- Child and family services (e.g., child care, health, employment, foster care, family planning)
- Community organizing
- Counseling
- Dental care
- Domestic and sexual violence services
- Employment services (e.g., training, referrals)
- Food services (e.g., free meals, nutrition counseling)
- Housing and homelessness services (e.g., housing rehabilitation, placement, referrals, shelters)
- Legal services (e.g., immigration issues)
- Mental health services
- Medical care (including primary care, preventive care, health education, and reproductive health care)
- Senior services
- Spiritual support and counseling
- Substance abuse counseling and treatment
- Support groups
- Survival assistance
- Youth services (e.g., school outreach, tutoring, leadership development)

### **Services for HIV-positive People**

- Case management
- Complementary therapies (e.g., acupuncture)
- Housing services (e.g., subsidies)
- Mental health services
- Money management
- Peer and treatment advocacy
- Primary care
- Residential substance use treatment programs
- Social events
- Support groups

### **HIV Prevention Services**

- Condom distribution
- General prevention education
- HIV counseling, testing, and referral (CTR)
- HIV/AIDS hotline
- Individual risk reduction counseling (IRRC)
- Needle exchange
- Outreach (i.e., VBIO, VBGO)
- Partner counseling and referral services (PCRS)
- Prevention case management (PCM)
- Single session groups (SSG) and multiple session workshops (MSW)
- Social marketing
- STD testing

## **HIV AND AIDS IN THE TENDERLOIN**

### **People Living with AIDS**

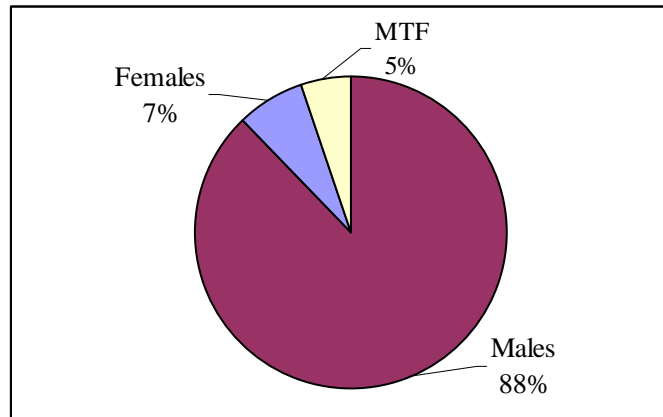
Data on people living with AIDS by neighborhood reflect where they were living at the time they were diagnosed. Because people relocate within or outside the city, it is not possible to say exactly how many people currently living in the Tenderloin are living with AIDS. However, these data do provide a general picture of who is affected by AIDS in the Tenderloin.

As of December 2003, there are 885 people living with AIDS who were diagnosed while living in the Tenderloin (HIV/AIDS Statistics and Epidemiology Section, special data request, 2004). Service providers estimate that there are a total of 2,000 to 2,500 people with HIV or AIDS currently living in this neighborhood who know their HIV status, and an additional 1,200 who are unaware they are HIV-positive (TCWG 2004).

Exhibits 13-16 show the demographics of Tenderloin residents living with AIDS. Most people living with AIDS in the Tenderloin are male (93%), white (57%) and African American (19%), and either MSM or MSM-IDU (79%). African Americans in particular are disproportionately impacted; they make up 9% of the Tenderloin population but 19% of people living with AIDS.

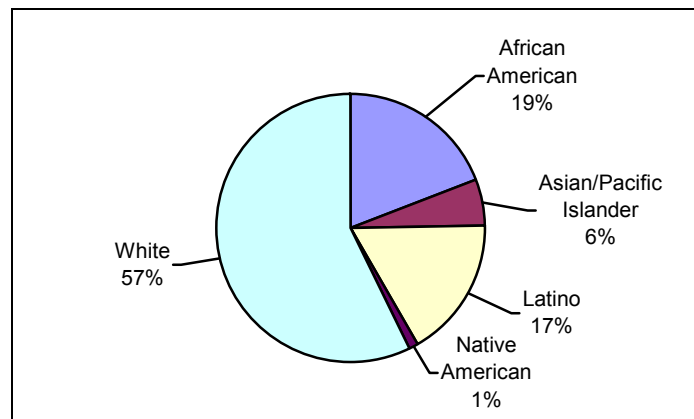
Injection drugs users (IDUs) and transgendered persons are also greatly affected. IDUs (including MSM-IDU) make up 39% of people living with AIDS, and transgendered persons make up 5%.

**Exhibit 13**  
**People Living with AIDS in the Tenderloin by Gender, December 2003**



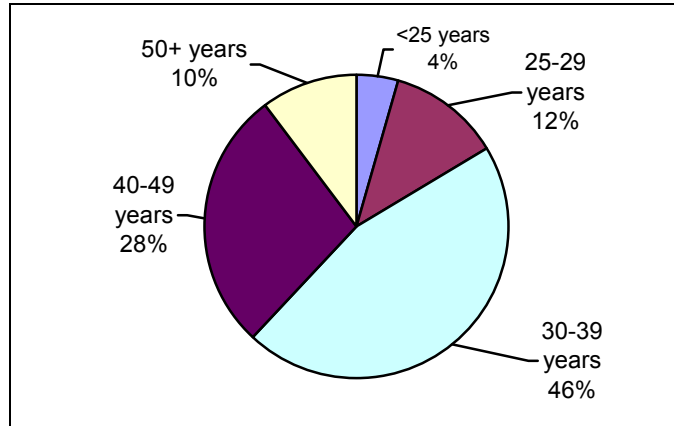
Source: SFDPH Statistics and Epidemiology Section, special data request, 2004.

**Exhibit 14**  
**People Living with AIDS in the Tenderloin by Race/Ethnicity, December 2003**



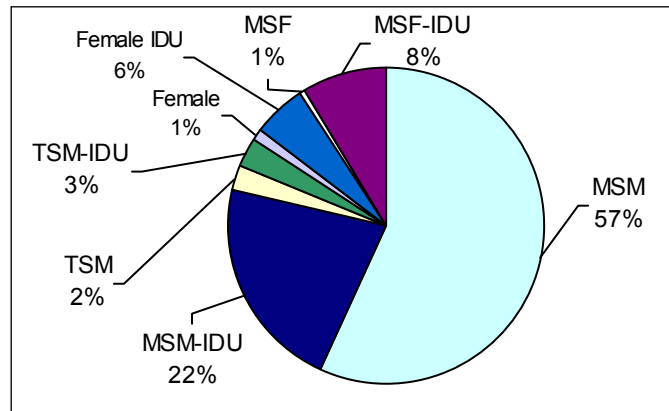
Source: SFDPH Statistics and Epidemiology Section, special data request, 2004.

**Exhibit 15**  
**People Living with AIDS in the Tenderloin by Age, December 2003**



Source: SFDPH Statistics and Epidemiology Section, special data request, 2004.

**Exhibit 16**  
**People Living with AIDS in the Tenderloin by Risk, December 2003**



Source: SFDPH Statistics and Epidemiology Section, special data request, 2004.

**HIV Incidence**

A practical method for estimating HIV incidence is analysis of counseling and testing data. All publicly funded confidential and anonymous test sites report their data to SFDPH, and these data are used to monitor trends in incidence over time for various populations. These data represent Tenderloin residents who voluntarily sought anonymous or confidential HIV testing and therefore may not reflect true incidence rates among the larger Tenderloin population.

Recent counseling and testing data for Tenderloin residents were analyzed using the STARHS methodology (serological testing algorithm for recent HIV seroconversion). These data show that the highest rates of new HIV infections in the Tenderloin are among MSM and MSM who inject drugs. It is noteworthy that, among non-injection drugs users, MSM who also have sex with females have a higher incidence rate compared with men who have sex only with men (3.9% vs. 2.4%). Data on transgendered persons is difficult to interpret because of the small population

size. Nevertheless, MTF transgendered persons have the highest rate of new HIV infections in San Francisco (HPPC 2004), and a large MTF population lives in the Tenderloin. Other populations have lower, but not insignificant, levels of risk. Males who have sex only with females – both those who inject drugs and those who do not – have estimated incidence rates greater than 1%. Females who have sex only with males, both those who inject drugs and those who do not, also have incidence rates ranging from 0.8% to 1.1% (Exhibit 17).

**Exhibit 17**  
**Incidence Rates among Tenderloin Residents Receiving**  
**Voluntary Counseling and Testing**

<b>Risk Group</b>	<b>Incidence Rate</b>	<b>Number of Testers*</b>
MSM-IDU	9.0%	73
MSM/F-IDU	4.4%	71
MSM/F	3.9%	128
MSM	2.4%	637
MSF-IDU	1.8%	145
FSM-IDU	1.1%	73
MSF	1.0%	643
FSM	0.8%	344
TSM	3.8%	22*
TSM-IDU	25.7%	6*

\*At least 50 testers are required to consider the data to be useful for analysis and interpretation. Therefore, data on TSM and TSM-IDU are difficult to interpret.

## SECTION IV: RESULTS

### TENDERLOIN RESIDENTS' PERSPECTIVE

#### HIV and AIDS Knowledge Levels

The level of HIV and AIDS knowledge in a population is one indicator of their access to HIV prevention and AIDS-related information. Therefore, knowledge levels were explored through a short survey as well as in the focus groups and interviews.

#### Methods Used to Document Tenderloin Residents' Perspective:

- Focus groups
- In-depth interviews
- Self-administered survey completed by focus group and interview participants

#### **Finding 1: Participating Tenderloin residents had high levels of HIV-related knowledge.**

Overall, the 39 individuals who completed a brief written survey before their focus group or interview demonstrated high levels of AIDS-related knowledge (Exhibit 18). However, nearly one third of participants reported they thought there was currently a cure for AIDS, which may be related to the fact that the results of the vaccine trials conducted by VaxGen were released around the time that the survey was conducted.

**Exhibit 18**  
**AIDS-Related Knowledge Among Focus Group and Interview Participants**

Statement	Answered "No" or "Probably No"	
	n	%
Do you think AIDS is a problem only for homosexuals and drug addicts?	34	89.5%
Do you think it's possible to know by appearance if a person has the AIDS virus?	31	79.5%
Do you think there is currently a cure for AIDS?	26	68.4%
	Answered "Yes" or "Probably Yes"	
Do you think condoms protect against AIDS?	33	86.8%

Participants demonstrated high levels of knowledge during the focus groups as well. Participants in all three focus groups (MSM drug users, recently released men, MTF persons) discussed several cofactors that put people at risk for HIV, including exchanging sex for money or drugs, having sex while high on drugs, and having access to condoms and clean syringes. Recently

released men, in particular, had high levels of knowledge due to classes they had attended in jail/prison. One participant pointed out that hepatitis C kills more people than HIV, another talked about exchange of blood as a transmission route, and a third highlighted the presence of the virus in semen.

**Finding 2: There may be some gaps in HIV-related knowledge among Tenderloin youth.**

For the youth interviews, participants were recruited through Larkin Street Youth Services (LSYS) and the Vietnamese Youth Development Center (VYDC). The four interviewees from LSYS, which provides HIV prevention services, were very informed and named the specific routes of HIV transmission (i.e., unprotected sex, unsanitary needles, semen and vaginal fluids, and blood-to-blood contact). One young person also mentioned the risk of transmitting the virus through breast milk and giving birth. The four interviewees from the VYDC also had a lot of correct information about HIV transmission, but also had some misinformation. For example, a fourteen-year-old was unsure whether HIV could be contracted through kissing. Another stated, “You can’t get it [HIV] if you have sex with a virgin.” Another young person from VYDC posited, “If they use a condom, they can still get HIV” and went on to say that a sure way to prevent HIV is “by staying away from people with HIV.” Overall, abstinence and using condoms were mentioned in both groups as ways to prevent HIV transmission.

## **HIV Prevention in the Tenderloin**

In addition to knowledge levels, people’s exposure to HIV prevention messages or reported use of HIV prevention services is another indicator of their access to HIV prevention. Questions in the focus groups explored to what extent individuals had participated in HIV prevention activities and what their experiences were like. The focus groups also explored gaps in services and participants’ recommendations for improvements in HIV prevention.

**Finding 3: HIV prevention information appears to be reaching high-risk Tenderloin residents.** “There is plenty of information out there.” This statement from the MSM-IDU focus group reflected the general sentiment across focus groups and interviews that people in the Tenderloin have adequate access to information about how to prevent HIV transmission. However, there are many reasons why people do not put the information into practice (see Finding 4).

**Finding 4: Multiple cofactors represent barriers to acting on HIV prevention information.**

It is noteworthy that not a single participant mentioned HIV or AIDS when asked, “What are the biggest health concerns in the Tenderloin?” Throughout the focus groups, there was continual discussion about a core set of needs that are going unmet in the Tenderloin: food, housing, money, jobs, mental health and substance abuse treatment, and many others. Participants reported that when these needs go unmet, their ability to act on HIV prevention information and messages is impeded. This is borne out in study after study showing that these conditions are cofactors for HIV. A few participants characterized this phenomenon, referring to the saying, “You can take them to the waterhole, but you can’t make them drink.” Another participant summarized the crux of the issue by pointing out how drug addiction and mental health issues interact to create high-risk situations:

*Basically, you are trying to find out what makes a person be safe. You can keep on preaching, but most of us know—we know how to clean needles, we know how to put condoms on...Info is not the problem. Nobody cares about us so why should I care about myself. People do something because they get something from it...Our behavior stems from our addiction. If we weren't using then we wouldn't do dangerous acts. They use to hide, run, not to feel. I hate feeling. When I feel I hurt.*

**Finding 5: To address the cofactors that affect HIV, specific changes in the health and social service system are needed: more money, more housing, better mental health services, more substance use treatment.** Participants expressed concerns about recent budget cuts and how local services are being reduced or eliminated. In general, community members are worried that needed services will no longer be available. One participant who had recently been released from prison summarized the impact of budget cuts from his perspective:

*Quit closing places down. You got budget cuts, but then you think about it and those are the things you need, unless you want to increase drug flow and crime and disease...You shouldn't have to save your neighborhood by yourself. There are people in your neighborhood that care about you but you need it matched by people down in city hall saying, 'yeah, we're going to keep this program open cause this community has pulled together in the last 5 years.'*

In addition, in every focus group and in most interviews, participants mentioned that housing is a major health issue. Many participants talked about the fact that homelessness is extremely unhealthy (e.g., it contributes to poor nutrition, people lack access to showers, and shelters often have unhealthy conditions). Both transgendered and MSM-IDU community members mentioned a need for mental health services that are culturally and linguistically appropriate and sensitive to the needs of transgender or MSM-IDU individuals (i.e., transgender clients feel safe from discrimination or harm).

**Finding 6: Different HIV prevention approaches and services work for different people, on different timetables, and in different ways.** Tenderloin residents clearly communicated that HIV prevention information is not sufficient to change behavior, and they identified several structural barriers to acting on HIV prevention. On an individual level, however, each person has a different experience with behavior change. For one participant, behavior change appeared to result from the long-standing relationship he had with one agency, which helped him work on his self-esteem and met him “where he was at”:

*All of a sudden something clicks and you decided to change your behavior. That's it. I had nothing to live for and no one to communicate with...Telling people what to do doesn't work...[my HIV prevention provider] has a mission: they give out needles, harm reduction, and it saves lives.*

**Finding 7: Participating MSM drug users reported easy access to HIV prevention information and services, highlighting outreach, media messages, and peer approaches as effective.** The MSM drug users who participated in a focus group reported that they were familiar with and had participated in HIV prevention services, including individual outreach and groups. They all noted that they had seen a particular recent social marketing campaign, and as a group, they spontaneously named over five agencies that offer services, some funded through the

HPS and some not. Participants widely agreed that they were satisfied with the HIV prevention services they received. However, a few HIV-positive participants expressed that secondary prevention information they had received from primary care providers was inadequate. One person said he “had an ignorant response from the medical community” in relation to reinfection. He finally received the answer not from a doctor but from an HPS-funded HIV prevention provider. Finally, participants believed that HIV prevention in the Tenderloin would be enhanced with more outreach targeted to specific groups (including handing out condoms and lubrication) because “they [outreach workers] reach you wherever you’re at. It’s more effective than if you go to a group because you have to be in the mindset to do that.” Participants also voiced an interest in more media coverage (e.g., press, television, radio) of HIV and AIDS “encouraging people to stay safe.” The group highlighted the effectiveness of peer educators in HIV prevention, especially for HIV-positive people, and proposed increasing the use of this strategy: “The agencies need to realize that we can spread the word better than someone who’s [HIV-] negative and sitting behind a desk. We can pass the word on.”

**Finding 8: Participating men recently released from prison or jail have been reached by prevention messages, and reported that 1) jail- and prison-based prevention should focus more on preparing individuals for accessing the service system upon release, and 2) more needle exchange services are needed.** These focus group participants indicated that they received HIV prevention information both in jail and from Tenderloin HIV prevention providers through outreach and groups after their release. As in other focus groups, this group agreed that information is available but not sufficient to change behavior: “You can keep on preaching, but most of us know. We know how to clean needles, we know how to put condoms on. But we know this. See, this is one of them cities that tells everybody. Info is not the problem.” Participants highlighted low self-esteem, drug addiction, and the need to trade sex for drugs as three reasons why they engage in unsafe behavior, despite having adequate knowledge. They also pointed out that HIV prevention and health information provided in the jail/prison setting should have an increased focus on linking people to existing resources, not just on how it is transmitted. This is critical, as the Tenderloin has a wealth of resources to support people. According to one participant (although not all agreed with his statement), “They finally got a good structure out here. They have outreach...youth services...a food line...These people would provide services to the neighborhood...We finally have a structure that doesn’t alienate the people it provides services to.” The participants noted that their health care providers were not a source of information about HIV, and HIV prevention providers were the primary source. Finally, the group agreed that needle exchange programs should have longer hours of service to be able to reach people at the moment when they are needing a fix.

**Finding 9: Participating MTF persons reported easy access to HIV prevention information and services, and noted opportunities for building on the existing infrastructure to improve and expand the services.** Transgendered MTF focus group participants were very familiar with Tenderloin services in general and had extensive experience with HIV prevention groups, outreach, and other HIV prevention services. They found many of these resources and services useful, including a resource guide for transgendered women and health fairs. Discussions of HIV do happen in the health care setting, according to participants, but often the health care providers simply give information and do not take HIV prevention to the next level. As one participant noted, “Why is it difficult to practice safer sex? They [health care providers] don’t really ask that. What would help make you use condoms? They don’t ask that.” Although the group reported

easy access to HIV prevention services, they noted several limitations in the available services, both HIV prevention and general health-related:

- Insufficient transgender-friendly and transgender-specific mental health services;
- No “one-stop shop” for transgendered people;
- Limited visibility of transgendered people in social marketing and media campaigns (although they did note the inclusion of a transgendered spokesperson in a recent campaign aimed at HIV-positive people); and
- Lack of services in appropriate languages, especially Spanish.

Throughout the focus group, the participants highlighted the great need to deal with HIV cofactors, such as mental health, low self-esteem, lack of job opportunities, homelessness, sex work, and drug use, before HIV prevention can be effective. One participant explained, “You have to tell me why I should care about HIV first if I don’t even have a job, a place to live. Why should I care about HIV?” Finally, the importance of a peer approach to transgender services was noted; one person stated that, “information needs to be delivered by somebody who looks like me.” Finally, one participant summed up the challenge related to being transgendered in the Tenderloin: “We are the most visible invisible community.”

**Finding 10: Participating Tenderloin youth have been reached by HIV prevention messages and services through a wide range of channels, and reported that peer approaches, outreach, skits, and group discussions are the preferred services.** Interviews with youth revealed that HIV prevention reaches youth in a number of settings and using multiple methods. Youth reported seeing skits, being approached by street outreach workers, participating in HIV prevention activities at school, being given condoms, talking about HIV with Planned Parenthood providers and outreach workers from Asian/Pacific Islander Wellness Center, getting tested for HIV at a service provider (Tenderloin AIDS Resource Center or LSYS) or in the mobile van, and accessing HIV prevention information on the Internet. This was true for youth recruited from LSYS, an HPS-funded HIV prevention provider, as well as youth recruited from VYDC, which does not do formal HIV prevention. One youth interviewee noted that he had seen a presentation on HIV at VYDC given by an HPS-funded provider, indicating that Tenderloin HIV prevention providers are networking with other agencies to ensure they reach youth. Youth widely agreed that skits, groups, outreach, and HIV prevention activities should be integrated into other youth services. Many youth mentioned trusted youth organizations where they believed they could seek information about HIV; YMCA, their school, and the Vietnamese Youth Development Center. This possibly indicates a need to ensure that these sources have accurate and relevant information on HIV through training and capacity-building activities with these organizations. The youth interviewed also agreed that peer education models are most effective for reaching young people. For example, participants said that skits are effective in engaging young people in thinking about prevention, and that they need to be performed by other young people who they can “relate to.” One young person suggested expanding outreach to more places where young people hang out, such as places with pool tables and ping-pong tables, and Girls and Boys Clubs. Finally, nearly all youth mentioned having seen social marketing campaigns or advertisements relating to HIV and AIDS, indicating that this is an effective mechanism for reaching youth. Another young person talked about having a youth community center where young people could find a range of information and services all in one place.

## HIV PREVENTION PROVIDERS' PERSPECTIVE

### Referrals, Linkages, and Coordination

Having a system of referrals and linkages in place that meets a wide range of client needs is an indicator of capacity; thus, the processes that agencies put in place for referring clients and establishing organizational relationships to create referral networks were explored in both the interviews and the PIFs. These referral

relationships can reveal the extent to which agencies are 1) familiar with the constellation of services available in the Tenderloin, 2) highlight other health and social services that are closely linked to prevention, and 3) show the most common services utilized outside the Tenderloin, which could indicate gaps in services within the Tenderloin.

#### Methods Used to Document HIV Prevention Providers' Perspective:

- In-depth interviews
- Self-administered provider information forms (PIFs) gathering information about service delivery

**Finding 11: Tenderloin HIV prevention providers have referral systems in place to meet their clients' health and social service needs.** Providers suggested that prevention services to Tenderloin residents should be more “wrap-around,” targeting more than just sexual and drug use-related risk behaviors. They stressed that clients come to their programs with many different needs, of which prevention may not always be the most pressing. Through referrals and other linkages, providers attempt to fill in the gaps in the larger system that clients are a part of. Results from the PIF indicate that Tenderloin HIV prevention providers commonly refer their clients and contacts to a range of services both in the Tenderloin and throughout the city. A number of providers have established formal referral relationships (i.e., memoranda of understanding, subcontract, or other written agreement) with multiple programs, again both in the Tenderloin and throughout the city, but most programs rely on informal organizational relationships for referring clients. The four most common referral destinations were:

- Medical services (primarily STD treatment and primary care for HIV+ clients);
- Substance abuse services;
- Mental health services; and
- Housing services (e.g., subsidies, placements).

Referrals to other services, though less frequently cited, include domestic violence services, job placement services, money management, adult day care, and services for persons recently released from the criminal justice system. Providers did not report referrals to HIV counseling and testing, as most Tenderloin providers have their own CTR programs within their agencies (see later section on Services Provided).

**Finding 12: HIV prevention providers are aware of and refer clients to population-specific services when appropriate.** HIV prevention providers also take advantage of the many population-specific HIV prevention programs and services available in the Tenderloin. Prevention programs that serve transgendered persons, MSM of color, women, and youth are frequently the target of referrals, indicating that providers are keenly aware of their clients' needs and are familiar with the resources that are available to meet those needs. Generally, providers will refer clients to other agencies' HIV prevention services when the client needs a service that

they do not provide themselves, or when a client could be served in a more culturally and/or linguistically appropriate manner at another agency.

**Finding 13: The efficiency and effectiveness of referrals and linkages to other services (e.g., substance use, mental health, housing, other HIV prevention services) could be improved.**

Although the basic structure of HIV prevention providers' referral systems and linkages are sound, the systems are not being used to maximum effect. The primary challenge many HIV prevention providers face is in following up on referrals. Providers reported that, with most interventions, the time and resources are not sufficient to follow up on referrals or coordinate with a client's other providers. One agency described,

*It's difficult because we're not doing PCM. I feel like the climate is moving towards referrals that are outcome based – not random referrals. How do you know if the client followed up on that [the referral]? I don't know how we would do that logistically with the interventions that we do.*

Providers also reported that some of the existing linkages are so complex that they are forced to send clients all over town to get their needs met. For example, one provider described the challenge with referrals to housing services and a possible solution:

*Housing is the worst issue for us to deal with - it's horrendous. I'm really feeling like there may be some agencies collaborating, but some of the gaps are in being able to link people up with comprehensive services. You can't go to one agency and get all your needs met. You have to send people to all these different agencies...Let's say there was a housing specialist at [Agency X]. It would be great to have that person on my site one day a week to directly link people in.*

One provider noted that current and impending budget cuts have the potential to compromise the linkages that have already been established:

*We keep a close relationship with the agencies we work with. It's been difficult because of the budget cuts that have led to turnover in agencies. We are having to reestablish relationships we've had for years [with new staff members]...It's easy [for clients] to fall through the cracks of services. When those relationships are strong, it benefits the client.*

Finally, agencies who offer a range of services on site may face fewer challenges regarding coordination and linkages. One provider noted, "A lot of agencies are doing things internally. Nobody is communicating in terms of maximizing prevention. Prevention in general needs to be better coordinated [in the Tenderloin]." Another reported, "There is not coordination in the TL [Tenderloin]. Last fall, the HPPC held a Tenderloin providers meeting and it was the first time I ever met some of the people in that room."

Despite the reported under-coordination of services in the Tenderloin, one provider speculated that it does not create barriers for clients:

*In the Tenderloin, I'd say [the capacity is] pretty good. From a client's perspective, they get plenty of incentives, and everyone is really good at talking to*

*clients about all the different services in the neighborhood. And the clients are savvy. They can tell you stuff that you don't know. The Tenderloin is pretty well covered.*

**Finding 14: In some instances, there may not be sufficient referral resources to meet the needs.** As reported time and again by Tenderloin residents and providers alike, substance use, mental health, and housing are the primary needs, and they take priority over prevention. A few providers suggested that, although they do have linkages in place to refer clients to these services, more are needed to meet the demand. One provider commented, “There are huge waiting lists for transitional housing. There is no drug treatment program specifically for HIV-positive individuals that I know of... There is nothing too much in the way of harm reduction.” Another noted gaps in services for transgendered persons: “Sure, populations are being served by prevention, but not all needs are being met. Substance abuse in the transgender community is very high. Where are they going to be treated? New Leaf can only do so much.”

### **Target Populations Reached**

Another indicator of capacity is the extent to which the HIV prevention services are directed at and reaching the highest risk populations in the neighborhood, as indicated in the epidemiologic profile.

**Finding 15: Collectively, Tenderloin HIV prevention programs cover all the BRPs, and there are more programs for the highest-risk BRPs.** Exhibit 19 shows the number of agencies serving each of the eight BRPs. In comparing the epidemiologic profile of the Tenderloin with the BRPs being targeted by providers, it is evident that those at highest risk are receiving prevention services. The highest risk BRPs in the Tenderloin — MSM, MSM/F; MSM-IDU, MSM/F-IDU; TSM; and TSM-IDU — are each served by four or more programs.

**Finding 16: Tenderloin providers are reaching a diverse group of subpopulations within the BRPs.** For example, although eight different agencies provide prevention services to BRP 1, there are a number of subpopulations being targeted by individual providers, including youth, Asian/Pacific Islanders, African Americans, and homeless persons. In addition, multiple strategies and interventions are provided to each of the BRPs (see the next section on Services Provided).

**Exhibit 19**  
**Tenderloin HIV Prevention Programs by BRP**

	<b>BRPs</b>	<b>Number of Agencies Serving Specific BRPs</b>
1	MSM, MSM/F	9
2	TSM, TSM/F, TSF	6
3	MSM-IDU, MSM/F-IDU	6
4	FSM-IDU, FSM/F-IDU, FSF-IDU	7
5	MSF-IDU	5
6	TSM-IDU, TSM/F-IDU, TSF-IDU	4
7	FSM, FSF/M, FSF	2
8	MSF	1

Note: All agencies listed in Exhibit 2 were included in this analysis, except Centerforce and Forensic AIDS Project, whose services are focused citywide, although a substantial proportion of their clients are Tenderloin residents.

**Services Provided**

Assuming that different individuals and groups respond to HIV prevention services and messages differently, another indicator of neighborhood capacity is the extent to which there is a variety of services available reaching people on an individual, group, and community level, but that are not duplicative. For the purposes of this report, “duplication” is defined as two or more services that reach the same target population using the same service modality (e.g., multiple session workshop), the same strategy/approach (e.g., harm reduction), and the same intervention content. As one provider explained in his interview, “If two people get the service twice in a different way, it’s not bad. There’s an assumption that A and B shouldn’t do the same service. People respond differently to different environments. Duplication is not unnecessary.”

**Finding 17: There appears to be little duplication with most HIV prevention services in the Tenderloin.** Exhibit 20 below indicates the number of agencies providing specific strategies and interventions to each of the eight BRPs. It is clear that each BRP is served by a wide variety of intervention types. For example, there are nine different intervention types for BRP 1. Although it may appear as if there is duplication of some interventions (e.g., there are four IRRC programs for BRP 1), Exhibit 20 does not take into account the subpopulations being reached within each BRP. For example, the seven IRRC programs available all target different subpopulations, including African Americans, youth, Asian/Pacific Islanders, and sex workers. All of this information indicates that HIV prevention service duplication in the Tenderloin is not as widespread as commonly believed. As one provider succinctly stated, “There are a lot of providers in the Tenderloin, but we don’t end up duplicating services. Everyone is doing something different and reaching different groups.” Comments such as “We’re the only ones that are providing prevention services that are peer-based [to our population]” and “[Compared with other agencies], we provide more integrated health-related and other programs within [our agency]...It’s a one-stop shop” support the notion that each service fills a unique niche.

**Exhibit 20**  
**Tenderloin HIV Prevention Interventions by BRPs**

<b>BRP</b>	<b>IRRC</b>	<b>PCM</b>	<b>MSW</b>	<b>SSG</b>	<b>Needle Exchange</b>	<b>VBGO</b>	<b>VBIO</b>
MSM, MSM/F	7	2	4	7	1	3	7
TSM, TSM/F, TSF	5	1	3	6	1	1	6
MSM-IDU, MSM/F-IDU	4	1	2	5	2	1	4
FSM-IDU, FSM/F-IDU, FSF-IDU	5	1	3	6	2	1	5
MSF-IDU	2	1	1	3	2	1	3
TSM-IDU, TSM/F-IDU, TSF-IDU	2	1	1	3	2	1	2
FSM, FSF/M, FSF	1	2	-	1	1	1	1
MSF	-	1	-	1	-	-	-

Note: All agencies listed in Exhibit 2 were included in this analysis.

**Finding 18: There may be some duplication of CTR services.** Ten agencies provide some level of CTR services to Tenderloin populations (HPS, special data request). The majority of the services are for BRPs 1 through 6 (i.e., MSM, transgendered persons, and IDUs), suggesting that high-risk Tenderloin populations have ready access to CTR. Some data suggests that ten programs providing this service is too many, and there is little neighborhood-level coordination. In January through September of 2003, nearly one fifth (19%) of all individuals tested at publicly funded providers report a Tenderloin residence, but the Tenderloin represents less than 5% of the city population (special data request, HIV/AIDS Statistics and Epidemiology Section, 2004). Because many high-risk populations reside in the Tenderloin, one would expect that Tenderloin residents would be slightly overrepresented among testers, but not by as much as they are. Further, providers reported competition for units of service with this intervention, especially given that some agencies provide financial incentives for testing and others do not. One provider explained,

*I think there's a lot of duplication of services [with CTR]. It doesn't serve the clients to have three, four, five sites doing testing, and some do cash incentives and others don't. It's created a 'shopping around' situation – 'I already got my \$10 at TARC this month, now let's see what I can get from Glide.'*

Like with other types of interventions, providers of CTR each target specific subpopulations, which is perhaps an effective approach to ensuring widespread access to CTR for Tenderloin residents. However, providers suggested that, at the very least, more coordination is needed to ensure that the Tenderloin-based CTR system does not encourage over-utilization or unnecessary utilization of testing.

**Finding 19: HIV prevention outreach in the Tenderloin needs to be better coordinated.**

Despite a quarterly outreach providers meeting convened by the HPS, providers report that lack of coordination of outreach schedules and locations can result in populations being missed. One provider explained:

*There are gaps in the outreach I think. There are several programs who have been doing outreach in the Tenderloin for years, it's just that no one is able to take the lead in coordinating those efforts. DPH could at least create an outreach calendar so people would know what is happening and when. Even if people couldn't make a [coordination] meeting, they would still know.*

**Finding 20: Corroborating what neighborhood residents stated in the focus groups, providers widely agreed that immediate and life-threatening concerns, such as food and shelter, take priority over HIV prevention for residents.** This reality presents opportunities for integrating HIV prevention into programs that are meeting these more pressing needs. As one provider put it:

*In the Tenderloin... people can get what they need through HIV prevention. HIV prevention is definitely something – clients are open to talking about it. But they have much bigger issues on their minds, so it has to be weaved into something else – food, shelter, substance abuse. HIV prevention is not the big priority. It needs to be weaved in.*

The question was raised regarding whether prevention services can have an impact if other more important quality of life issues and basic needs are left unattended. One provider said:

*Every day when I walk to and from work three to ten people ask for change. It's obvious that on the surface, the need that's being presented is not – hey, I need condoms.... They're not worried about condoms if they're hungry or strung out. When you step back and look at the broader picture, it makes you ask, what are we doing? Are we really making a difference?*

## SECTION V: CONCLUSIONS

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Using the project framework of community need, community assets, and community access, the SCAN results point to the following conclusions:

- **Community Need:** There is a high level of HIV prevention need in the Tenderloin, but from the perspective of residents, more pressing issues such as homelessness, mental health and substance use take priority. Although HIV prevention information and services are readily available, HIV cofactors are not being sufficiently addressed.
- **Community Assets:** There is a strong HIV prevention presence and a wealth of health and social service agencies in the Tenderloin, all of which represent community assets. Each existing HIV prevention service appears to fill a unique niche in the landscape of HIV prevention services in the Tenderloin, resulting in the availability of a wide variety of mostly non-duplicative, population-specific HIV prevention services. HIV prevention providers have linkages in place to refer clients to additional needed services.
- **Community Access:** HIV prevention information and services are readily available and accessible to high-risk populations in the Tenderloin. In particular, CTR services and outreach need to be better coordinated to ensure appropriate access to these services. Linkages and coordination between HIV prevention and other health and social services (e.g., substance use, mental health, housing) could be better utilized to improve access for Tenderloin residents.

In summary, the Tenderloin has a high capacity to meet HIV prevention needs in the sense that it is well-covered in terms of BRPs, subpopulations, strategies, and interventions. Its capacity to meet HIV prevention needs is limited, however, when the need falls outside the scope of what prevention providers are able to offer. For example, when lack of housing is one of the primary factors driving an individual's HIV risk, the role of the HIV prevention provider becomes more complex and is generally limited to referring a person to housing services, which may or may not result in the client finding a place to live. High-risk populations in the Tenderloin have the knowledge and skills to prevent HIV infection, due to the strong and consistent presence of HIV prevention programs in this neighborhood. For HIV prevention to be effective, a greater focus is needed on the root causes of HIV and AIDS in this neighborhood, including lack of affordable housing, poverty, drug use, mental health, incarceration, and others.

## SECTION VI: RECOMMENDATIONS

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The following recommendations represent a synthesis of the researchers' recommendations as well as those from the HPPC and community members and providers who attended a community forum where the results of the SCAN were presented.

### **General Recommendations**

- Develop and implement a plan to improve linkages among HIV prevention providers and between prevention providers and health and social services (e.g., mental health, substance use) in the Tenderloin. This might include the development of a resource guide, trainings for line staff on available resources, increasing units of services for referral and follow-up, and developing a referral tracking system.
- Explore policy and structural interventions directed at changing the availability and accessibility of services for meeting basic health and social needs.
- Improve the coordination of outreach efforts in the Tenderloin. This might include developing an outreach calendar (with times, locations, target population, and goal of outreach) that includes not only HIV prevention outreach but other outreach services as well.
- Develop a neighborhood-based plan for CTR that includes strategic allocation of resources, availability of a variety of testing options (e.g., standard, rapid, Orasure), policies regarding incentives for testing, and strong linkages and referrals from HIV prevention and other programs to counseling and testing.
- Put in place a system for analyzing units of service delivered/number of clients served by neighborhood to provide information for planning purposes (e.g., planning for neighborhood-based resource allocation).
- Provide incentives for collaboration, partnerships, and coordination among HIV prevention providers.
- Examine and replicate other relevant models of collaboration and coordination (e.g., integrated services model used in HIV/AIDS care).
- Ensure that services are delivered at times and in locations that are convenient for consumers (i.e., bring the services to the consumers instead of bringing the consumers to the services).
- Utilize suggestions regarding methodology to improve future SCANS. For example, future surveys might include more open-ended knowledge questions to improve the assessment of participants' knowledge regarding HIV/AIDS.

## **Recommendations for Specific Strategies and Interventions**

- Provide Tenderloin-based culturally appropriate speed treatment and mental health services for gay men and other MSM.
- Ensure the availability of peer-delivered services and that peer educators are perceived as true peers by the population.
- Implement innovative outreach programs (e.g., street theater, musicals).
- Offer both professional and paraprofessional street and community based outreach and counseling.
- Emphasize a harm reduction model that meets people “where they’re at.”
- Offer acupuncture and other health promotion services on a drop-in basis.

## REFERENCES

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## COMMON ABBREVIATIONS

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<b>CAB</b>	Community Advisory Board
<b>CTR</b>	Counseling, testing, and referral
<b>HPPC</b>	HIV Prevention Planning Council
<b>HPS</b>	HIV Prevention Section
<b>IRRC</b>	Individual risk reduction counseling
<b>MSW</b>	Multiple session workshop
<b>PCM</b>	Prevention case management
<b>PCRS</b>	Partner counseling and referral services
<b>SCAN</b>	Systems Capacity Assessment by Neighborhood
<b>SSG</b>	Single session group
<b>SFDPH</b>	San Francisco Department of Public Health
<b>VBGO</b>	Venue-based group outreach
<b>VBIO</b>	Venue-based (street and community) individual outreach

# APPENDIX 1: COMMUNITY FOCUS GROUP PROTOCOL

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## Introduction

Thank you for coming today. My name is \_\_\_\_\_ and I am from Harder+Company Community Research. We are working with the Department of Public Health and the HIV Prevention Planning Council. We are here today because we want to hear about your concerns around health and HIV/AIDS. Your experiences and the information you provide will be used to help improve HIV/AIDS prevention services in the Tenderloin.

We're very interested in your honest opinions so that we can make HIV prevention activities more effective. We want to learn as much from you as we can. This discussion will last about 1 1/2 hours, and we welcome and invite everyone to participate. Everything we discuss is completely confidential. That means that we will be writing a report that tells what the group as a whole had to say and use quotes but without anyone's name attached.

Before we begin, I'd like to go over a few ground rules:

- Everyone's ideas and comments are valid. There are no right or wrong answers.
- Please give everyone an equal chance to speak, and try not to dominate the conversation. As the facilitator, I will try to make sure that everyone has a turn.
- Please be sure to speak one at a time and not interrupt anyone else.
- Please respect everyone's confidentiality and do not share information from the group outside the group. In other words, everything said in this room stays in this room. As I said before, we will be describing in general to other people what was said, but we will not tell anyone who participated in the group.
- \_\_\_\_\_ is going to take notes (on a computer) during our discussion so please try to speak slowly, clearly and also one at a time.

Can everyone agree to these rules?

We would also like to ask permission to tape record the session. This is to help us in case we miss anything you say while taking notes. We will not share the tape with anyone outside Harder+Company. Is that OK with everyone?

Does anyone have any questions before we begin?

## Protocol

1. A. What are the biggest health problems in the Tenderloin community?  
  
B. What do you think puts people at risk for HIV in the Tenderloin? (Probe: What is going on in the Tenderloin that may affect people's risk for HIV? [e.g., drug use, sex work])
2. If you wanted information about HIV or AIDS, such as how to prevent it, where would you go? (Probes: Where would someone who lived in the Tenderloin go to get more information or assistance for protecting yourself from getting HIV or from giving it to others? Do you know of any places here in the Tenderloin or in the city? Can you identify specific agencies or resources that exist?)
3. I am going to read a list of different types of HIV prevention activities that exist here in San Francisco. Please tell me if you have participated in any of these activities before.
  - A. Have you ever had an outreach worker come up to you on the street or in a bar or other location and talk to you about HIV? (Probes: If yes, where? What did you discuss?)
  - B. Have you ever attended a group where you talk about HIV together? (Probes: If yes, where? What did you discuss?)
  - C. Have you ever seen a presentation or a skit or play about HIV? (Probes: If yes, where? What was discussed?)
  - D. Have you ever discussed HIV with your health care provider? (Probes: If yes, where is your health care provider? What did you discuss?)
  - E. Have you seen a poster, television, or radio ad about HIV? (Probes: If yes, what was it? Where did you see it?)
  - F. Have you ever called an HIV or AIDS hotline? (Probes: If yes, what did you discuss?)
  - G. Have you ever participated in any other HIV prevention activities? (Probes: If yes, please describe the activity.)
  - H. In general, when you participated in HIV prevention activities, how satisfied were you? (Probe: Did you get the information or help you needed? Were your questions answered well? Did the person or people at the agency respect your culture and background?)
4. If you had an opportunity to participate in any of these activities, which ones most appeal to you, if any? (Probes: Why? Specifically, what would you want that activity to include to make it most useful for you? Are there any other types of HIV prevention activities you would like to see?)

5. Was drug use discussed during any of the HIV prevention activities you participated in, or during any other activities or services? (Probe: What did you talk about? Did you talk about how drug use might influence your risk for HIV?)

6. (MSM drug users only) What kinds of HIV prevention services should there be in the Tenderloin that aren't currently there, specifically services for drug users?

(Recently released only) What kinds of HIV prevention services should there be in the Tenderloin that aren't currently there, specifically for people who are released from jail or prison?

(Transgender only) What kinds of HIV prevention services should there be in the Tenderloin that aren't currently there, specifically for transgendered persons?

## APPENDIX 2: INTERVIEW PROTOCOL: YOUTH

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### Introduction

Thank you for coming today. My name is \_\_\_\_\_ and I am from Harder+Company Community Research. We are working with the Department of Public Health and the HIV Prevention Planning Council. I am here today because we want to hear about your concerns around health and HIV/AIDS. Your experiences and the information you provide will be used to help improve HIV/AIDS prevention services in the Tenderloin.

We're very interested in your honest opinions so that we can make HIV prevention activities more effective. We want to learn as much from you as we can. I have some questions for you, which should take about 20 to 30 minutes. Everything we discuss is completely confidential. That means that we will be writing a report that tells what you had to say and use quotes but without your name attached.

I need to read over the consent form with you and ask you to sign it if you agree to participate. [READ AND SIGN CONSENT. GIVE ONE COPY OF CONSENT TO PARTICIPANT.]

### Protocol

1.
  - A. What do you do for fun here in the Tenderloin? (Probes: What activities are you involved in? Where do you hang out? Do you go to any community centers? Which ones?)
  - B. What kinds of services have you used here in the Tenderloin? (Probes: Where do you get your health care? Have you ever gone to an agency here for help with something – money, finding a place to stay, counseling, or anything else? Where have you gone? What did they help you with?)
  - C. Do you go to school here in the Tenderloin? Where? What grade are you in?

### Now I want to talk a little bit about HIV and AIDS.

2.
  - A. What can you tell me about HIV and AIDS? (Probes: What are some ways to get HIV? How can you prevent from getting HIV, or passing it to others?)
  - B. What questions do you have about HIV or AIDS that you haven't been able to get answers to?
3. If you wanted information about HIV or AIDS, such as how to prevent it, where would you go? (Probes: Where would a young person who lived in the Tenderloin go to get more information or assistance for protecting yourself from getting HIV or from giving it to others? Do you know of any places here Tenderloin or in the city? Can you identify specific agencies or events that exist?)

4. I am going to read a list of different types of HIV prevention activities that exist here in San Francisco. Please tell me if you have participated in any of these activities before.
  - A. Have you ever had an outreach worker come up to you on the street or other location and talk to you about HIV? (Probes: If yes, where? What did you discuss?)
  - B. Have you ever attended a group where you talk about HIV together? (Probes: If yes, where? What did you discuss?)
  - C. Have you ever seen a presentation or a skit or play about HIV? (Probes: If yes, where? What was discussed?)
  - D. Have you ever discussed HIV with your health care provider? (Probes: If yes, where is your health care provider? What did you discuss?)
  - E. Have you seen a poster, television, or radio ad about HIV? (Probes: If yes, what was it? Where did you see it?)
  - F. Have you ever called an HIV or AIDS hotline? (Probes: If yes, what did you discuss?)
  - G. Have you ever participated in any other HIV prevention activities? (Probes: If yes, please describe the activity.)
  - H. In general, when you participated in HIV prevention activities, how satisfied were you? (Probe: Did you get the information or help you needed? Were your questions answered well? Did the person or people at the agency respect your culture and background?)
5. If you had an opportunity to participate in any of these activities, which ones most appeal to you, if any? (Probes: Why? Specifically, what would you want that activity to include to make it most useful for you?)
6. What kinds of HIV prevention services should there be in the Tenderloin that aren't currently there, specifically services for young people like you?

## APPENDIX 3: FOCUS GROUP/INTERVIEW PARTICIPANT SURVEY

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**Directions:** Please answer the following questions. This survey is anonymous – DO NOT write your name on this survey.

1. What neighborhood do you live in?
  - Tenderloin
  - Bayview/Hunter's Point
  - Other: \_\_\_\_\_
  
2. How long have you lived in that neighborhood? \_\_\_\_\_
  
3. What race or ethnicity do you consider yourself? (check all that apply)
  - African American
  - Asian/Pacific Islander
  - Latino/Hispanic
  - Native American
  - White
  - Other \_\_\_\_\_
  
4. How old are you? \_\_\_\_\_
  
5. What is your gender?
  - Male
  - Female
  - Transgender MTF
  - Transgender FTM
  - Intersex
  - Other: \_\_\_\_\_
  
6. What is your sexual orientation?
  - Heterosexual or straight
  - Bisexual
  - Gay/lesbian or homosexual
  - Other: \_\_\_\_\_
  
7. Are you currently employed?
  - Yes
  - No

8. What is your yearly household income, all sources included, before taxes?
- Under \$25,000
  - \$25,000-\$50,000
  - Over \$50,000
  - Don't know
9. Do you think there is currently a cure for AIDS? (check one)
- Yes
  - Probably Yes
  - Probably No
  - No
10. Do you think AIDS is a problem only for homosexuals and drug addicts? (check one)
- Yes
  - Probably Yes
  - Probably No
  - No
11. Do you think it's possible to know by appearance if a person has the AIDS virus?
- Yes
  - Probably Yes
  - Probably No
  - No
12. Do you think condoms protect against AIDS?
- Yes
  - Probably Yes
  - Probably No
  - No
13. How worried are you that you might get the virus that causes AIDS?
- Very worried
  - A little worried
  - Not worried at all
14. In the last 12 months, have you had sex with...(check all that apply)
- Men
  - Women
  - Transgendered persons

15. Which drugs have you used in the last 6 months, if any? (check all that apply)

- Alcohol
- Marijuana
- Heroin
- Crack
- Cocaine
- Amphetamines, speed, or crystal meth
- Poppers
- Ecstasy
- LSD/Acid
- Other: \_\_\_\_\_
- I have not used any drugs in the last 6 months

16. Have you used a needle to inject drugs in the last 6 months?

- Yes
- No

😊 Thank you!

# APPENDIX 4: PROVIDER INFORMATION FORM (PIF)

Agency: \_\_\_\_\_

## PROVIDER INFORMATION FORM SECTION I: AGENCY INFORMATION

This Provider Information Form is part of an on-going effort by the SF HIV Prevention Planning Council and the SFDPH AIDS Office to identify all available HIV/AIDS prevention services in the Bayview-Hunter's Point and Tenderloin neighborhoods. We have completed as much of the form as was possible based on data available from the AIDS Office. Please confirm that the information we have provided is correct (and replace it with new information if it is not) and answer any questions that are blank. **If you are unsure about how to respond to a specific question, please refer to PIF INSTRUCTIONS, or call Michael DeMayo or Laura Lanzerotti at LaFrance Associates (415) 241-0605.**

Please complete this survey by March 28, 2003 and fax it to: 415-252-1068 or mail it to: Laura Lanzerotti / 1242 Market Street, 3rd Floor / San Francisco, CA 94102

1. Person completing the form:		2. Position:	
3. Telephone:		4. Fax:	
		5. Email:	
6. HIV Prevention Program Director (if different than above):			
7. Telephone:		8. Fax:	
		9. Email:	
10. Agency name:		11. (Agency) Also Known As:	
12. Street address (main site):		13. Street address (Tenderloin/ Bayview Site):	
14. Type of agency (check all that apply):			
<input type="checkbox"/> All volunteer <input type="checkbox"/> Governmental <input type="checkbox"/> For-profit <input type="checkbox"/> Non-profit -501c (3) or 501 (c) (4)			

15. Please answer the following questions about your clients' languages and your organization's language capacity:				
Language(s)	15a. Do you serve clients that speak this language?	If "Yes" to 15a, please answer 15b-d for each language:		
		15b. # of staff that speaks this language	15c. Are written materials available in these languages?	15d. Are translations services available in these languages?
Spanish	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chinese	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hawaiian	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hindi	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ilokano	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



**PROVIDER INFORMATION FORM**  
**SECTION I: AGENCY INFORMATION**

Agency: \_\_\_\_\_

15. Languages (cont):				
Language	15a. Do you serve clients that speak this language? <input type="checkbox"/> Yes → <input type="checkbox"/> No	If "Yes" to 15a, please answer 15b-d for each language:		
		15b. # of staff that speaks this language ____ FTE staff	15c. Are written materials available in these languages? <input type="checkbox"/> Yes <input type="checkbox"/> No	15d. Are translations services available in these languages? <input type="checkbox"/> Yes <input type="checkbox"/> No
Japanese	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Khmer	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Korean	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lao	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tagalog	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thai	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vietnamese	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visayan	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sign (ASL)	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (specify):	<input type="checkbox"/> Yes → <input type="checkbox"/> No	____ FTE staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

16. Does your agency refer clients to any other agency or program?		
<input type="checkbox"/> Yes → <input type="checkbox"/> No	If <b>YES</b> , please list the agency(s) or program(s) below, indicate the type of service for which you refer to this agency/program, and specify whether you have a formal or informal referral relationship with this agency/program. If you need more room, please attach an additional sheet of paper	
Agency/ Program	Type of Service	Please check one:
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship

**PROVIDER INFORMATION FORM**  
**SECTION I: AGENCY INFORMATION**

Agency: \_\_\_\_\_

17. Do other agencies/programs refer clients to this agency?		
Yes →No	If <b>YES</b> , please list the agency(s) or program(s) below, and indicate the type of service for which you refer to this agency/program and whether you have a formal or informal referral relationship with this agency/program:	
Agency/ Program	Type of Service	Please check one:
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship
		<input type="checkbox"/> Formal Relationship (e.g., MOU, subcontract) <input type="checkbox"/> Informal Relationship

18. How much does each funding source pay for your HIV prevention services? (Please enter the amount this agency receives for HIV prevention services and the begin date and end date of funding received in the most current funding period that covers 2002.)			
Funding Source	Amount	Begin Date	End Date
SF AIDS Office – State Grants	\$		
SF AIDS Office – CDC Grants	\$		
SF General Fund	\$		
Direct CDC funding	\$		
Foundations	\$		
Corporate grants/ donations	\$		
Endowment	\$		
Individual contributions	\$		
Reimbursement / client fees	\$		
Other (specify) _____	\$		
Other2 (specify) _____	\$		

19. For calendar year 2002, what was your <i>total</i> HIV prevention budget, including all sources?	\$
20. Please estimate the percent of your total HIV prevention funds that goes toward programs that specifically target residents in these neighborhoods.	a. Bayview/Hunters Point: _____%
	b. Tenderloin: _____%



**PROVIDER INFORMATION FORM**  
**Section III: Intervention Table**

Agency: \_\_\_\_\_

We ask that you complete the table below about the different HIV-prevention interventions you offer. We have entered in the number of clients you were contracted to serve, please complete the blank cells with information about the number of duplicated and (where available) unduplicated clients you served in 2002. If your current contract began in July 2002, please tell us the number of duplicated and unduplicated clients you have served to date. Table 1 includes counseling and testing interventions and Table 2 includes all other HIV-prevention interventions funded by the AIDS Office. **If you are unsure how to respond to a specific question, please refer to *PIF Instructions* for more information, or contact Laura Lanzerotti or Michael DeMayo at 415-241-0605 if you have any questions.**

		RA CTR	Disc CTR	+Disc CTR	PD CTR	Ref CTF	+Ref CTR	NSFUCTR	PCRS	HIV Lab Test
MSM MSM/F	Target									
	Duplicated									
	Unduplicated									
TSM TSM/F TSF	Target									
	Duplicated									
	Unduplicated									
MSM-IDU MSM/F-IDU	Target									
	Duplicated									
	Unduplicated									
FSM-IDU FSF/F-IDU FSF-IDU	Target									
	Duplicated									
	Unduplicated									
MSF-IDU	Target									
	Duplicated									
	Unduplicated									
TSM-IDU TSM/F-IDU TSF-IDU	Target									
	Duplicated									
	Unduplicated									
FSM FSF/M FSF	Target									
	Duplicated									
	Unduplicated									
MSF	Target									
	Duplicated									
	Unduplicated									



**PROVIDER INFORMATION FORM**  
**Section III: Intervention Table**

Agency: \_\_\_\_\_

		IRRC	PCM	MSW	SSG	NE	Hotline	CD	SMM	VBGO	VBGOSE	VBIO	1/2Training	FTraining	FRetreat	NRetreat
<b>MSM MSM/F</b>	Target															
	Duplicated															
	Unduplicated															
<b>TSM TSM/F TSF</b>	Target															
	Duplicated															
	Unduplicated															
<b>MSM-IDU MSM/F-IDU</b>	Target															
	Duplicated															
	Unduplicated															
<b>FSM-IDU FSF/F-IDU FSF-IDU</b>	Target															
	Duplicated															
	Unduplicated															
<b>MSF-IDU</b>	Target															
	Duplicated															
	Unduplicated															
<b>TSM-IDU TSM/F-IDU TSF-IDU</b>	Target															
	Duplicated															
	Unduplicated															
<b>FSM FSF/M FSF</b>	Target															
	Duplicated															
	Unduplicated															
<b>MSF</b>	Target															
	Duplicated															
	Unduplicated															



## APPENDIX 5: SERVICE PROVIDER INTERVIEW PROTOCOL

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Thank you for participating in the SCAN (Systems Capacity Assessment by Neighborhood) of HIV prevention services in the Tenderloin. As you are aware, this project is being conducted on behalf of the SFPDH AIDS Office by LaFrance Associates in collaboration with Harder+Company Community Research. The purpose of the SCAN is to create an inventory of the **HIV prevention services** in this area, assess the strengths of these services, and determine how the system of HIV prevention services can be improved. The purpose of this interview is to clarify information you provided in the Provider Information Form you submitted to LaFrance Associates, LLC and to get more detailed information about the HIV prevention services you provide.

The information you provide may be associated with your agency in the final report, but your name will not be. The interview should take about 45 minutes to 1 hour. Do you have any questions before we begin?

1. In the last few years, how have the HIV prevention services your organization provides changed to meet the needs of your target population(s)?
2. Do you anticipate making any significant changes to the HIV prevention services you offer in the near future?
  - A. Why are you making these changes?
3. How do your target populations access the HIV prevention services you provide? (Probes: Outreach, referral from outside, referral from within agency, people call in, drop-in, etc.)
4. What other organizations are you aware of in this neighborhood that are providing HIV prevention services to your target population(s)?
  - A. What makes the services you provide unique?
5. You mentioned on your PIF referral relationships with [list agencies here]. For each of these relationships, can you tell me about the referral process?
  - A. Referrals out to other services: When do you refer clients to these services? How does the process work? Do you give the client a card, make an appointment for them? Do you conduct referral follow-up? Do you coordinate with the client's provider at this agency once he or she is hooked up?
  - B. Referrals from other agencies: When do clients get referred to you? How does the process work? Does the agency call you to make an appointment for the client? Do you coordinate with the client's provider at this agency once he or she becomes a client of yours?
6. Based on your PIF, it looks like you are/are not meeting your goals in reaching the numbers of clients projected in your contract.
  - A. Those meeting goals: What factors have helped you meet your goals?
  - B. Those not meeting goals: What factors have contributed to not meeting your goals?

7. To what extent do you serve clients that come from other parts of San Francisco? (Probes: What neighborhoods do they live in? Why do they come to the Tenderloin for services?)
8. A. In general, how would you characterize the coordination of services in the Tenderloin, both HIV prevention and other services? (Probes: Are the needs of the whole person being met through coordination and referrals? Do agencies communicate with each other to create an overall plan for clients? Are clients able to access a variety of services, regardless of their entry point into the system?)  
  
B. How does HIV prevention fit into the overall landscape of services in the Tenderloin? (Are HIV prevention services well-connected to other health and social services?)  
  
C. Are there any issues with HIV prevention service duplication in the Tenderloin? Please describe.
9. What gaps do you see in the HIV prevention services provided in this neighborhood? (Probes: What needs are not being met? Which populations are not being reached effectively? What gaps are there in types of HIV prevention services available? What types of HIV prevention messages are not getting out there effectively?)
10. Do you have any other suggestions for what the AIDS Office or the HPPC could do to help to improve the system of HIV prevention services available in the Tenderloin?
11. How would you rate the capacity of the services in the Tenderloin to meet the HIV prevention needs of Tenderloin residents?

Very high capacity  
High capacity  
Medium capacity  
Low capacity