

Day 1

Session 1: Syndemics and Structural Issues, Gender/Empowerment and Community-Based Participatory Research

Presenters:

- Ron Stall
- Nabila El-Bassel
- Joyce Moon-Howard

Community Panelist:

- Lisa Dianne White

Moderator:

- Darrell Wheeler

Summary of Discussion:

Discussions following Session 1 included the following key points:

Syndemics:

- Should it be assumed that there is a self-selection bias inherent in couples HIV-prevention interventions? This type of bias was found to be an issue in an earlier study that enrolled women and then encouraged women to invite male partners. Couple-based recruitment is being used in two other studies, but some level of bias is still anticipated.
- In order to minimize syndemic impact on men would it be preferable for there to be more primary prevention interventions for young gay men, or would more studies with that used comprehensive strategies with older men be required? Interventions with gay youth are needed, but some feel that by late adolescents there is strong syndemic impact that must be addressed. Non-randomized trials that use power studies to measure possible impact of HIV rate by interventions, such as increased access to substance use treatment, are being conducted.

Community Based Participatory Research:

- How are the challenges in establishing a definition of community and the selection of community representatives addressed when conducting CBPR? Community has common symbols and common historical definitions and meanings, therefore what is defined as community by a given group may not be geographically based. Leadership representation of sub-populations must be defined by the members of the community.
- How can issues of resilience found in MSM syndemic studies be applied to HIV prevention work with women? Suggestions including domestic study/use of micro-financing approach and other approaches that may build on strength based assets already identified. Point emphasized that resilience should not be thought of as the converse of vulnerability.
- How does concurrency impact the implementation of a couple's intervention? Prior studies have found that when women have multiple partners whom she can bring to an intervention she will select the partner with whom she is having the greatest amount of unprotected sex, or with whom she feels the greatest fear of IPV. Safety protocols must be in place to reduce the risk of violence should other partners become aware of intervention participation.
- Challenges in forming research collaborations with community based organizations, particularly given the required rigor of clinical trials. Intervention facilitators at the community agency may feel that he or she is the one being examined, since facilitator must limit previous habits of adjusting intervention delivery to conform to perceived needs of the session attendees.
- It is important to consider which community based agencies are being invited to be at the table. It may be easier for researchers to repeatedly work with the same groups, but that may result in a failure to reach smaller sub-populations. The potential participants who are reached may not be representative, so certain groups will continue to be disenfranchised.

- Researchers must start relationships with CBOs before clinical trials start by building capacity development that empowers community agencies to understand the mechanisms involved in clinical trials therefore allowing agencies to assert themselves during process. Demonstrations of the diffusion model can be used to explain why becoming trained in understanding clinical trials is useful, including knowledge of how research findings may be made available in shaping future interventions.
- Has there been a MSM couple's intervention study? Yes, a pilot study that had a high participation and follow-up rate was conducted.

Day 1

Session: Session 2: Interventions and populations I

Presenters:

- Mary Ann Chiasson
- William Woods
- Don Operario

Community Panelist:

- Ernest Hopkins

Moderator:

- Sally Hodder

Summary of Discussion:

Discussions following Session 2 included the following key points:

Bathhouses:

- There is little known about bathhouses outside of outside of West Coast. Future studies should evaluate bathhouses outside of this area.
- Prevention interventions should include those that people can "walk away with"- it is not just about changing the behavior in the bathhouse, because people have sex outside the bathhouse as well
- Cities that have the least bathhouses per population (NY) have more sex parties. Sex parties are more difficult venues for prevention since they move, may not be organized by same people, etc. The average age that men start going to the bathhouses is late 20s. Relatively speaking, these younger men have higher risk behavior and naïve to the community- they may also be more attractive to men (including older men who are more likely to be positive) as a result of their age, and may need additional support negotiating safer sex.

Transgender Individuals

- The transgender community exists, and exists in large numbers in the hotspots indicated in earlier slides.
- Transgender women are calling for HIV prevention research and are very at risk in their community. There are opportunities for innovative prevention interventions with this group.
- Transgender communities are complicated (not homogeneous) and will require responses accordingly.
- Non-trans identified individuals may not identify as "transgender", but want to live their lives as men/women
- Surgical status (and desires for surgery) vary.
- Diversity with regards to sexual orientation with respect to gender identification.
- Most of the research in US has been conducted with transwomen.
- 28% seroprevalence in transwomen, only 12% self-reported HIV seropositive status (significant portion of population does not know their status).

- Sex work may be seen as a “right of passage,” drugs and alcohol may be used in preparation for sex work.
- Transphobia unique from other types of homophobia/stigma.
- This group generally lacks basic access to health care and other social services.
- Currently, there are no efficacious HIV prevention interventions for transpopulations, particularly trans- women.
- The transpopulation, in general is very responsive to public health interventions- HIV outreach seen as a way to legitimize their voice.
- For those who are out, transnetworks are very cohesive and are an entry point for people entering the transcommunity. These networks may be a good opportunity for the entry of interventions.
- PrEP and microbicides may acceptable options (the community very used to pill taking, product use).
- To date, there are only a handful of studies on male partners of transwomen. This group defies categories of “MSM” and/or “bisexual”. Of men who are primary partners of transwomen. 1/3 identify as gay, 1/3 identify as bisexual. These men may also have concurrent male partners outside of their partnership with transwoman. Literature indicates 30% of partnerships were discordant and many had unprotected sex in these partnerships (potential opportunity for intervention).
- The dynamics in younger populations are changing; there is more gender fluidity in younger populations.
- Transmen who have sex with men have high prevalence of risk behavior
- There is not much known about transmen, there is a lot more in the way of trans/gender fluidity with people born female at birth, but identify somewhere more towards male spectrum. Literature suggests that non-identified women use their vagina in the context of unprotected sex- there is a need for further research in this area. Since transmen were raised as girls, they may also have increased vulnerability to violence and body image.
- Some participants expressed interest in learning more about the “trans queer” community, violence inflicted against kids that express non-conformist gender identity at an early age
- Where do transmen fall in the spectrum of prevention? What about transmen who have sex primarily in the vagina?

Internet:

- Internet still represents a world of the “unknown”
- Some felt that there is a lack of acknowledgement of how the internet has diminished the need for “brick and mortar” for the facilitation of sex parties and how to acknowledge this.
- Internet sex is “safe sex”, but few are satisfied by internet sex only and may ultimately meet at another location in person (homes, bathhouses, etc).
- The internet sex environment is specialized and may attract men with specific fetishes. We need to consider internet as opportunities to tap into these growing populations. Data indicates that men who find sex in multiple types of places are more likely to be higher risk (men who use internet and also find partners in multiple other places are highest risk).
- Some felt that the internet may be difficult place to find a partner because people lie. However, some felt that the internet may enhance opportunities to meet more people.

Overarching discussions/considerations:

- How broadly is the transcommunity geographically? Currently, this is not known- could probably take a capture/recapture approach.
- Is there sufficient heterogeneity to support intervention in transcommunity?
- If men are frequent flyers at internet and bathhouses, should interventions include interventions that engage people through both mediums?
- How can we use the internet as a recruitment tool? May be challenging to recruit online- a sophisticated online campaign is essential, but online recruitment is expensive. Targeted email blasts are more effective than banners. Live focus groups with real people participating in recruitment are possible with new technology and may be more effective. Internet is attractive because it may allow you to reach people you would otherwise miss (rural areas).

- Should bathhouses and the internet be seen as ways to recruit people, intervene, or both? Need to make the distinction between online interventions and online recruitment. It can be challenging to actually get someone to call, email or walk into a site in response to online recruitment.
- When considering internet and bathhouses, you need to consider who you want to recruit and for what purpose (anyone or specifically those at the highest risk?) For example: Qualitative interview with highest risk men identified using exit survey at sex clubs- 2 week turnaround, 40% of men participated in focus groups.
- 30% of men in a recent MSM study (Beryl) indicated that men met partners on Chat phone lines who they later had unprotected sex with.
- The National MSM web-based study- web chat room recruitment was very unsuccessful (difficult, ethical concerns related to chat rooms).
- Are bathhouses a problem? Literature suggests that they are not as high risk as other venues, but may be a good access point for intervention. Bathhouses may be a good opportunity to intersect with men who have made choices regarding what is an acceptable level for them. What sort of interventions should be made available to the subcategory of populations who have found an acceptable level of risk? Can we predict a certain level of new infections based on this decision making paradigm? What type of access does this population need?
- On the West Coast, bathhouses are seen as “safe”. Risk behavior does happen, but is happening outside of the bathhouse. Additional work needs to be done outside of the West Coast to determine whether or not the context is similar in bathhouses in other areas. Private parties with meth may be more difficult access points. For example: Cocodorm in Chicago identified niche as raw, bareback sex and snowballing- saw a significant number of new HIV infections and rather than be prosecuted in Chicago, moved to Florida (where he was later shut down). Another entrepreneur in NYC promoted sex without condoms in NYC- eventually moved further underground (by invitation only) in response to national protest. Part of the problem may be using the term “population”- how do you estimate the population size if someone engages in a behavior once? Should be instead by engaging with venues? (Men who have safe sex in bathhouses may be engaging in unsafe sex at other venues).
- What kind of quantitative ways can we be thinking about this? If 40,000 new infections occur in men, how can we quantify how many new infections occur in each of these groups/venues? (transgender, internet, bathhouses, etc?) Could we more effectively address new infections by looking at the intersections? For example, bathhouses are a place where high risk men go, but not everyone at the bathhouses engages in high risk sex and not everyone who engages in high risk sex goes to bathhouses (may be a very effective way to target specific groups).
- Internet provides an opportunity to identify a large number of men and may be an effective way to reach people, but may not be the most targeted approach. Many men participating in internet studies already know their status and may be more likely to engage people because they do not have to go anywhere to participate in the intervention. Studies with internet-based populations have consistent demographics and suggest that these approaches consistently capture a high risk group of men.
- Attending bathhouses may be expensive (and suggest that they may not be a good place for people at low SES), but they are less expensive than hotels/motels. Some bathhouses may have “nights” with specific subpopulations. Some suggested that public, free places may be good places to recruit since people can frequent venues at no cost.
- What is the risk of subsequent risk of infection with respect to HIV testing behaviors (how much routine testing takes place and what is the impact on behaviors)? (No prospective cohort data in these populations).

- What information is available on internet use with Black women (recruitment, internet education, etc)? While there is a digital divide, it may not be as great as originally suggested. There is data on internet use by different groups, but very little published data on internet use by women. Would be a good idea to contact group running “We want the kit” website- good response by young Black women accessing this resource, but all pictures on the site are white.
- Key issues in study are both recruitment and retention- need to consider retention issues in internet based studies (poor retention, no access to biological specimens unless intersect with clinic at some point). What hybrids are available? Staff are usually motivators for retention (internet based studies are often lacking this). How can we do part of the intervention on the internet, but also link people back to a place? There have been few HIV prevention studies online, but there is a need for innovative interventions that venture into this arena.

Lunch Session: The IMAGE Study

Presenters:

- Paul Pronyk

Summary of Discussion:

Discussions following Paul Pronyk’s talk included the following key points:

- The importance of considering cross-discipline interventions and engaging professionals and communities with expertise outside of your expertise (don’t try to do something on your own that is not within in your expertise!)
- Understand that it may take time to develop the capacity of the people delivering the intervention (it is a process).
- It is important to speak to the community regarding interventions- interventions that may be applicable to women may not actually be feasible in the field and/or for other groups (women wanted workshops in IMAGE, but men were accessed in different ways)
- How can interventions engage men? Economic stress that men experience may be an important contributing factor to the epidemic (in both men and women?)
- How could the IMAGE model be transferred to the US epidemic? Recent urban planning looked at access to green space- lower rates of IPV in households with access to green space (even after controlling for other confounders). How do we look at the broader social conditions that influence these conditions?
- IMAGE intervention reflected priorities of the community- there was a multi-year run in
- When considering interventions, we need to also focus on the big picture issues (we do not live in a race neutral society) that have implications for the roll out of interventions.
- Women’s access to resources and empowerment may have potential for backlash (increased levels of vulnerability due to assertion of self), which should be considered and addressed. For IMAGE, in general, limited backlash from men, due both

to community mobilization (police, churches, community members) and increased ability of women to contribute to household, assert self.

- For IMAGE, community was involved at both development and implementation stage. Women often took their action plans in a different direction than originally anticipated (ex. Water) and then later came back to gender/HIV issues. It is important to acknowledge the voice and priorities of the community.

Day 1

Session 3: Interventions and populations II

Presenters:

- Crystal Fuller- Substance Use
- Conall O’Cleirigh- Mental Health
- Tim Flanigan- Incarceration

Panel Moderator:

- Beryl Koblin

Summary of Discussion:

Discussions following Session 3 included the following key points:

- Mental health treatment resources may not be available at a community level (empirically supported interventions are not available, other resources may be, but may not be empirically sound)
- Jail/prison causes gender imbalance in communities. Incarceration is linked to concurrency, substance use, mental health, social norms and expectations, etc. It is important to engage men as a means to prevent community infection.
- HIV risk and incarceration- most of the HIV infection happens in the community (not in the correctional system).
- Risk behaviors may be relatively low, but the HIV burden in communities is high (due to disparities in communities of color).
- Microfinance has been tried in the community, but may not have been evaluated scientifically. Important to evaluate why partnerships develop in low-income communities (economic reasons).
- GIS mapping may be an important tool- HIV and incarceration- community-based interventions.
- How often are people not getting tested in correctional settings? What proportion of people aren’t being tested? Data indicates the knowledge on HIV/AIDS of inmates is good. Testing appears to be acceptable across prisons. Most jails do not test for HIV. How feasible is it for jails to test? The feeling is that it is feasible, but that the political will is not there. HIV testing in jails should be following the syphilis model (if we can test everyone with syphilis, why can’t we test for HIV?)

- Need to look at ways to effectively counsel for HIV (pre and post test) - knowledge may be high, but if we don't take advantage of post-test counseling, we have missed opportunities for prevention.
- Women that are incarcerated have much higher rates of HIV than general community. Interventions for men in prison should not be the same as interventions for women.

Day 1

Session 4: Biomedical Research

Presenters:

- Bernard Branson- HIV Testing
- Ken Mayer- Biomedical Update-Antiviral Chemoprophylaxis (PEP/PrEP)

Panel Moderator:

- Jessica Justman

Community Representative:

- Richard Jefferys

Summary of Discussion:

Discussions following Session 4 included the following key points:

- Potential downsides of PrEP with Maraviroc: blocking CCR5 could have some yet-unknown deleterious effect, and any PrEP might cause disinhibition and result in uptick in HIV or STI rates.
- Home Testing/OTC HIV test kits. Will face a lot of financial, regulatory, logistical hurdles because no counseling with results. Could be used 10 days after a 4th generation test to basically eliminate the seroconversion window.
- How realistic it will be that a successful PrEP trial could become programmatic would depend on the results and would have to be targeted to specific risk communities. Giving PrEP to high risk communities may "medicalize" sexual identity. Side effects of PrEP drugs must be weighed against benefit. Possible concern with intermittent PrEP if not rolled out with testing could expose virus to sub-optimal ART. PrEP won't be more than 40-60% efficacious...will be a hard message to sell to people.
- Eighty percent of MSM engaging in AI are using lube anyway- adding ART would not add any real cost...it's a shame that we're not doing many rectal microbicide trials.
- Regarding data on disclosure by positive people, there has been some change- CDC guidelines used to be don't disclose b/c of discrimination you may experience. That will probably change now that there is treatment available broadly.

Day 1 Wrap Up- Ken Mayer, Moderator

Summary of Discussion:

- Consideration of Studies Already in the Field
 - Domestic 3MV under Susan Buchbinder. Menu-driven intervention, but some menu components are TBD, pending results. Selection of menu items will depend on the participant's situation.
 - Community-level interventions:
 - Connie Celum study in the works- door-to-door testing, with couples counseling and linkage to care, maybe male circumcision.
 - Wafaa's Lesotho study- includes testing of women.
 - Estonia study.
 - UNC study.
- The team was reminded of the utility of doing smaller feasibility/formative studies before undertaking large studies, but should not avoid thinking big where warranted.
- The team was reminded that R01 mechanisms may sometimes be the more appropriate funding mechanism for formative or single-site studies.
- If structural/community interventions only change risk behaviors by 25%, will that actually have an effect on incidence...especially at the community level? On the other hand, individual-level behavior change only reaches so far when the need is to affect sexual networks, community norms and attitudes, etc.
- If we do combination interventions, what do we include? How do we pick what works?
- Concern was raised about how this process of DPWG science generation meshes with the interagency national HIV/AIDS research strategy. It was agreed that any new DPWG proposal/science may need to go to broader discussion if it falls outside or not only within the HPTN purview.

Day 2

Session: Design Considerations and Potential Impact

Presenter: Jim Hughes

Summary of Discussion:

Discussions following Jim Hughes's talk included the following key points:

- Discussion ensued about the legitimacy of surrogate endpoints. It was noted that Deborah Donnell has a more nuanced way to collect self-report, which may generate a better surrogate endpoint. In Explore, self reported risk endpoints were correlated with the HIV endpoints, but the response was just not as robust.
- If you do roll-out or step-wedge in prisons, you compare those who are receiving intervention to those who are not, but will in future. The problem can be what if you roll out today and measure them tomorrow, but the full effect of the intervention won't be seen for 2 years?

- Since HIV is rare, a 20% reduction of risk behaviors may be effective at reducing individuals' risk for infection, but may be not show up in a significant, measurable change in the incidence rate.
- When we look at risk in a couple, and whether an intervention is protective, don't we need to look at the negative's lifetime story...what if the negative partner gets HIV infected 15 years later?
- A sub-issue when doing couples' studies is whether the infection of the partner is from the other-- linked vs. unlinked transmissions. However, the main point is just whether the partner is infected, whoever may be the source. Still, it is important to know if your intervention is having the effect it is expected to, that is, the linked transmission.

Day 2

Session : Surveillance Data- A Valuable Resource

Presenter: Irene Hall

Summary of Discussion: Discussions following Irene Hall's talk included the following key points:

- Transmission rate is based on the Total incidence trend and the total prevalence trend (Holtgrave paper).
- At the moment, the incidence rate is fairly flat, but the prevalence will continue to rise.
- A current gap in the literature is that we do not know what percentage of viral loads represents people on ARVs; however, this data could be collected. States often collect the minimal amount of data due to funding (ARVs could be collected, but is not required). The group wondered if it would be possible for the provider to select a box that indicates whether or not the person is on ARVs at the time the VL is collected and sent to the lab?

Day 2

Brainstorming New Science

Summary of Discussion:

- PrEP with Maraviroc seems worth pursuing and should go forward with the ACTG.
- Male circumcision study was suggested, but others felt that there would probably not be a lot of bang for the buck.
- Suggestion that there would be value in focusing on heterosexual minority men as partners of women, and not just incarcerated men.
- Question was asked whether the HPTN could take an approach that actually begins with community input to develop an intervention...perhaps multiple, structural interventions...that will arise organically from community and address what they see as their needs?
- In San Francisco, there's a sense that what O61 is doing is reduplicative with what's already out there at CBOs and it was felt that we should work with the CBOs to go to the next step from where they are now.
- As for concentrating on new, high-risk populations, what about "throw-way" gay youth, specifically Black MSM, who form new identities through House-Ball, turn tricks, have relationships with older men?
- Reminder that if you move beyond individual interventions with minority, bear in mind that the partners of participants may not look like them.
- Although there are different sub-populations we are talking about, there are co-occurring issues occurring across these groups who are co-localized. Propose a structural intervention in the community that reaches all of these groups. Many of the same issues apply for women that were noted for MSM, especially MSM of color—abuse, depression, violence, sexual violence, economic disempowerment. What about a structural intervention across these communities?
- One approach would be to offer a menu of interventions for the individual to choose from based on their needs.
- To do structural or community level interventions, and especially work with youth, we would need to form partnerships with other groups- e.g. adolescent trials network, schools, etc.

- We have individual behavioral interventions and they aren't enough- maybe we have no choice but to look to structural interventions
- Note that incidence measurements may be a significant challenge with community and structural-intervention types of studies.
- If bathhouses and internet were used in future study, should they be venues for recruitment and/or intervention?
- Male circumcision is an intervention that we know works in male heterosexuals. Can we map areas of low male circumcision in the US and use this information to target groups?
- It was asked what proportion of the US epidemic is heterosexual men, and what proportion of the men are uncircumcised. There was a suspicion that a circumcision study would not have a significant impact on the epidemic.
- What is the role of geomapping? Should we explore community structures for populations that are overlapping or do we need specific focus on groups?
- The idea was suggested of TLC for MSM, with measurements for incidence. Questions: would such a study move out of the Black-only focus, would it address syndemic issues, include biomedical interventions? It was also asked why restrict to MSM, that is, what was the advantage of treating less than everybody? Since TLC is in more heterosexual populations, it was suggested to start with an efficacy study in MSM. It was suggested that TLC expand to include STIs. Feedback from communities on TLC has emphasized the need for focus on syndemic issues. Part of the problem with any TLC approach that looks to provide something for negatives is that there are no services for negatives-- we can't refer people to a service that does not exist.
- Noted that there have been only 3 weak HIV prevention interventions for women with co-occurring issues. We need to do more with couples. Substance abuse needs to be better integrated into programs with women.
- The team was asked: What are the next generation ideas?
 - Does the next generation of protocols for women include partners and/or substance abuse?
 - Should we focus in on incarceration? (this may include a focus on men, what causes incarceration, linking services post release) Is this included in an evaluation for women or does it stand on its own?
 - Do we need to focus on young MSM?
 - Should we consider a PROMISE model with multiple nested interventions/studies?

Day Two

Brainstorming Sessions:

First topic of discussion: Women and Men

- It was noted that a couples study is coming out soon in which 8 discordant couples received a series of counseling sessions. In the study, they referred participants out for assistance as needed, since a lot of needs were revealed during the sessions.
- Can we study men who are getting women infected and the women themselves, without focusing on the dyadic pair? Once we understand the *people*, can we use that data to come up with a real *intervention*? It was pointed out that the Isis qualitative component will answer some of these questions.
- Is there wisdom in studying high risk heterosexuals in high risk areas, but not just as couples? It was pointed out that incidence per act in Black MSW is lower than in women, and we already have a hard time getting up with these women and making an impact.
- Regarding transmission among heterosexual couples, is it stable—even transiently stable-- couples where transmission takes place? Can we study them?
- What is the data on “heterosexuals”? We don't know but the data should be in the just-coming-out NHBS data. Prior data suggest that Black MSW, make up 5% of U.S. infections vs. Black WSM at 15%
- What about a study design where you enroll a couple and then have them refer (for enrollment), or at least describe, ALL their sexual partners/sexual network? Then could you do a TLC based on a network level?
- It was suggested that we need to include MSMW as we consider this group. And it was asked if transwomen are considered in this mix.

- It was asked if it would be possible to scale up such an intervention.
- Couples work is very exciting to the providers, well accepted by them.
- Prior studies defined couple as 6 months. Intervention actually adds stability to the couples' partnerships. In these studies 90% of couples attended all sessions. Rates of concurrency weren't that high among the couples, perhaps reflecting selection bias.
- Possible approach- bring people in, if they're in a stable couple, offer couples' intervention, if they're not, offer individual interventions. Map their networks, attempt to recruit sexual partners.
- The group felt that the recruiting of sexual partners would be tough...why not get their social networks and eventually you'll capture the community including the sexual partners. Also, will you enroll partners who are referred as partners but are not in the community?

Second topic of discussion: MSM

A proposed study design:

(Young?) MSM

- If pos, → TLC+
- If neg, → PREP trial

Offer all participants syndemic management tailored to their needs (don't forget Black MSM services)

Comments and notes:

- Can't cure everyone of PTSD, but can use evidence-based approaches to do brief interventions to address the effects of PTSD on their HIV risk.
- Can we provide case management to high risk men so they don't have to get infected to get the services they need?
- Agree that these are very important points- we need to be mindful of what services exist in communities, what is ideal, what is realistic and ethical issues resulting from creating unmet needs
- We need to be mindful of the term syndemic management. True syndemic management means controlling the factors driving the syndemic. What we can do is offer services to help cope. May need to address root causes of the syndemic (for example, job training may create more discontent because there are no jobs to go to). In addition, there are structural barriers to accessing services (felons can not access HUD)
- Microenterprise should be considered as a possibility (tabled to 3rd discussion)
- Psychotherapy may alleviate symptoms. Don't have enhanced services everywhere, just in the communities where we are working.
- Should consider protective factors and strengths- can the people with these strengths help support other people on the study (set up peer support outside of formal, paid PHN)
- Need to review the literature regarding scalability and reproducibility of peer models
- What is the role of internet and bathhouses?
 - Combine internet and bathhouses for both on and offline interventions. What is the sustainability of the proposed intervention (one under discussion)?
 - If the science is reasonable and key stakeholders agree it makes sense, we need to cost out this interventions vs. the cost of new infections going forward
 - Bathhouses may help us identify who to target. There is an emerging technology of very efficient empirical interventions. The same issues that often impair someone's ability to stay safe may also impair their ability to stay adherent.
- Structural Interventions:
 - How different are the syndemics in MSM and women? CBT is intrinsically tailored to the individual. Not convinced that the ways to address syndemics are so different across groups.

- Still need to consider that there are existing social structures driving the syndemic that we need to take incremental steps to address. What about race? What do we mean by “Black”? “People of color” and “others”? People may move on that scale- how do you design interventions for “black” men that may be fluid on the scale?
- Interventions should take people in the context of where they are (intervention may be the same).
- There are disparities in outcomes and treatment/retention in young MSM that this study could really address.

Day 2 Brainstorming Session cont:

Third Topic of discussion: Incarceration

The group brainstormed around the role of incarceration in the HIV epidemic, and possible capsules that may address some of these issues, to include:

- TLC Plus for correctional system (test at entry and at discharge, treatment for positives, intervention for negatives, discharge planning for people leaving system)
- What about interventions with men while they are in prison? Project START has been effective in reducing risk behaviors. The group agreed that interventions that specifically address safer sex in prison can be challenging, since laws/condom access vary from state to state. For example, in NC sex is illegal in prison, so condoms are not available.
- What about the impact of corrections on community (in)stability?
- Where are the transmissions taking place (inside or outside the correctional facility)? Is the majority of sex in prison is consensual sex? Literature suggests that most transmission occurs outside of prison.
- Need to think beyond incarceration to alternatives to traditional incarceration?
- What do we do with the folks that are negative getting out?
- People in and out of the prison tend to go back to the same community- how do build positive communities? (MSM, low income, incarcerated communities) What are concrete, measurable ways to attain this?
- What if we focus on people in the jail? The group agreed that access to people in jail or prison can be very difficult (and variable across states). How could we intervene using an internet intervention (something that doesn't require personnel to be on site)?

4th Topic of Discussion: School-level interventions

- Junior/high school like this is a very important time in the life course to intervene- potentially good captive audience, good mechanism of randomization
- The HPTN's Adolescent Working Group is currently working on a capsule to incentivize girls to stay in school (traditional cash transfer). It may be a good idea to work with international counterparts to transfer knowledge.

Other Topics of Discussion:

Structural Interventions that Target Precursors of Childhood Sexual Abuse:

- The group discussed working with parents and community messaging. Also, the group discussed whether working with HPTN be a good mechanism for this type of structural intervention. What about R01 and R21s if not previously tested

Engaging Black Churches:

- Engaging the black church as a way to raise awareness/acceptability of testing and to reduce homophobia. Participants also discussed that interventions may be more sustainable within the church.

Structural Intervention with Sex Workers:

- The group discussed following international models to develop structural interventions for sex workers.

Role out Paul Pronyk IMAGE Model to US setting:

- Participants discussed that structural interventionist acknowledged that it takes longer to roll out, and would need to make sure the design allows for significant time to show impact.

Emergency Rooms as Location to Intervene:

- Participants discussed that the literature for this type of intervention exists but has not been followed up. Discussion also included standardizing testing in emergency rooms and follow-up as well as potential negative consequences. TLC-Plus will be exploring this model of intervention.

Capsules for development:

Social Sexual Networks in Heterosexuals

- Gina Wingood
- Nabila El-Bassel
- Carol Golin
- Ada Adimora
- Jessica Justman
- Wafaa El-Sadr
- Sally Hodder
- Gina Brown
- Jim Hughes
- Ann O'Leary
- Non FHI point person: Sally Hodder and Jessica Justman

MSM multi-factorial designs

- Don Operario
- Ernest Hopkins
- Conall O'Cleirigh
- Jim Hughes
- Trip Gulick
- Michael Arnold
- Wafaa El-Sadr
- Hong Van Tieu
- Mary Ann Chaisson
- Richard Jefferys
- William Woods
- Irene Hall
- Non FHI Point person: Ken Mayer

Correctional Settings

- Carol Golin
- Laura McTighe
- Tim Flannigan
- David Wohl
- Cathie Fogel
- William Woods will refer someone from CAPS

- Non FHI Point Person

Form Structural Intervention Working Group

- Michael Arnold
- Don Operario
- Ernest Hopkins
- Beryl Koblin
- Ann O'Leary
- Ada Adimora
- Darrell Wheeler (Non FHI Point Person)

Other Notes:

- The group agreed to blend in MSM with Maraviroc and that there is not sufficient incidence to conduct intervention in women.
- If anyone needs surveillance data, please contact Irene Hall.