

Pilot Study on HIV Among Gang Members



City of Los Angeles AIDS Coordinator's Office

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PILOT STUDY ON HIV AMONG GANG MEMBERS

EXECUTIVE SUMMARY

The overall findings from this pilot study indicate that young Latino and African American gang members in Los Angeles are engaging in high risk sexual and substance use behaviors associated with HIV transmission.

There are an estimated 39,000 young people involved in gangs in the City of Los Angeles and up to 100,000 in Los Angeles County.¹ In spite of the positive aspects of gang affiliation, such as cohesiveness, peer support, and enhanced feelings of self-efficacy, gang membership is also often associated with negative activities such as drug use, violence, delinquent behaviors, and criminal activity that can result in incarceration. Gang activity may also be associated with higher rates of HIV infection among this marginalized and often stigmatized population. In an effort to identify new opportunities for preventing HIV infection among young people – particularly young people on the fringes of our communities – this unique, pilot study of HIV issues among gang members in Los Angeles was conducted.

The goal of this pilot study was to assess HIV prevalence and factors that influence HIV transmission among Los Angeles gang members. A cross-sectional epidemiological descriptive study was conducted in two parts. Part I was a survey of gang members' knowledge of HIV and its transmission; attitudes about the disease, infected individuals, and protection methods; and prevalence of high risk behaviors. Part II included optional rapid HIV counseling and testing to estimate HIV prevalence.

¹ Estimate provided in 2005 by the Los Angeles Bridges Program, Community Development Department.

Three hundred active gang members completed the study survey, and 144 were tested for HIV. Sixty-three percent of study respondents were Latino; 36% were African-American (see Figure 1E). Eighty-five percent of participants were male; 15% were female (see Figure 2E). Participants ranged in age from 17 to 26 years, with about half under age 21 (see Table 1E). On average, participants reported having joined a gang at age 13.

Figure 1E. Sample: Race/Ethnicity

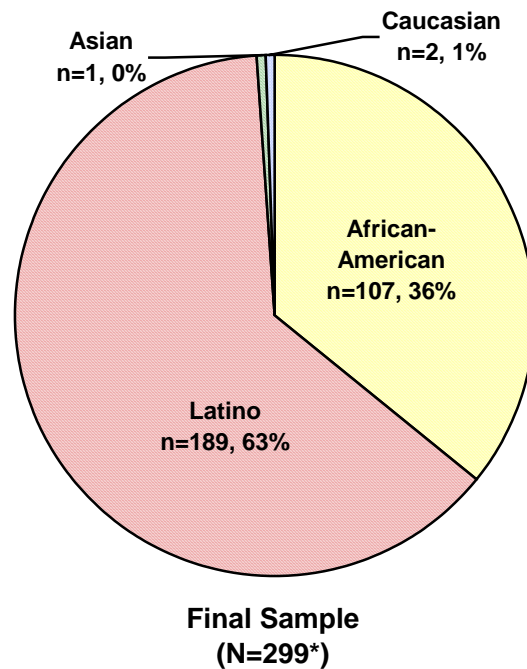
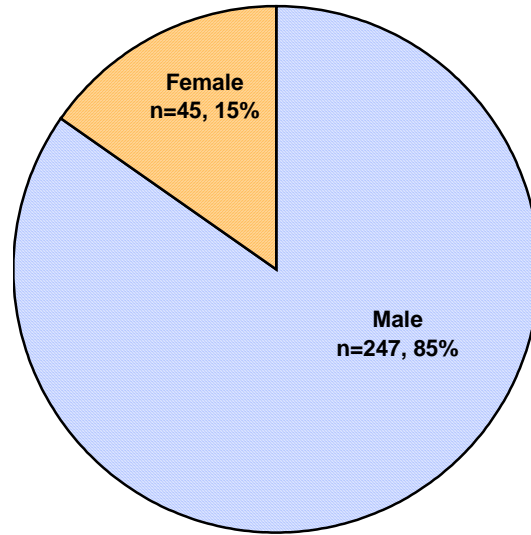


Figure 2E. Sample: Gender



**Final Sample
(N=292)***

Table 1E. Sample: Age

Age	n	%
17-20	143	47.7
21-23	104	34.7
24-26	46	15.3
Missing	7	2.3

Key Findings

Knowledge about HIV

Gang members were knowledgeable about the various ways HIV is transmitted; the average score on the knowledge test was 74% correct. Gang members struggled most with questions related to HIV transmission and medical knowledge about the virus (see Table 2E).

Table 2E. Common Misconceptions

Medical Knowledge	% Incorrect
Most people who have HIV are sick with AIDS	57.3
People usually become very sick with AIDS a few days after being infected with HIV	47.3
A vaccine has recently been developed that prevents people from getting HIV	31.3
HIV Transmission	% Incorrect
People have been known to get HIV and develop AIDS by tongue kissing a person who is infected with HIV	47.7
With treatment, babies of HIV/AIDS mothers can be born without HIV/AIDS	44.0
You cannot get HIV from getting a tattoo	39.3
Men have a higher chance of getting AIDS from having sex with a woman than with a man	38.3
You can get HIV and eventually AIDS by donating blood	37.3
Lambskin condoms are better than latex condoms for preventing HIV infection	35.0
You are safe from HIV if you have oral sex without a condom	33.0
You can get HIV from having your body pierced	31.7

Attitudes Regarding HIV Infection

Gang members were highly likely to agree that they were able to protect themselves from HIV (Self-Efficacy) and had support of friends to do so (Peer Support) (see Table 3E). Less than half of the study participants considered themselves at risk for getting HIV (Perceived Vulnerability). In addition, nearly one-quarter considered HIV to be a stigmatizing disease (HIV Stigma). See complete attitude scales on page 5 of this report.

Table 3E. What are Los Angeles Gang Members' attitudes towards HIV infection?

Scale²	% of Participants Who Agree
Self-Efficacy I can protect myself from HIV	78.3
Peer Support I have peer support to avoid HIV	66.2
Perceived Vulnerability I believe I am at risk	40.0
HIV Stigma There is stigma associated with HIV	22.7

Gang members perceive HIV as a serious problem affecting their community that requires more attention (see Table 4E: Community items). Gang members also reported contrasting views of how family and friends would treat them if they were HIV positive (see Table 4E: Friends and Family items). For gang members, HIV is far-removed from their reality, which can lead to skepticism regarding their personal risk (see Table 4E: Self items).

² Participants rated each item (1=Strongly Disagree, 2=Disagree, 3=Agree, 4=Strongly Agree). Scale scores were cut at 2.49 (1-2.49=Disagree; 2.50-4.0=Agree).

Table 4E. Attitudes Towards HIV Infection

Item	% of Participants Who Agree
Community	
There should be more public information about HIV	90.9
HIV is a problem in my community	74.2
There is a cure for HIV, but we aren't being told about it	58.0
HIV is a conspiracy against minorities	39.1
Friends and Family	
If I had HIV, my family would help me	77.8
If I had HIV, my friends would stay away from me	53.7
Self	
I don't have to worry about HIV/AIDS because I don't share needles and/or "works"	44.4
I don't have to worry about HIV/AIDS because I'm not gay	36.9
I am very healthy so my body can fight off an HIV infection	33.0
It doesn't matter if I get HIV because I'll probably die young anyway	26.0
I don't worry about getting HIV because if I take medicine, I'll be okay	24.7

For gang members, knowledge of HIV is related to their level of Self-Efficacy and HIV Stigma. Among gang members, knowledge of HIV was positively correlated with Self-Efficacy, suggesting that as knowledge increases, self-efficacy also increases. HIV Stigma was negatively correlated with knowledge; as knowledge increases, the belief that HIV is stigmatizing decreases.

Moreover, a regression analysis found that attitudes – particularly Perceived Vulnerability and Self-Efficacy – are the best predictors of risk among gang members. In

other words, as scores on the Perceived Vulnerability scale increased, the prevalence of risk behaviors also increased. As Self-Efficacy increased, the prevalence of risk behaviors decreased.

Risk Behaviors – Sexual

Gang members reported engaging in several high risk sexual behaviors. Nearly all of the respondents (97.3%) reported that they are sexually active (see Table 5E). The top three sexual risk behaviors of gang members include: 1) unprotected anal or vaginal sex (i.e., inconsistent condom use); 2) having casual sex (i.e., sex with someone you just met); and 3) engaging in sex while under the influence of alcohol or drugs (see Table 5E). About a quarter of gang members also reported other sexual behaviors that are often associated with HIV transmission. (For gender differences in sexual behaviors see pg. 34 of this report).

Table 5E. Lifetime and 12-Month Sexual Behaviors

Behavior	Lifetime N=300³		Last 12 Months N=300⁸	
	n	%	n	%
Sexually Active	291	97.3	292	97.3
Inconsistent Condom Use ⁴			266	88.7
Casual Sex (Sex with Someone You Just Met)	216	72.7	195	65.0
Sex while High or Intoxicated	258	88.6	146	48.7
Sex with High Risk Partners ⁹			86	28.8
Survival Sex	78	26.9	78	26.1
Sex with Multiple Partners	80	26.9	74	25.6

³ Some N's are less than 300 due to non-response.

⁴ Survey question does not allow for lifetime estimation.

Risk Behaviors – Drug Use

As seen in Table 6E, substance use was high; over 85% of gang members reported using drugs in the past twelve months. In particular, about a quarter of participants report using drugs that have been associated with HIV transmission, such as methamphetamine, crack, and ecstasy.

Table 6E. Drug Use

Drug use in the last 12 months	TOTAL	
	n	%
Marijuana	240	91.6
Crack Cocaine	77	29.4
Methamphetamine	63	24.0
Ecstasy	62	23.7
Powder Cocaine	52	19.8
Heroin	23	8.8
Psychedelics	23	8.8
Other	15	5.7
Inhalants	10	3.8

Risk Behaviors – Incarceration

A total of 178 participants had been incarcerated at some time, and of those, 142 participants reported the number of days they had been incarcerated, which ranged from one day to over eight years (median = 243.2 days). Most of the twenty participants who reported having sex while incarcerated had total incarceration time of more than six months. Of the twenty participants reporting sex while incarcerated, 41.2% were in

county jail, 29.4% were in juvenile hall, 5.9% were in probation camp, 17.6% were detained by the youth authority, and 29.4% were in prison⁵.

Risk Behaviors – Tattooing

High risk tattooing was extremely prevalent among gang members; 39.3% of gang members reported being tattooed by friends or in prison, jail, or juvenile hall rather than in a licensed tattoo parlor.

HIV Prevalence

A total of 144 HIV tests were conducted. All tests were negative. An additional 65 participants reported having been previously tested for HIV; one participant reported being HIV positive, yielding a reported prevalence of 1/209, or 0.48% among the study sample. The result of the pilot study suggests that HIV prevalence among gang members is lower than the 1% found in the general population⁶. However, based on reported risk behaviors, gang members appear to be at risk for HIV infection; if everyone in the sample had been tested or a larger sample of gang members had been tested, prevalence may have exceeded that of the general community.

Participants were homogeneous in terms of their willingness to be tested; no significant differences existed by race/ethnicity, gender, age, risk behaviors, knowledge or attitudes, with the exception of Stigma and Access to Care. Participants who believed that HIV is stigmatizing were significantly less likely to be tested (35.3%) than those who did not believe it is stigmatizing (51.7%). Participants who scored higher on the Access

⁵ Participants may have been incarcerated in more than one type of facility.

⁶ Centers for Disease Control and Prevention (2001). *HIV Prevalence Trends in Selected Populations in the United States: Results from National Serosurveillance, 1993–1997*. Atlanta: Centers for Disease Control and Prevention.

to Care scale were more likely to be tested (51.2%) than those who scored lower (33.3%).

Implications for HIV Prevention

The current sexual and substance use behaviors of gang members place them at high risk of contracting or transmitting HIV. Prevention efforts are needed to help reduce these behaviors among the gang population of Los Angeles. Effective HIV prevention programs developed for other at-risk young people, such as runaway and homeless youth, could serve as a starting point for developing interventions for gang-affiliated populations. An intervention designed to address attitudes and beliefs about HIV; that capitalizes on the importance of peer support and influence among gang members; and that has a strong emphasis on skill-building to reduce sexual and substance abuse behaviors would be particularly appropriate for gang members, as described in recommendations 1-11.

1. CDC-identified effective behavioral interventions for high risk young people can be adapted for gang-affiliated populations. This would be a cost effective way of developing an HIV prevention program that could be tailored to the specific issues of Los Angeles gang members as well as individual neighborhoods.
2. HIV prevention efforts should focus on promoting personal goal setting and reducing sexual and substance abuse risk behaviors. A peer support approach that includes building a social support network would help gang members gain risk reduction skills and change behaviors.
3. Gang members would benefit from targeted knowledge (e.g., HIV transmission through tattoos, effective condom use) to decrease their risk-taking behaviors.

4. High prevalence of risky sexual behavior suggests the need for HIV prevention efforts focused on reducing sexual risk, and in particular, on enhancing the efficacy of gang members to use condoms for protection.
5. HIV prevention efforts must also address substance abuse behaviors (particularly substances highly correlated with HIV transmission such as methamphetamines, crack cocaine, and ecstasy).
6. Safe procedures for tattooing and piercing should be part of any HIV educational intervention designed for gang members.
7. Thirty-eight percent of gang members reported having children. The issue of family responsibility should be included as a topic in HIV prevention programs for this population.
8. Two-thirds of gang members reported being unemployed. Combining HIV prevention education with job training and counseling programs may be a way of reaching this population.
9. Peer outreach might be an effective approach to take to get gang members to participate in HIV prevention programs as well as encourage them to be tested.
10. Destigmatizing HIV could further encourage testing among gang members.
11. Because HIV is considered a community problem by gang members, it is possible that they might be interested in constructively participating in a public information campaign.

Implications for Future Research

This pilot study was the first of its kind to systematically examine HIV prevalence, knowledge, attitudes, and risk behaviors among gang-affiliated youth. As a result, this

study provided the opportunity to pilot procedures for accessing, recruiting, and surveying gang members as well as for testing them for HIV. Suggestions for improving study procedures in future research are listed in recommendations 12-18 below.

12. Conduct a follow-up study with a larger sample, using cluster sampling and a coding system to obtain a sampling frame from each gang intervention agency.
13. Select gang intervention agencies representing major gang areas across Los Angeles and conduct HIV education for all gang intervention workers and case managers at each agency.
14. Obtain a coded list of active gang members from each agency's case manager and randomly sample from each list.
15. Consider hiring a small number of full time temporary data collectors to administer the survey to gang members in each agency throughout the study.
16. Revise the survey based on findings of the pilot study.
17. Subcontract with one or more HIV testing services such that all geographic areas participating in the study are physically served.
18. Change the incentive structure so that participants receive \$10.00 for survey completion and \$25.00 for HIV testing. Try to coordinate HIV testing so that it is available at the time of surveying.

PILOT STUDY ON HIV AMONG GANG MEMBERS

INTRODUCTION

There are an estimated 39,000 young people involved in gangs in the City of Los Angeles and up to 100,000 in Los Angeles County.⁷ In spite of the positive aspects of gang affiliation, such as cohesiveness, peer support, and enhanced feelings of self-efficacy, gang membership is also often associated with negative activities such as drug use, violence, delinquent behaviors, and criminal activity that can result in incarceration. Gang activity may also be associated with higher rates of HIV infection among this marginalized and often stigmatized population. Currently, the proportion of new HIV infections for individuals that are between the ages of 14 and 25 is increasing⁸. In an effort to identify new opportunities for preventing HIV infection among young people – particularly young people on the fringes of our communities – this unique, pilot study of HIV issues among gang members in Los Angeles was conducted. The findings from this study may help guide the City in addressing HIV among gang members.

PURPOSE OF THE STUDY

The goal of this pilot study was to assess HIV prevalence and factors that influence HIV transmission among Los Angeles gang members. The influencing factors explored were demographics, attitudes, knowledge, and risk behaviors. Eleven research questions were posed to guide the pilot study:

1. What is the prevalence of HIV among Los Angeles gang members?
2. What are Los Angeles gang members' attitudes towards HIV infection?

⁷ Estimate provided in 2005 by the Los Angeles Bridges Program, Community Development Department.

⁸ Centers for Disease Control and Prevention (2004). *HIV/AIDS Surveillance Report*, 2003 (Vol.15). Atlanta: US Department of Health and Human Services, Center for Disease Control and Prevention.

3. How accurate is the knowledge displayed by gang members regarding HIV/AIDS and the transmission of the virus?
4. What types of risk behaviors are gang members engaging in?
5. What steps do gang members take to protect themselves and others from HIV infection?
6. Is there a significant relationship between attitudes, behaviors, personal characteristics, and HIV prevalence?
7. How does HIV prevalence in gang members compare with community-wide prevalence?
8. Are there differences in knowledge, attitudes or behaviors according to selected demographic characteristics?
9. Do patterns of prevalence differ according to demographic characteristics?
10. What is the relationship between knowledge and self-reported attitudes and risk behaviors?
11. What attitudes, behaviors, knowledge, and demographic characteristics are significant predictors of a positive HIV result?

METHODS

Study Design

A cross-sectional epidemiological descriptive study was conducted in two parts. Part I was a survey of gang members' knowledge of HIV and its transmission; attitudes about the disease, infected individuals, and protection methods; and prevalence of high risk behaviors. Part II included optional rapid HIV testing and counseling as well as

follow-up testing (if needed) to estimate HIV prevalence. Testing was administered by Minority Aids Project (MAP), an HIV testing and counseling service in Los Angeles. A field coordinator, who was also a part-time employee of MAP, assisted with coordinating both parts of the pilot study. Demographic subgroups of gang members (such as ethnic groups, gender, age groups) were compared and relationships among factors influencing HIV infection (attitudes, knowledge, risk behaviors) were examined.

Instrument

The survey contained 150 questions in four sections: demographics, attitudes about HIV, HIV knowledge, and risk behaviors (see Appendix A). The *demographic* section included questions about age, gender, ethnicity/race, marital status, living arrangements, number of children, education level, employment status, health insurance status, HIV status, and the age at which the participant joined a gang.

There were 45 statements related to *attitudes* about HIV, and participants were asked to rate their level of agreement or disagreement with each statement on a four-point scale (strongly agree, agree, disagree, strongly disagree). A literature review identified several preexisting attitude measures related to perceived threat of HIV, self-efficacy for prevention, condom use, and peer support⁹. Constructs and items for the present survey were derived in part from preexisting surveys; several items were also created to examine particular attitudes of interest that were relevant for the population

⁹ Koopman, C., and Reid, H. (1998) Assessment of Knowledge and Beliefs About HIV/AIDS Among Adolescents. In C. M. Davis, W. L. Yarber, R. Baureraman, G. Schreer, and S. L. Davis (Eds.), *Handbook of sexuality-related measures: A compendium* (2nd ed.). Thousand Oaks, CA: Sage, 321-324.

DeHart, D.D. & Birkimer, J.C. (1997). Trying to practice safer sex: development of the sexual risks scale. *The Journal of Sex Research*, 34, 11-25.

Lux, K.M., & Petosa, R. (1994). Preventing HIV infection among juvenile delinquents: educational diagnosis using the health belief model. *International Quarterly of Community Health Education*, 15, 145-163.

under study (e.g., “It doesn’t matter if I get HIV since I’ll probably die young anyway”). Factor analyses (using principal components factoring, varimax rotation) and subsequent reliability analyses resulted in the construction of five scales with acceptable reliability, as shown in Table 1 (see Appendix B). Coefficient alpha assesses the internal consistency of a scale score, examining the relationship of each item’s score to the overall scale score with that item deleted. Coefficient alpha of .70 or higher is considered acceptable for research purposes and indicates that a scale is measuring a unified construct.

Table 1. Survey: Attitudes

Scale	Number of Items¹⁰	Coefficient alpha
Perceived Vulnerability	7	.86
Self-Efficacy	8	.76
Peer Support	6	.72
Stigma	5	.77
Access to Care	3	.72

The contents of each attitude scale are displayed in Figure 1, in which “(R)” indicates that the item was reverse-coded during score computation. In order to examine validity, correlations among attitude scale scores were computed (see Table 2). All of the coefficients were in the anticipated direction and ranged from low to moderate in magnitude, indicating that the scales were not redundant. Peer Support, Access to Care, and Self Efficacy were all positively intercorrelated, whereas, these three scales were negatively correlated with HIV Stigma and Perceived Vulnerability.

¹⁰ The remaining 16 items did not factor into reliable attitude subscales. Results of selected items are reported separately.

For purposes of analysis, attitude scale scores were dichotomized so that a score of 1-2.49 was classified as “disagreeing” with the attitude being measured, and 2.50-3 was classified as “agreeing” with the attitude being measured.

Figure 1. Contents of Attitudes Scales

Self Efficacy
<p>13. I think I know the facts about HIV/AIDS and how you get it. 20. It's easy to get condoms. 26. There is still time for me to protect myself against HIV/AIDS. 34. I don't use condoms because sex is better without them. (R) 39. It is a hassle to use condoms. (R) 43. If I had HIV/AIDS, I would want to know. 44. It's easy to get clean needles and “works” if you need them. 46. Condoms are irritation. (R)</p>
Peer Support
<p>20. My friends have changed the way they have sex because of HIV/AIDS. 25. My friends practice “safer” sex. 28. My friends think that practicing “safer” sex can lower the spread of HIV/AIDS. 30. Using condoms means you really care about someone. 31. My friends think that it is too much trouble to use condoms. (R)</p>
Perceived Vulnerability
<p>23. There is a good chance I will get HIV/AIDS during the next five years. 27. I am at risk for HIV/AIDS. 32. My friends are at high risk for HIV/AIDS. 35. There is a possibility that I have HIV/AIDS. 37. I may have had sex with someone who was at high risk for HIV/AIDS. 40. My sexual activities put me at risk for HIV/AIDS. 45. I am worried that I might get an HIV infection.</p>
Stigma
<p>33. Anyone who gets HIV/AIDS deserves it. 41. HIV/AIDS is a punishment from God. 52. I would only worry about getting HIV/AIDS if I went to jail. 53. I would kill myself if I found out I had HIV/AIDS. 54. If I found out someone had HIV/AIDS, I would stay away from them.</p>
Access to Care
<p>55. If I had HIV/AIDS, there is a place I could go to get treatment. 56. I am able to see a doctor when I get sick. 57. If I had HIV/AIDS, I would get medical care.</p>

Table 2. Survey: Attitudes - Construct Validity

	Perceived Vulnerability	Self-Efficacy	Peer Support	HIV Stigma	Access to Care
Perceived Vulnerability	1	--	--	--	--
Self-Efficacy	-.57*	1	--	--	--
Peer Support	-.25*	.61*	1	--	--
HIV Stigma	.36*	-.36*	-.04	1	--
Access to Care	-.25*	.42*	.30*	-.28*	1

*p<.001

The knowledge test consisted of 31 true-false questions about HIV, its transmission, and risk behaviors, selected and modified from Koopman and Reid (1998)¹¹. There were 31 questions on the knowledge test; one point was given for each correct answer (see Appendix B). The knowledge score had acceptable reliability (coefficient alpha=.83).

Risk behaviors were assessed using 51 questions about sexual behavior, condom use, drug and alcohol use, incarceration history, and tattoos and body-piercing. Risk behavior questions were used to describe lifetime and last 12 month risk prevalence based on the skip patterns embedded in the survey. As seen later in the Data Analysis section, 18 risk behaviors were examined (see Table 3).

¹¹ Koopman, C., and Reid, H. (1998) Assessment of Knowledge and Beliefs About HIV/AIDS Among Adolescents. In C. M. Davis, W. L. Yarber, R. Baureraman, G. Schreer, and S. L. Davis (Eds.), *Handbook of sexuality-related measures: A compendium* (2nd ed.). Thousand Oaks, CA: Sage, 321-324.

Table 3. Survey: Risk Behaviors

Risk Behaviors	Item
Sexually Active	<i>Composite: 89a, 89b, 89c, 89f</i>
Vaginal Sex	89c
Anal Sex	89f
Inconsistent Condom Use	<i>Composite: 89d, 89g</i>
Heavy alcohol use	91
Drug Use	90
Sex while high or intoxicated	<i>Composite: 89j, 89k</i>
Survival sex	<i>Composite: 89p, 89q</i>
Sex with someone you just met	89l
Sex with multiple partners	89m
Incarceration	93
Sex while incarcerated	89n
Sex with high risk partners	<i>Composite: 92a, 92b, 92c, 92d, 92e</i>
Sexually transmitted diseases	89r
Injecting street drugs	89o
Shared needles	89s
High risk tattooing	94
High risk piercing	95

Five risk behaviors – sexually active, inconsistent condom use, sex while high or intoxicated, survival sex, and sex with high risk partners – were composite variables; responses on two or more items were combined to calculate risk. Participants were classified as sexually active or not, based on reports of having sex with men or women,

vaginal sex, or anal sex (“Yes”) or not (“No”). Participants were classified as consistent or inconsistent condom users according to use of condoms with vaginal or anal sex. Those who never, rarely, or sometimes used condoms were classified as “Inconsistent” and those who almost always or always used condoms were classified as “Consistent” users. Having sex while high on drugs and having sex while intoxicated were combined into a single composite variable, classified as “Yes” if either or both, and “No” if neither. If the participant either gave someone money or drugs for sex or received money or drugs for sex, they were classified as “Yes” for survival sex. Sex with high risk people was classified as “No” if the participant did not check off having sex with any of the high risk people listed in Question 92, and “Yes” if one or more were checked off. Correlations among selected risk behavior indicators are displayed in Table 4.

Table 4. Correlations Between Selected Lifetime Risk Behaviors

	Sexually Active	Ever Had Survival Sex	Ever Had Sex With Someone You Just Met	Ever Had Sex With Multiple Partners At The Same Time	Ever Had an STD	Ever Injected Street Drugs, Steroids or Vitamins
Sexually Active	1	--	--	--	--	--
Ever Had Survival Sex	0.14***	1	--	--	--	--
Ever Had Sex With Someone You Just Met	0.58*	0.25*	1	--	--	--
Ever Had Sex With Multiple Partners At The Same Time	.09	0.31*	0.23	1	--	--
Ever Had an STD	0.12***	0.46*	0.22*	0.24*	1	--
Ever Injected Street Drugs, Steroids or Vitamins	0.13***	0.29*	0.23*	0.17**	0.36*	1

* p<.001
 ** p<.01
 *** p<.05

All risk behaviors had significant low to moderate positive correlations with survival sex being moderately correlated with having sex with multiple partners at one time and having had a STD. Injecting street drugs was also moderately correlated with having had a STD, and casual sex was moderately correlated with sexual activity.

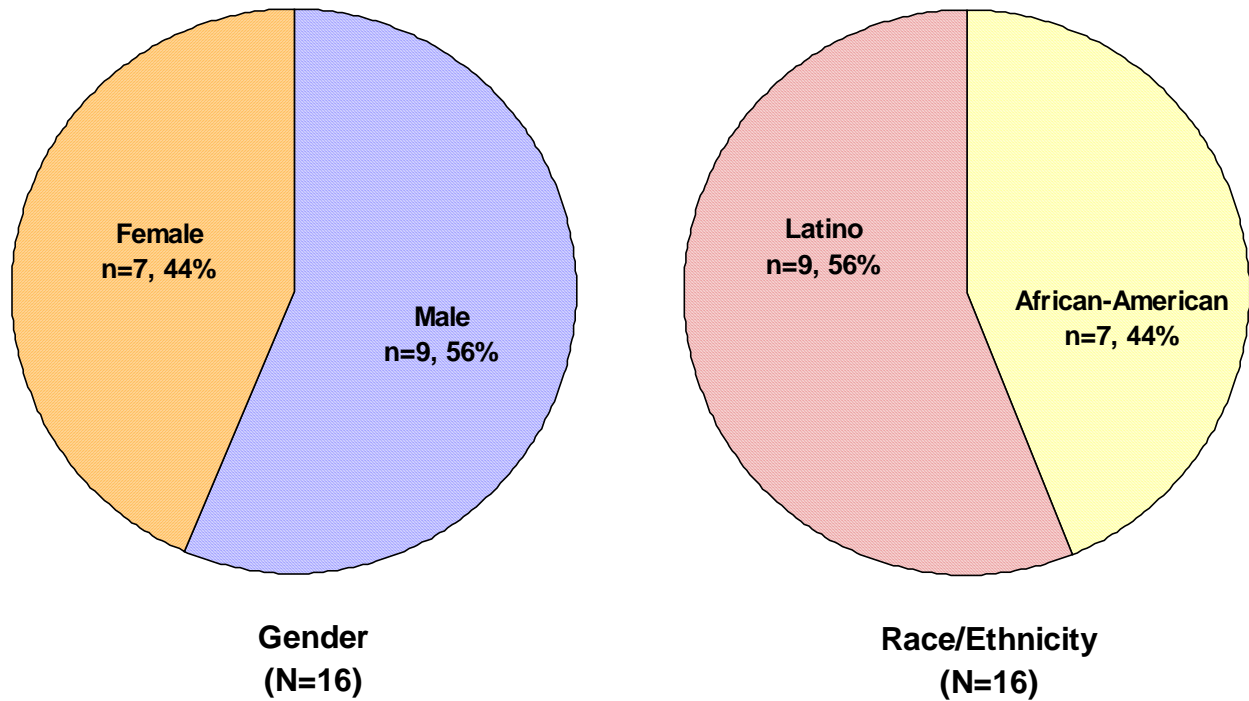
Procedures

Sixteen Research Assistants (RAs) were recruited and trained (see Appendix C for the training manual) from among eight community-based agencies that provided intervention or outreach programs targeting gang members in Los Angeles (see Table 5). Agencies were selected based on geographic distribution. Figure 2 displays the gender and racial/ethnic distribution of the RAs. RAs received \$15.00 for every participant that was recruited to the study and surveyed. To implement Part I of the study (the survey), RAs recruited active gang members and obtained their informed consent to participate. Surveys were administered to gang members individually, with RAs reading section introductions and each question out loud, while participants marked their responses on the surveys to maintain privacy. Each participant received \$25.00 for completing the survey.

Table 5. Research Assistants: Agency Representation

Agency	Number of Participants Recruited	%
Adelante (1 RA)	13	4.3
Communities in Schools (2 RAs)	21	7.0
El Centro del Pueblo (2 RAs)	80	26.7
Homies Unidos (2 RAs)	44	14.7
NO GUNS (3 RAs)	21	7.0
Stop the Violence (2 RAs)	32	10.5
Minority Aids Project (3 RAs)	61	20.3
Unity-One (1 RA)	28	9.3

Figure 2. Research Assistants: Demographic Characteristics

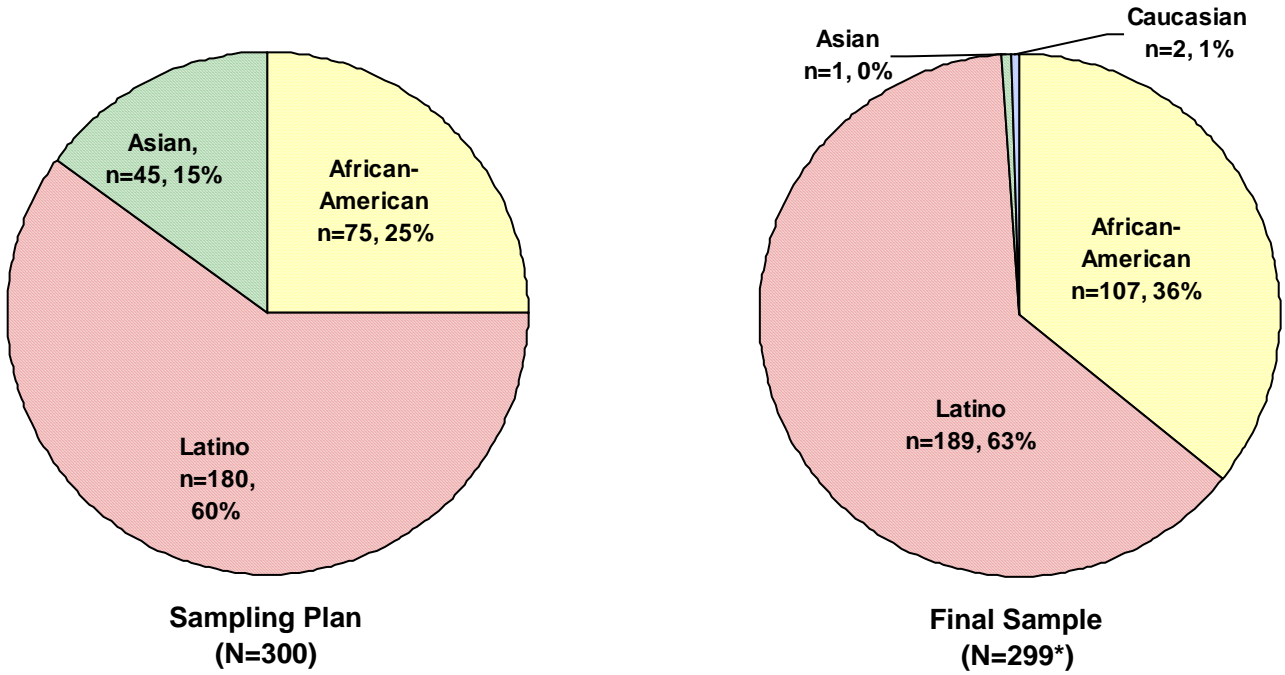


After completing the survey, RAs invited participants to be tested for HIV. Minority AIDS Project (MAP) provided rapid testing and counseling either through a mobile testing unit or at MAP headquarters. Unique identification (ID) codes were used to match surveys and HIV tests. Participants were given \$25.00 for completing HIV testing.

Sample

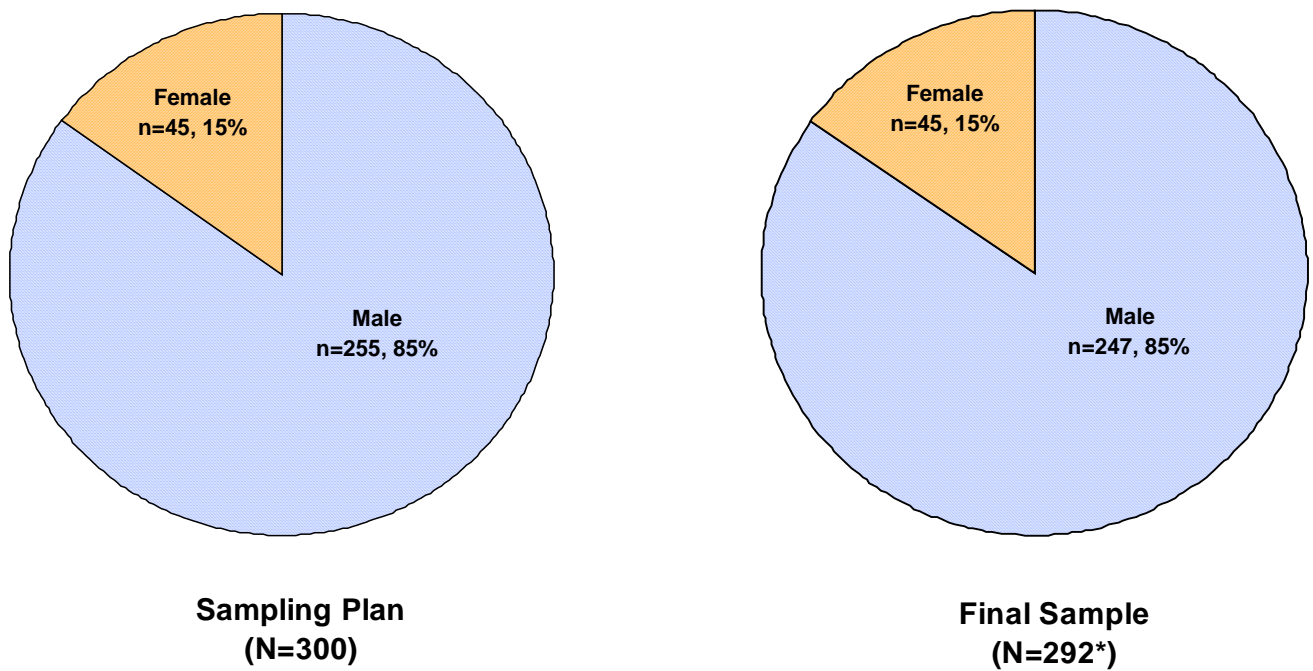
As planned, 300 participants completed the survey and just under half (n=144) were tested for HIV. As shown in Figure 3, the original sampling plan called for 60% of the participants to be Latino, 25% African-American, and 15% Asian. We were unable to gain access to Asian gang members within the City of Los Angeles and surveyed only one self-identified Asian participant, so the proportion of Latinos in the pilot study approximated the plan (63%), while the proportion of African-Americans (36%) was larger than expected. Two participants self-identified as Caucasian. The sampling plan also called for a gender balance of 85% males and 15% females (Figure 4), which was achieved.

Figure 3. Sample: Race/Ethnicity



*1 participant did not provide race/ethnicity

Figure 4. Sample: Gender



*8 participants did not provide their gender

Participants ranged in age from 17 to 26 years, as shown in Table 6, with nearly half being under age 21. The average age was 20.82 years. On average, participants reported having joined a gang at age 13.08 years (ranging from 0 to 23 years). A total of 32 participants did not indicate their age at joining a gang, and only one participant reported 0 years, which could be interpreted as being born into the gang, or never belonging to a gang. Nearly 1/3 of the participants (30.9%) indicated that they knew somebody with HIV/AIDS. The majority of participants (65.2%) reported living with their parents or other adult relatives (see Table 7). Eighty-one percent were single, widowed, or divorced, and 38% reported having children.

Table 6. Sample: Age

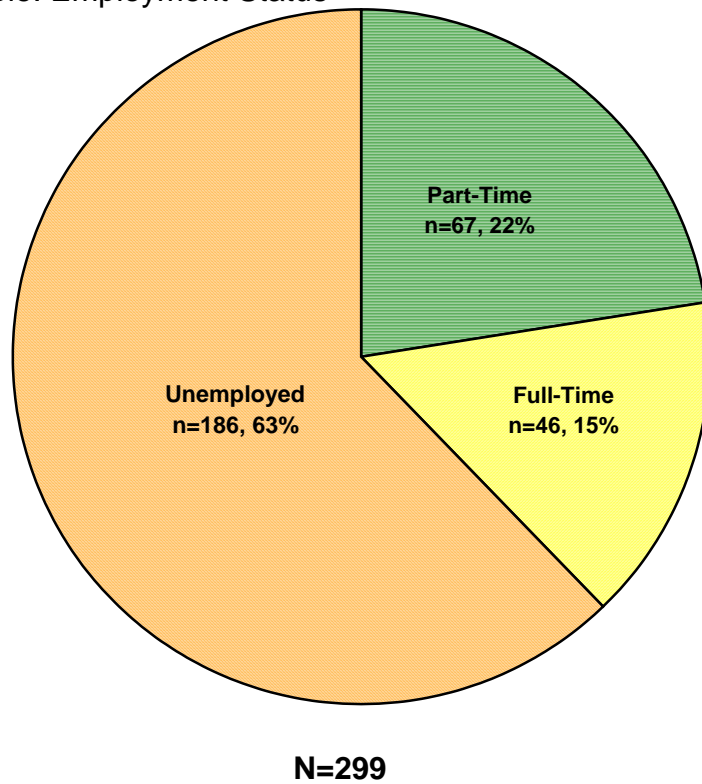
Age	n	%
17-20	143	47.7
21-23	104	34.7
24-26	46	15.3
Missing	7	2.3

Table 7. Sample: Living Arrangements and Marital Status

Living With:	n	%
Parents	155	51.8
Partner	46	15.4
Relatives	40	13.4
Alone	33	11.0
Friends	20	6.7
Children	19	6.4
Other	4	1.3
Marital Status		
Single, Widowed, Divorced	244	81.3
Married, Partnered	54	18.0
Other	2	0.7
Missing	9	3.0
Children		
Have Children (range: 1-7 children)	115	38.3

Only 15.1% of participants reported being in school now, and the average grade level of education completed was 11.1 years. Over half of the participants had not completed high school. Over 60% of the participants were unemployed, as shown in Figure 5. Almost one quarter (24.1%) reported having health insurance. Of those who had health insurance, 48% had Medi-Cal, 20% had Kaiser Permanente, and 12% had Blue Cross.

Figure 5. Sample: Employment Status



Most of the participants (88%) were born in the United States, and the average residency in Los Angeles exceeded 19 years. Using Los Angeles Police Department Bureaus, 50% of the sample (n=150) was located in the Central Bureau (including both central and east Los Angeles), 40% in the South Bureau, 7% in the Valley Bureau, and 3% in the West Bureau.

In Phase II of the pilot study, participants in the Central Bureau were more likely to be tested for HIV than those in the Valley Bureau. MAP was not able to conduct HIV testing in the San Fernando Valley, and Communities in Schools was not able to coordinate transportation of participants to a MAP testing location.

Data Analysis

Survey data were entered into ASCII files and audited for accuracy. The surveys were identified by confidential code, interviewer identification number, and geographic location of the participant (often a zip code or neighborhood area). HIV status by confidential code obtained from MAP was merged with the survey data file. Study consultants assisted in associating participants' geographic location with LAPD Police Bureau so that a broader geographic classification could be identified.

The attitude scales, knowledge scores, and risk indicators were calculated as described in the Instruments section.

Research Questions 1-7 were answered using descriptive statistics. Research Question 8 was answered using primarily contingency table analysis with Fisher's Exact Test or the Chi Square statistic, in which the association of attitude categories and selected demographic variables were tested. A t-test or one-way Analysis of Variance (ANOVA) was used to test for demographic differences in knowledge. Research Questions 9 and 11 could not be answered with data derived from the pilot study, and Research Question 10 was answered using bivariate Pearson correlation coefficients and hierarchical regression analysis in which risk behavior was regressed on demographic variables, knowledge, and attitudes. For purposes of the regression analysis only, a composite risk score was computed from four 12-month risk variables, as shown in Table 8. The sum of the four variables, ranging from 0-2, was the dependent composite risk score used in the regression analysis. Composite risk scores ranged from 0 to 8 (mean=2.9, sd=1.9; median=3.0).

Table 8. Coding of Composite Risk Score Components

Risk Variable	Code		
	0	1	2
Inconsistent condom use	Always or most of the time uses condoms	Sometimes or rarely uses condoms	Never uses condoms
Having sex while high or intoxicated	Never has sex after becoming high and/or intoxicated	Sometimes or rarely	Always or most of the time
Survival sex	No	Yes, Once	Yes, More than once
Sex with high risk partners	No high risk partners	Partner(s) in 1 high risk category	Partner(s) in 2-5 high risk categories

RESULTS

Research Question 1: What is the prevalence of HIV among Los Angeles gang members?

The prevalence of HIV infection in the pilot study was lower than expected, especially considering the age, ethnicity, and risk behaviors of the participants. A total of 144 HIV tests were conducted in Part II of the study. All tests were negative. An additional 65 participants had been previously tested for HIV at some time between 1994 and 2005. One participant reported being HIV positive, yielding a reported prevalence of 1/209, or 0.48% among the study sample. Among those who reported being tested, the reason cited most was “Someone suggested I should have a test.” (see Table 9). It would be of interest in follow-up studies to inquire as to why others suggested that participants be tested for HIV (e.g., their risk behaviors, etc.). Moreover, 20% of participants believed they had been tested as part of a battery of medical tests received. Future studies should examine the extent to which participants realize that

HIV tests require additional consent beyond the consent provided with other physical exams and medical tests.

Table 9. Reasons for Previous HIV Testing

Reason	n	% of Cases¹²
Someone suggested I should have a test	39	39.0
Other reason	22	22.0
It was part of a battery of medical tests	20	20.0
I thought I might be HIV positive	18	18.0
I was pregnant	9	9.0
It was required for employment or insurance	3	3.0

Research Question 2: What are Los Angeles gang members' attitudes towards HIV infection?

Gang membership is often associated with strong peer relationships and self-confidence, and participants in this study were highly likely to agree that they were able to protect themselves from HIV (self-efficacy) and had peer support to do so (see Table 10). Less than half of the participants considered themselves at risk for getting HIV, and nearly one quarter considered HIV to be stigmatizing.

¹² Because of multiple responses, % can exceed 100.

Table 10. What are Los Angeles Gang Members' attitudes towards HIV infection?

Scale¹³	% of Participants Who Agree
Access to Care I have access to health care	82.7
Self-Efficacy I can protect myself from HIV	78.3
Peer Support I have peer support to avoid HIV	66.2
Perceived Vulnerability I believe I am at risk	40.0
HIV Stigma There is stigma associated with HIV	22.7

Individual attitude statements that were not part of the attitude scales are included in Table 11. An overwhelming proportion wanted more public information about HIV (90%) and believed that HIV was a problem in their community (74%). More than half (58%) of the participants believed that “A cure for HIV exists but we aren’t being told about it,” and 39% believed that “HIV is a conspiracy against minorities.” Nearly one-third held the misconception that good health would protect them from HIV infection. Just under half (44%) believed that they don’t have to worry about HIV/AIDS because they don’t share needles or other “works,” and over one-third (37%) believed they don’t have to worry about HIV because they aren’t gay. Over a quarter (26%) of participants believe that they will probably die young anyway so it does not matter if they get HIV, and 24.7% are not worried about contracting the virus because they believe that if they take medicine, they will be “okay.” Despite the low percentage of participants that believed HIV to be stigmatizing (23%), over half indicated that their

¹³ Participants rated each item (1=Strongly Disagree, 2=Disagree, 3=Agree, 4=Strongly Agree). Scale scores were cut at 2.49 (1-2.49=Disagree; 2.50-4.0=Agree).

friends would shun them if they had HIV. Surprisingly, in a social group in which peer support is more powerful than family support, over 75% said their families would help them if they had HIV. This suggests that HIV may be perceived as more stigmatizing to peers than to family members.

Table 11. Attitudes Towards HIV Infection

Item	% of Participants Who Agree
There should be more public information about HIV	90.9
If I had HIV, my family would help me	77.8
HIV is a problem in my community	74.2
There is a cure for HIV, but we aren't being told about it	58.0
If I had HIV, my friends would stay away from me	53.7
I don't have to worry about HIV/AIDS because I don't share needles and/or "works"	44.4
HIV is a conspiracy against minorities	39.1
I don't have to worry about HIV/AIDS because I'm not gay	36.9
I am very healthy so my body can fight off an HIV infection	33.0
It doesn't matter if I get HIV because I'll probably die young anyway	26.0
I don't worry about getting HIV because if I take medicine, I'll be okay	24.7

Research Question 3: How accurate is the knowledge displayed by gang members regarding HIV/AIDS and the transmission of the virus?

Scores ranged from 0 to 31, with the average score on the knowledge test being 23.0 (standard deviation=5.24), or 74.1% correct. As seen in Table 12, participants struggled most with questions related to HIV transmission and medical knowledge about the virus. The desire for more public information, coupled with the importance of peer

support, suggest that the use of peer-based health education programs may be effective in increasing HIV knowledge and changing attitudes.

Table 12. Common Misconceptions

Medical Knowledge	% Incorrect
Most people who have HIV are sick with AIDS	57.3
People usually become very sick with AIDS a few days after being infected with HIV	47.3
A vaccine has recently been developed that prevents people from getting HIV	31.3
HIV Transmission	% Incorrect
People have been known to get HIV and develop AIDS by tongue kissing a person who is infected with HIV	47.7
With treatment, babies of HIV/AIDS mothers can be born without HIV/AIDS	44.0
You cannot get HIV from getting a tattoo	39.3
Men have a higher chance of getting AIDS from having sex with a woman than with a man	38.3
You can get HIV and eventually AIDS by donating blood	37.3
Lambskin condoms are better than latex condoms for preventing HIV infection	35.0
You are safe from HIV if you have oral sex without a condom	33.0
You can get HIV from having your body pierced	31.7

Research Question 4: What types of risk behaviors are gang members engaging in?

Most participants (97.3%) were sexually active and reported engaging in heterosexual behaviors only (87.6%) (see Figures 6 and 7). Lifetime and 12-month risk behaviors were calculated from the components of Question 89 of the survey. Lifetime was the first part of each component, and the question then branched to ascertain risk in the last 12 months. A total of 55 participants (11 males, 43 females, and 1 participant

of unknown gender) reported having sex with from 1-25 men over the past 12 months (mean=3.61, sd=4.73; median=2.0). A total of 231 participants (216 males, 8 females and 7 participants of unknown gender) reported having sex with 1-100 women over the past 12 months (mean=6.46, sd=11.15; median=3.0). Table 13 provides a summary of sexual partners by gender.

Table 13. Sexual Partners by Gender

	Men N=247	Women N=45
How many men have you had sex within the last 12 months?		
Mean	3.6	3.7
Median	2.0	2.0
Range	1-20	1-25
Standard Deviation	5.6	4.6
n	11	43
How many women have you had sex within the last 12 months?		
Mean	6.7	3.3
Median	3.0	2.0
Range	1-100	1-12
Standard Deviation	11.5	3.8
n	216	8

Figure 6. Lifetime Sexual Partners: Men^{14,15}

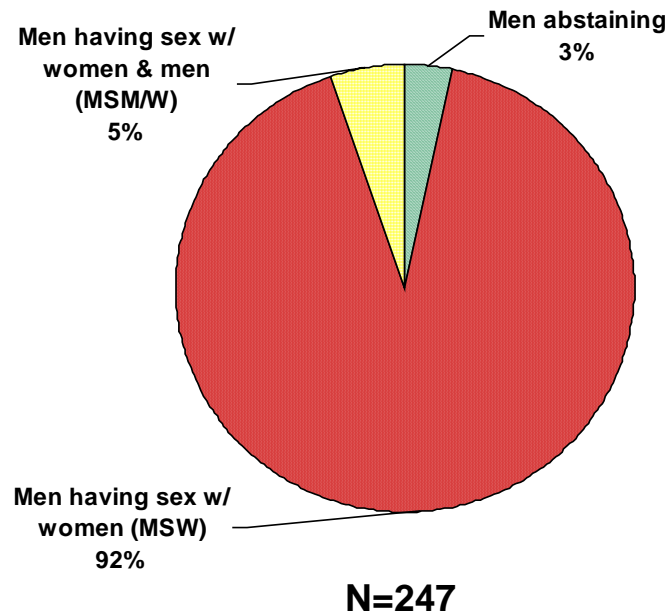
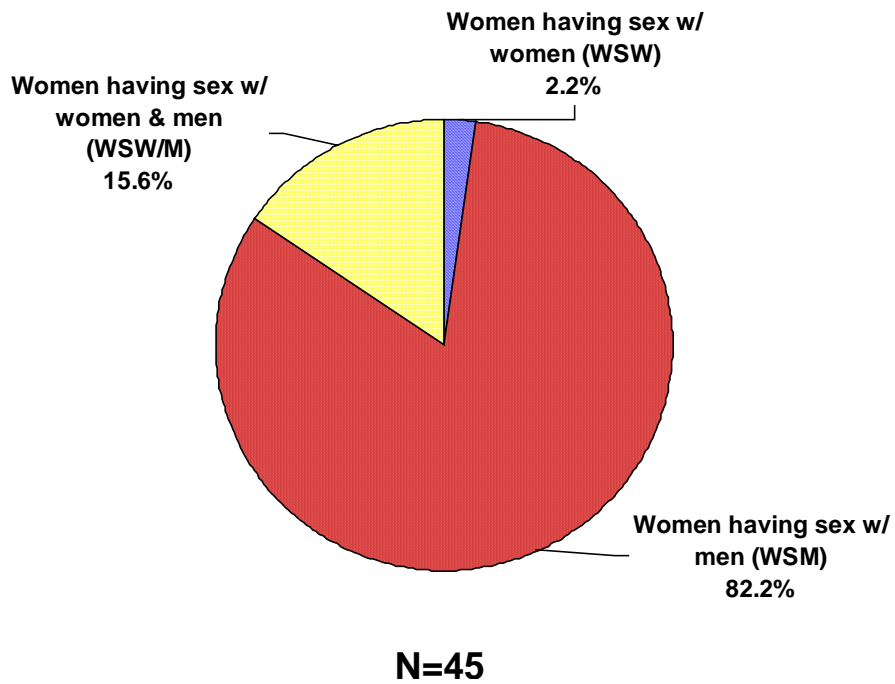


Figure 7. Lifetime Sexual Partners: Women^{15,16}



¹⁴ No men reported having sex with only men

¹⁵ 8 participants did not disclose their gender

¹⁶ No women reported abstaining

A total of 178 participants had been incarcerated at some time, and of those, 142 participants reported the number of days they had been incarcerated, which ranged from one day to over 8 years (median = 243.2 days). Most of the 20 participants who reported having sex while incarcerated had total incarceration time of more than six months. Of the twenty participants reporting sex while incarcerated, 41.2% were in county jail, 29.4% were in juvenile hall, 5.9% were in probation camp, 17.6% were detained by the youth authority, and 29.4% were in prison¹⁷.

Table 14 shows the lifetime and 12-month prevalence of various risk behaviors or risk factors. The data demonstrate small declines in engaging in vaginal sex, anal sex, sex while high or intoxicated, casual sex, sex while incarcerated, having an STD, injection drug use and sharing needles over the last 12 months compared to lifetime.

¹⁷ Participants may have been incarcerated in more than one type of facility.

Table 14. Lifetime and 12-Month High Risk Behaviors

Behavior	Lifetime N=300 ¹⁸		Last 12 Months N=300 ⁸	
	n	%	n	%
Sexually Active	291	97.3	292	97.3
Vaginal Sex	277	92.6	254	84.7
Anal Sex	125	41.7	114	38.0
Inconsistent Condom Use ¹⁹			266	88.7
Heavy Alcohol Use ^{9,20}			190	97.9
Drug Use ⁹			262	87.3
Sex while High or Intoxicated	258	88.6	146	48.7
Survival Sex	78	26.9	78	26.1
Casual Sex (Sex with Someone You Just Met)	216	72.7	195	65.0
Sex with Multiple Partners	80	26.9	74	25.6
Incarceration ²¹	178	59.9		
Sex while Incarcerated	20	11.2	16	9.0
Sex with High Risk Partners ⁹			86	28.8
STDs	58	19.4	50	16.7
Injected Street Drugs	37	12.4	23	7.7
Shared Needles	22	7.4	3	1.0
High Risk Tattooing ¹¹	118	39.3		
High Risk Piercing ¹¹	48	16.0		

Detailed information about drug use revealed that of the 262 drug users, the drug of choice was marijuana (overall, 92%), which did not differ by race/ethnicity or gender

¹⁸ Some N's are less than 300 due to non-response.

¹⁹ Survey question does not allow for lifetime estimation.

²⁰ Had 4-5 drinks on the same occasion in the past month. Answered by only 104 participants.

²¹ Survey question does not ask for 12-month information.

(see Tables 15, 16, and 17). Approximately 25% to 30% of the participants were using crack cocaine, methamphetamine or ecstasy. Latino participants were three to six times more likely to use heroine, powder cocaine, crack cocaine, methamphetamine, or inhalants than were African-Americans. African-American participants were twice as likely to use ecstasy compared to Latinos. Men were three to six times more likely to use heroine, powder cocaine, crack cocaine, and psychedelics than women.

Table 15. Drug Use

Drug use in the last 12 months	TOTAL	
	n	%
Marijuana	240	91.6
Crack Cocaine	77	29.4
Methamphetamine	63	24.0
Ecstasy	62	23.7
Powder Cocaine	52	19.8
Heroine	23	8.8
Psychedelics	23	8.8
Other	15	5.7
Inhalants	10	3.8

Table 16. Drug Use by Race

Drug use in the last 12 months	African-American		Latino	
	n	%	n	%
Crack Cocaine	8	8.2	68	42.0
Ecstasy	32	33.0	29	17.9
Heroin	2	2.1	21	13.0
Inhalants	1	1.0	9	5.6
Marijuana	92	94.8	145	89.5
Methamphetamine	10	10.3	50	30.9
Powder Cocaine	7	7.2	41	27.2
Psychedelics	10	10.3	10	6.2
Other	4	4.1	11	6.8

Table 17. Drug Use by Gender

Drug use in the last 12 months	Men		Women	
	n	%	n	%
Crack Cocaine	71	32.0	2	5.9
Ecstasy	55	24.8	7	20.6
Heroin	22	9.9	1	2.9
Inhalants	9	4.1	1	2.9
Marijuana	203	91.4	31	91.2
Methamphetamine	53	23.9	8	23.5
Powder Cocaine	49	22.1	2	5.9
Psychedelics	22	9.9	1	2.9
Other	15	6.8	0	0

Older participants (ages 21-26) were more likely to use heroine, powder cocaine, crack cocaine, and methamphetamines than younger participants (ages 17-20). Younger participants were more likely to use ecstasy than were older participants.

Research Question 5: What steps do gang members take to protect themselves and others from HIV infection?

Despite the high percentage of participants who reported on the attitudes section of the survey that they felt efficacious about protecting themselves against HIV (see page 20), most gang members were doing little to protect themselves or others from HIV infection. Only 11.3% of participants reported using condoms always or most of the time, or abstaining from sex. Only 16.1% of the sexually active participants reported being monogamous in the past 12 months. Just over 1/3 of the participants (37%) reported getting tattoos or body piercings only in licensed shops. While two-thirds of the participants had used a condom to protect against HIV/AIDS at some time in their lives, only about half (53.3%) had used this protective behavior in the past 12 months. However, nearly three-fourths (71.2%) reported not having sex with people engaging in high risk behaviors.

Research Question 6: Is there a significant relationship between attitudes, behaviors, personal characteristics, and HIV prevalence?

As noted in the findings for Research Question 1, all 144 of the HIV tests conducted were negative, and only one participant reported a previous positive HIV test, so there is not enough information to answer Research Question 6 in this pilot study.

Research Question 7: How does HIV prevalence in gang members compare with community wide prevalence?

Using self-report of HIV status from the survey, results of the pilot survey suggest that HIV prevalence among gang members is lower than the 1% found in the general population²². All of the pilot study participants were young people, a group with higher HIV prevalence than the general public²³. African-Americans, an over-represented group among HIV positive people²⁴, make up 36% of the pilot study participants. African-American women, who make up nearly 6% of the pilot study participants, are the fastest growing group acquiring HIV infection²⁵. Based on reported risk behaviors, gang members appear to be at risk for HIV infection; if everyone in the sample had been tested or a larger sample of gang members had been tested, prevalence may have exceeded that of the general community.

Research Question 8: Are there differences in knowledge, attitudes, or behaviors according to selected demographic characteristics?

Were there any differences between participants who volunteered to be tested and those who did not?

The participants were homogeneous in terms of their willingness to be tested, which differed neither by race/ethnicity, gender, age group, or other demographic

²² Centers for Disease Control and Prevention (2001). *HIV Prevalence Trends in Selected Populations in the United States: Results from National Serosurveillance, 1993–1997*. Atlanta: Centers for Disease Control and Prevention.

²³ Centers for Disease Control and Prevention (2004). *HIV/AIDS Surveillance Report, 2003 (Vol.15)*. Atlanta: US Department of Health and Human Services, Center for Disease Control and Prevention.

²⁴ Centers for Disease Control and Prevention (2004). *HIV/AIDS Surveillance Report, 2003 (Vol.15)*. Atlanta: US Department of Health and Human Services, Center for Disease Control and Prevention.

²⁵ Centers for Disease Control and Prevention (2004). Diagnoses of HIV/AIDS—32 states, 2000–2003. *MMWR*; 53:1106–1110.

factors, risk behaviors, knowledge or attitudes with the exception of Stigma and Access to Care. Participants who believed that HIV is stigmatizing were significantly less likely to be tested (35.3%) than those who did not believe it is stigmatizing (51.7%).

Participants who scored higher on the Access to Care scale were more likely to be tested (51.2%) than those who scored lower (33.3%).

Were there any differences by race/ethnicity?

Attitudes

While HIV prevalence is higher among African-Americans than Latinos, Latinos were nearly twice as likely as African-American participants (46.1% vs. 28.7%) to score high in Perceived Vulnerability and conversely, are somewhat more likely (29.3% vs. 16.8%) to hold the misconception that they don't worry about HIV because they would be OK if they took their medicine. African-Americans, on the other hand, were significantly more likely to desire more public information about HIV, to believe they can fight off HIV infection by staying healthy, and to believe that there is a cure they aren't being told about (see Table 18).

Table 18. Significant Differences in Attitudes by Race/Ethnicity

Attitude	% Agree		P value
	African-American	Latino	
Scale: Perceived Vulnerability – I believe I am at risk	28.7	46.1	<.01
Scale: Access to Care – I have access to health care	89.8	78.9	<.05
There is a cure for HIV, but we are not being told about it	66.0	53.8	<.05
There should be more public information about HIV	96.3	87.8	.01
I am very healthy so my body can fight off an HIV infection	40.0	28.7	<.05
I don't worry about getting HIV because if I take medicine, I'll be okay	16.8	29.3	<.05

Knowledge

There were no differences in overall knowledge according to race/ethnicity; however, Latinos were more likely than African-Americans to have the misconception that lambskin condoms are better than latex condoms for preventing HIV infection (40.2% versus 25.2%). African-Americans were more likely than Latinos to have the misconception that people have been known to get HIV and develop AIDS by tongue kissing (57.0% vs. 43.0%) and the misconception that you cannot get HIV from having your body pierced (41.1% vs. 26.5%).

Risk Behaviors

The two groups were quite similar in their risk behaviors. As seen in Tables 19 and 20, Latino participants were more likely to report inconsistent use of condoms and also more likely to report injecting street drugs, steroids, or vitamins. African-Americans were more likely to report sex with multiple partners at the same time.

Table 19. Risk Factors by Race/Ethnicity – Last 12 Months

Risk Factor	African-American N=107 ²⁶		Latino N=189 ²⁷		Total N=296 ²⁸	
	n	%	n	%	n	%
Sexually Active	105	98.1	183	96.8	288	97.3
Vaginal Sex	87	97.4	164	99.4	251	98.8
Anal Sex	44	41.1	69	36.5	113	38.2
Inconsistent Condom Use	88	82.2	174	92.1	262	88.5
Heavy Alcohol Use	59	55.1	128	67.7	187	63.2
Drug Use	97	90.6	162	85.7	259	87.5
Sex While High or Intoxicated	52	48.6	93	49.2	145	49.0
Survival Sex	35	33.0	43	22.8	78	26.4
Casual Sex (Sex with Someone You Just Met)	67	62.6	125	66.1	192	64.9
Sex with Multiple Partners at the same time	39	36.4	34	17.9	73	24.7
Sex while Incarcerated	7	6.5	9	4.8	16	6.1
Sex with High Risk partners	29	27.4	55	29.1	84	28.5
STDs	18	16.8	30	15.9	48	16.2
Injected Street Drugs	4	3.7	18	9.5	22	7.4
Shared Needles	1	0.9	2	1.1	3	1.0

²⁶ Some Ns are less than 107 due to non-response.

²⁷ Some Ns are less than 189 due to non-response.

²⁸ Some Ns are less than 296 due to non-response.

Table 20. Risk Factors by Race/Ethnicity – Lifetime

Risk Factor	African-American N=107 ²⁹		Latino N=189 ³⁰		Total N=296 ³¹	
	n	%	n	%	n	%
Sexually Active	105	98.1	184	97.4	289	97.6
Vaginal Sex	99	92.5	175	93.1	274	92.9
Anal Sex	49	46.2	74	39.6	123	42.0
Sex while High or Intoxicated	92	86.8	170	89.9	262	88.8
Survival Sex	35	33.0	43	22.8	78	26.4
Casual Sex (Sex with Someone You Just Met)	76	71.7	136	72.7	212	72.4
Sex with Multiple Partners at the same time	41	38.7	38	20.3	79	27.0
Ever Incarcerated	63	59.4	112	59.9	175	59.7
Sex While Incarcerated	7	6.6	13	6.9	20	6.8
STDs	21	19.8	35	18.5	56	19.0
Injected Street Drugs	7	6.6	29	15.4	36	12.2
Shared Needles	4	3.8	18	9.5	22	7.5
High Risk Tattooing	35	32.7	81	42.9	116	39.2
High Risk Body Piercing	13	12.1	35	18.5	48	16.2

²⁹ Some Ns are less than 107 due to non-response.

³⁰ Some Ns are less than 189 due to non-response.

³¹ Some Ns are less than 296 due to non-response.

Were there any differences by gender?

The only gender differences were found in risk behaviors. As seen in Tables 21 and 22, men were more likely to report engaging in survival sex – either giving or receiving money/drugs for sex – than women. Men engaged in more risky behaviors than did women in the last 12 months and over their lifetimes. In fact, men were at least twice as likely as women to have sex while high or intoxicated, to engage in survival sex, to have sex with multiple partners at the same time, and to inject street drugs within the last twelve months. Additionally, in their lifetimes, men were at least twice as likely as women to have sex while incarcerated, share needles and works, and engage in high risk tattooing.

Table 21. Risk Factors by Gender – Last 12 Months

Risk Factor	Male N=247 ³²		Female N=45 ³³		Total N=292 ³⁴	
	n	%	n	%	n	%
Sexually Active	239	96.8	45	100	284	97.3
Vaginal Sex	210	98.6	38	100	248	98.8
Anal Sex	98	39.7	12	26.7	110	37.7
Inconsistent Condom Use	219	88.7	40	88.9	259	88.7
Heavy Alcohol Use	160	64.8	25	55.6	185	63.4
Drug Use	222	89.9	34	75.6	256	87.7
Sex while High or Intoxicated	130	52.6	13	28.9	143	49.0
Survival Sex	73	29.7	4	8.9	77	26.5
Casual Sex (Sex with Someone You Just Met)	169	68.4	21	46.7	190	65.1
Sex with Multiple Partners at the same time	66	26.7	6	13.3	72	24.6
Sex while Incarcerated	16	6.5	0	0	16	5.5
Sex with High Risk Partners	68	27.6	15	33.3	83	28.5
STDs	41	16.6	8	17.8	49	16.8
Injected Street Drugs	21	8.5	2	4.4	23	7.9
Shared Needles	3	1.2	0	0	3	1.0

³² Some Ns are less than 247 due to non response.

³³ Some Ns are less than 45 due to non response.

³⁴ Some Ns are less than 292 due to non response.

Table 22. Risk Factors by Gender – Lifetime

Risk Factor	Male N=247 ³⁵		Female N=45 ³⁶		Total N=292 ³⁷	
	n	%	n	%	n	%
Sexually Active	240	97.2	45	100	285	97.6
Vaginal Sex	227	92.3	42	93.3	269	92.4
Anal Sex	107	43.3	14	31.1	121	41.4
Sex while High or Intoxicated	221	89.8	38	84.4	259	89.0
Survival Sex	73	29.7	4	8.9	77	26.5
Casual Sex (Sex with Someone You Just Met)	188	76.7	23	51.1	211	72.8
Sex with Multiple Partners at the same time	71	29.1	7	15.6	78	27.0
Ever Incarcerated	159	65.2	15	33.3	174	60.2
Sex While Incarcerated	19	7.8	1	2.2	20	6.9
STDs	49	19.9	8	17.8	57	19.6
Injected Street Drugs	34	13.9	3	6.7	37	12.8
Shared Needles	22	8.9	0	0	22	7.6
High Risk Tattooing	109	44.1	8	17.8	117	40.1
High Risk Piercing	39	15.8	7	15.6	46	15.8

Were there any differences by education level?

There were no differences in knowledge according to educational level.

Attitudes

Formal education was associated with positive attitudes among participants. As seen in Table 23, participants who completed high school were more likely to score high

³⁵ Some Ns are less than 247 due to non response.

³⁶ Some Ns are less than 45 due to non response.

³⁷ Some Ns are less than 292 due to non response.

on the Self-Efficacy and Peer Support scales and also more likely to report that their families would help them if they had HIV. Participants who did not complete high school were more likely to believe that their friends would stay away from them if they had HIV.

Table 23. Significant Differences in Attitudes by Education Level

Attitude	% Agree		P value
	Completed High School	Did Not Complete High School	
Scale: Self-Efficacy – I can protect myself from HIV	85.4	74.3	<.05
Scale: Peer Support – I have peer support to avoid HIV	73.0	61.2	<.05
If I had HIV, my family would help me	83.9	72.4	<.05
If I had HIV, my friends would stay away from me	47.7	52.7	.05

Risk Behaviors

Formal education was associated with avoidance of intravenous drug use and needle sharing. Participants who did not complete high school were significantly more likely than participants who completed high school to inject street drugs, steroids or vitamins in their lifetime (17.0% vs. 7.4%) and also more likely to share needles in their lifetime (10.8% vs. 3.7%).

Were there any differences by age?

There were no differences in knowledge about HIV/AIDS by age group.

Attitudes

There were no significant associations between attitudes and age group except for Perceived Vulnerability: Only 30.8% of younger participants (ages 17-20) believed they were at risk for HIV, compared with nearly 50% of the two older age groups.

Risk Behaviors

Older participants have had more time to accumulate high lifetime risks. As seen in Table 24, older participants were more likely to report being tattooed, having body-piercings, being incarcerated, having an STD, and having anal sex in their lifetime.

Table 24. Significant Differences in Risk Behaviors by Age

Risk Behavior	% At-Risk			P value
	17-20	21-23	24-26	
Had an STD	13.4	26.0	21.7	<.05
Incarceration	52.9	61.5	76.1	<.05
High Risk Tattooing	31.5	45.2	52.2	<.05
High Risk Body Piercings	14.0	13.5	28.3	<.05
Ever had anal sex	40.1	36.9	60.0	<.05

Were there any differences by health insurance status?

There were no significant associations between insurance status and risk behaviors.

Attitudes

Having health insurance was associated with more positive attitudes about HIV. As seen in Table 25, participants without health insurance were more likely to believe they were at risk for HIV (Perceived Vulnerability) and to also believe that there is a cure for HIV, but we are not being told about it. Participants with health insurance were more likely to score high on the Access to Care, Self-Efficacy, and Peer Support scales. They were also more likely to believe that their families would help them if they had HIV.

Table 25. Significant Differences in Risk Behaviors by Health Insurance Status

Risk Behavior	% Agree		P value
	Health Insurance	No Health Insurance	
Scale: Perceived Vulnerability – I believe I am at risk	25.0	44.7	<.01
Scale: Access to Care – I have access to health care	93.1	79.6	<.01
Scale: Self-Efficacy – I can protect myself from HIV	91.7	74.3	<.01
Scale: Peer Support – I have peer support to avoid HIV	79.2	62.2	.01
If I had HIV, my family would help me	88.7	74.1	<.01
There is a cure for HIV, but we are not being told about it	46.5	62.3	<.05

Knowledge

Participants with health insurance were more knowledgeable than those without health insurance. The average score on the knowledge test for participants who had health insurance (24.44) was significantly higher than the average score of participants who did not have health insurance (22.51).

Research Question 9: Do patterns of prevalence differ according to demographic characteristics?

As noted in the findings for Research Question 1, all 144 of the HIV tests conducted were negative, and only 1 participant reported being HIV positive on the survey. Hence, there is not enough information to answer Research Question 9.

Research Question 10: What is the relationship between knowledge and self reported attitudes and risk behaviors?

Correlations were computed to examine the relationships among knowledge, attitudes, and self-reported risk behaviors. There were no significant correlations found between knowledge and risk behaviors, suggesting that knowledge has a weak relationship to risk behavior.

As seen in Table 26, significant correlations beyond +/- .30 were found between knowledge and scores on three of the attitude scales: Self-Efficacy, Stigma, and Access to Care. Self-Efficacy and Access to Care were both positively correlated with knowledge, suggesting that as each increase, total knowledge also increases. HIV Stigma was negatively correlated with knowledge; as knowledge increases, the belief that HIV is stigmatizing decreases.

Table 26. Attitudes and Knowledge

Attitudes	Knowledge
Perceived Vulnerability	-.25*
Self-Efficacy	.47*
Peer Support	.27*
HIV Stigma	-.52*
Access to Care	.31*

* p<.001

As seen in Table 27, six correlations beyond +/- .30 were found between various attitudes and risk behaviors. Self-Efficacy was negatively related to inconsistent condom use and having sex while high or intoxicated in the last twelve months, suggesting that

as participants feel more efficacious about their ability to avoid HIV, risk associated with inconsistent condom use and having sex while high or intoxicated decreases. Perceived vulnerability was positively correlated with having sex with high risk people and having sex while high or intoxicated in the last twelve months. Finally, peer support was negatively correlated with having sex while high or intoxicated in your lifetime and also with having sex with someone you just met in your lifetime. As Peer Support increases, risk associated with having sex while high or intoxicated and having sex with someone you just met tends to decrease.

Table 27. Attitudes and Risk Behaviors

Risk Behavior	Self-Efficacy	Perceived Vulnerability	Peer Support
Inconsistent Condom Use in the Last 12 Months	-.40*		
Sex While High or Intoxicated in Last 12 Months	-.36*	.33*	
Sex While High or Intoxicated in Your Lifetime			-.32*
Sex With High Risk People in the Last 12 Months	.30*		
Sex With High Someone You Just Met in Your Lifetime			-.31*

* $p < .001$

A regression analysis was conducted to examine the unique effects of demographics (race/ethnicity, gender, age, and number of years of formal education), attitude scores (Perceived Vulnerability, Self-Efficacy, Peer Support, HIV Stigma, and Access to Care), and knowledge on a composite risk behavior score. Demographic characteristics and knowledge score each accounted for a significant but small proportion of variance of risk behavior. Attitudes accounted for a large and significant

amount of variance in risk behavior. Confirming previous theories such as the Health Belief Model, Perceived Vulnerability and Self-Efficacy were the only variables found to significantly explain risk ($t=2.89$, $p<.01$ and $t=-4.36$, $p<.001$, respectively). When Perceived Vulnerability increases, the prevalence of risk behaviors also tends to increase. When Self-Efficacy increases, the prevalence of risk behaviors tends to decrease.

Research Question 11: What attitudes, behaviors, knowledge, and demographic characteristics are significant predictors of a positive HIV result?

As noted in the findings for Research Question 1, all 144 of the HIV tests conducted were negative, and only 1 participant reported being HIV positive on the survey. Hence, there is not enough information to answer Research Question 11.

STUDY LIMITATIONS

Because gang members are a marginalized group, it is challenging to implement a probability sampling plan with them. Ideally, cluster sampling should be used to first sample the agencies providing services to gang members and then to obtain a list of gang members that each agency believes is accessible to them from which a sample can be drawn. However, gang intervention workers are uncomfortable with (and it may be dangerous for them to) identifying the names of gang members.

There were some differences about the definition of an active gang member across agencies, which were probably related to the philosophy used to help gang members exit gangs (working with gang members more on the periphery, and “picking

them off” from the outside vs. working with gang leaders in hopes of winning over more members at once). Such differences in philosophies may have influenced the recruitment and selection of participants for the study.

There were several barriers to working with gang intervention workers and their supervisors. Although all agencies recruited for this study recognized the risk of HIV among their clients, only a few were comfortable discussing risk behaviors openly. The preferred method of data collection, the individual interview with questions read aloud to the participant (to ensure understanding of each question and overcome issues of reading level), was awkward for some of the workers who became trained as RAs.

Logistically, all RAs had another primary job that had to take precedence over data collection for this project. Personal problems or community unrest came first. Moreover, the project manager and field coordinator had to focus more than usual on maintaining the integrity of the data, and some surveys had to be removed from the database due to inconsistencies or absent consent forms.

There was a difference of opinion among researchers and RAs on the team as to whether the incentive for gang members (\$50.00 for completing both the survey and HIV test) was too high and might have provoked a sampling bias or measurement error. Likewise, the incentive for RAs (\$15.00) also needs to be examined for its appropriateness.

The plan to coordinate HIV testing in close proximity (time and place) with survey completion was successful only about three-quarters of the time. Miscommunication or equipment failures were most often the cause of difficulties.

In future studies, the attitude section of the survey could be shortened to exclude some of the items that did not work well. The knowledge test could be made more sensitive by selecting primarily the items about which many gang members had misconceptions. The risk behaviors section of the survey could be focused on the behaviors that have been shown to be most predictive of HIV, such as inconsistent condom use, survival sex, sex with high risk partners, sex while high or intoxicated, casual sex, and sex while incarcerated. More detailed information about reasons for previous HIV testing could also be obtained.

SUMMARY AND DISCUSSION

Demographics

Participants ranged in age from 17 to 26 years, with nearly half being under age 21. However, on average, participants reported having joined a gang at age 13, suggesting that HIV education and prevention may be needed at an early age. Over half of the participants had not completed high school indicating that school-based HIV interventions for gang members are likely not sufficient mechanisms for preventing infection. Finally, it is important to note that an overwhelming number of participants reported living with others (e.g., parents, relatives, partners), and 38% reported having children. Hence, the high risk behaviors reported here have the potential to affect entire families.

HIV Prevalence

As noted in the Results section, prevalence was less than half a percent. This result was lower than expected, particularly when considering the high risk behaviors

reported by participants (e.g., sexual risk, drug use, etc.) It is important to note that the sample for the study was relatively small; a larger sample might result in different findings. Another potential limitation in this study is that participants determined whether or not to be tested for HIV. It is possible that participants who self-selected to be tested were fairly confident they did not have HIV; hence, there was little risk to them in participating in Part II. Lastly, participants may also have underreported their HIV+ status in Question 97 of the survey.

Attitudes about HIV

Findings from this study suggest that attitudes – particularly Perceived Vulnerability and Self-Efficacy – are the best predictors of risk among gang members. As scores on the Perceived Vulnerability scale increased, the prevalence of risk behaviors also increased. As Self-Efficacy increased, the prevalence of risk behaviors decreased. This finding is consistent with other research on health education and prevention: attitudes are generally better predictors of behavior than are demographics or knowledge. Increasing self-efficacy would likely have the greatest impact on reducing risk in gang members.

Peer support is a critical aspect of adolescent development, and plays a key role in gang formation and decision-making about gang membership. The findings from this study also suggest that the influence of peers is particularly important for gang members in terms of acquiring HIV risk-reduction skills. Many of the participants who reported previously being tested for HIV were encouraged to do so by someone else. Participants also believe they have peer support to help them avoid HIV.

Furthermore, the belief that HIV is stigmatizing was significantly related to the likelihood of being tested. Participants who scored high on the HIV Stigma scale were less likely to be tested. In addition, although only 23% of participants believed HIV was stigmatizing, over half of participants believed that their friends would stay away from them if they had HIV.

Many gang members also exhibited attitudes that put them at risk for HIV. Less than half of gang members believed they were at risk for HIV (Perceived Vulnerability). Nearly half believed they did not have to worry about HIV because they did not share needles, and over a third were not worried about HIV because they were not gay, suggesting that many gang members do not believe they are “the type” that is vulnerable to HIV. Furthermore, many gang members believed that they were healthy enough to fight off an HIV infection, or that if they had HIV and took medicine they would be OK, confirming that many gang members have misconceptions about the disease.

Gang members also seem to believe in conspiracy theories related to HIV. A high number of participants perceive that there is a cure for HIV, but they are not being told about it, and that HIV is a conspiracy against minorities. Despite these beliefs in conspiracy theories, gang members also think that HIV is a problem in their community and that there should be more public information about HIV.

Knowledge about HIV

In general, gang members are fairly knowledgeable about HIV. They lack knowledge in some areas related to medical facts about the virus and HIV transmission. Because of the high risk behaviors reported by many gang members, educational

interventions should focus on misconceptions related to HIV transmission. For example, nearly 40% of gang members did not think you can get HIV from getting tattoos. Additionally, many gang members think that lambskin condoms are better than latex condoms for preventing HIV infection. Given the prevalence of tattoos and sexual activity among gang members, it is particularly important for them to understand the risks involved.

Risk Behaviors

Gang members are engaging in several high risk sexual behaviors. Nearly all of them are sexually active; nearly all of those who are sexually active report inconsistent condom use. Furthermore, a majority of gang members report having sex while high or intoxicated and having sex with someone they just met. Over a quarter of gang members reported having sex with high risk partners, survival sex, and sex with multiple partners at the same time.

As in other vulnerable populations, such as sex workers, injection drug use was reported far less often than the use of other drugs (e.g., marijuana, ecstasy, etc.). However, when gang members were injection drug users, they were highly likely to share needles and/or works, suggesting that gang members might benefit from clean needle programs. In general, drug use in the population is high; over 85% of gang members reported drug use in the last twelve months. Furthermore, it is important to note that drug use differed by race/ethnicity. For example, Latinos were more likely to use cocaine and methamphetamines, whereas African-Americans were more likely to use ecstasy.

Finally, tattooing was extremely prevalent among gang members. Gang members were often tattooed by friends or in prison, jail, or juvenile hall rather than in a licensed tattoo parlor.

RECOMMENDATIONS

Implications for HIV Prevention

The current sexual and substance use behaviors of gang members place them at high risk of contracting or transmitting HIV. Prevention efforts are needed to help reduce these behaviors among the gang population of Los Angeles. Effective HIV prevention programs developed for other at-risk young people, such as runaway and homeless youth, could serve as a starting point for developing interventions for gang-affiliated populations. An intervention designed to address attitudes and beliefs about HIV; that capitalizes on the importance of peer support and influence among gang members; and that has a strong emphasis on skill-building to reduce sexual and substance abuse behaviors would be particularly appropriate for gang members, as described in recommendations 1-11.

1. CDC-identified effective behavioral interventions for high risk young people can be adapted for gang-affiliated populations. This would be a cost effective way of developing an HIV prevention program that could be tailored to the specific issues of Los Angeles gang members as well as individual neighborhoods.
2. HIV prevention efforts should focus on promoting personal goal setting and reducing sexual and substance abuse risk behaviors. A peer support approach

that includes building a social support network would help gang members gain risk reduction skills and change behaviors.

3. Gang members would benefit from targeted knowledge (e.g., HIV transmission through tattoos, effective condom use) to decrease their risk-taking behaviors.
4. High prevalence of risky sexual behavior suggests the need for HIV prevention efforts focused on reducing sexual risk, and in particular, on enhancing the efficacy of gang members to use condoms for protection.
5. HIV prevention efforts must also address substance abuse behaviors (particularly substances highly correlated with HIV transmission such as methamphetamines, crack cocaine, and ecstasy).
6. Safe procedures for tattooing and piercing should be part of any HIV educational intervention designed for gang members.
7. Thirty-eight percent of gang members reported having children. The issue of family responsibility should be included as a topic in HIV prevention programs for this population.
8. Two-thirds of gang members reported being unemployed. Combining HIV prevention education with job training and counseling programs may be a way of reaching this population.
9. Peer outreach might be an effective approach to take to get gang members to participate in HIV prevention programs as well as encourage them to be tested.
10. Destigmatizing HIV could further encourage testing among gang members.

11. Because HIV is considered a community problem by gang members, it is possible that they might be interested in constructively participating in a public information campaign.

Implications for Future Research

This pilot study was the first of its kind to systematically examine HIV prevalence, knowledge, attitudes, and risk behaviors among gang-affiliated youth. As a result, this study provided the opportunity to pilot procedures for accessing, recruiting, and surveying gang members as well as for testing them for HIV. Suggestions for improving study procedures in future research are listed in recommendations 12-18 below.

12. Conduct a follow-up study with a larger sample, using cluster sampling and a coding system to obtain a sampling frame from each gang intervention agency.

13. Select gang intervention agencies representing major gang areas across Los Angeles and conduct HIV education for all gang intervention workers and case managers at each agency.

14. Obtain a coded list of active gang members from each agency's case manager and randomly sample from each list.

15. Consider hiring a small number of full time temporary data collectors to administer the survey to gang members in each agency throughout the study.

16. Revise the survey based on findings of the pilot study.

17. Subcontract with one or more HIV testing services such that all geographic areas participating in the study are physically served.

18. Change the incentive structure so that participants receive \$10.00 for survey completion and \$25.00 for HIV testing. Try to coordinate HIV testing so that it is available at the time of surveying.

Appendixes

Appendix A

Instrument

Section B

Please mark whether you “Strongly Agree”, “Agree”, “Disagree” or “Strongly Disagree” by placing an in the appropriate column for each of the following statements.

	Strongly Agree	Agree	Disagree	Strongly Disagree
13. I think I know the facts about HIV/AIDS and how you get it.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. With medication, people with HIV/AIDS can still live long and healthy lives.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. It doesn't matter if I get HIV/AIDS because I'll probably die young anyway.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I don't have to worry about HIV/AIDS because I'm not gay.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I don't have to worry about HIV/AIDS because I don't share needles and/or “works”.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. If I had HIV/AIDS, my family would help me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. HIV/AIDS is a conspiracy (plan) against minorities.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. My friends have changed the way they have sex because of HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. The thought of getting HIV/AIDS scares me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. It's easy to get condoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. There is a good chance I will get HIV/AIDS during the next five years.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I think HIV/AIDS is a problem in my community.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. My friends practice “safer” sex.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. There is still time for me to protect myself against HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I am at risk for HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Strongly Agree	Agree	Disagree	Strongly Disagree
28. My friends think that practicing “safer” sex can lower the spread of HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. It is important to protect myself from HIV/AIDS....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Using condoms means you really care about someone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. My friends think that it is too much trouble to use condoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. My friends are at high risk for HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Anyone who gets HIV/AIDS deserves it.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. I don’t use condoms because sex is better without them.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. There is a possibility that I have HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. My friends talk about how to protect themselves from getting HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. I may have had sex with someone who was at risk for HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. People like me do not get HIV infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. It is a hassle to use condoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. My sexual activities put me at risk for HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. HIV/AIDS is a punishment from God.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. I am very healthy so my body can fight off an HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. If I had HIV/AIDS, I would want to know.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. It’s easy to get clean needles and “works” if you need them.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Strongly Agree	Agree	Disagree	Strongly Disagree
45. I am worried that I might get an HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Condoms are irritating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. If I had HIV/AIDS, my friends would stay away from me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. There is a cure for HIV/AIDS but we are not being told about it.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. There should be more information about HIV/AIDS available to the public.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. I don't worry about getting HIV/AIDS because if I take medicine, I'll be okay.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. If someone gave me HIV/AIDS, I wouldn't care if I gave it to someone else.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. I would only worry about getting HIV/AIDS if I went to jail.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. I would kill myself if I found out I had HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. If I found out someone had HIV/AIDS, I would stay away from them.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. If I had HIV/AIDS, there is a place I could go to get treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. I am able to see a doctor when I get sick.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. If I had HIV/AIDS, I would get medical care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section C

Please circle "T" if you think the following statement is true. Circle "F" if you think the following statement is false.

True False

- T F 58. Most people who develop AIDS eventually get better.
- T F 59. A baby born to a mother with HIV/AIDS can get HIV/AIDS.
- T F 60. HIV is carried in the blood.
- T F 61. Most people who have HIV infection are sick with AIDS.
- T F 62. HIV/AIDS is carried in men's cum (semen).
- T F 63. AIDS weakens the body's ability to fight off disease.
- T F 64. People have been known to get HIV and develop AIDS from toilet seats.
- T F 65. If the HIV test comes out negative, it means that the person has AIDS.
- T F 66. You can die from AIDS.
- T F 67. Men have a higher chance of getting AIDS from having sex with a woman than from having sex with a man.
- T F 68. Using a condom will lower the chance of getting AIDS.
- T F 69. It is safe to have sexual intercourse without a condom with a person who shoots drugs as long as you don't shoot drugs.
- T F 70. People of any race can get HIV and develop AIDS.
- T F 71. People have been known to get HIV and develop AIDS by tongue kissing a person who is infected with HIV/AIDS.
- T F 72. Lambskin condoms are better than latex condoms for preventing HIV infection.
- T F 73. People usually become very sick with AIDS a few days after being infected with HIV.
- T F 74. It is safer not to have sexual intercourse at all than to have sexual intercourse using a condom.

True False

- T F 75. Pregnant women are safe from getting HIV infection.
- T F 76. A vaccine has recently been developed that prevents people from getting HIV infection (which can lead to AIDS).
- T F 77. HIV can be passed by an infected person who doesn't look sick.
- T F 78. People have been known to get HIV and develop AIDS by eating at a restaurant where a worker has AIDS.
- T F 79. You can get HIV and eventually AIDS through an open cut or wound.
- T F 80. You are safe from AIDS if you have oral sex (with mouth to penis or mouth to vagina) without a condom.
- T F 81. Anal (rear end) sex without a condom is one of the safer sexual practices.
- T F 82. You can get HIV and eventually AIDS by donating blood.
- T F 83. Using drugs like marijuana, alcohol, cocaine and crack makes it more likely that you may have unsafe sex.
- T F 84. You can get HIV/AIDS by getting tested for it.
- T F 85. You can get HIV/AIDS from sharing needles and "works".
- T F 86. You cannot get HIV/AIDS from getting a tattoo.
- T F 87. With treatment, babies of HIV/AIDS mothers can be born without HIV/AIDS.
- T F 88. You can get HIV/AIDS from having your body pierced.

Section D

Please mark "Yes" if you have ever in your lifetime had the experience described in the following questions. Mark "No" if you have not ever had the experience.

In addition, if you answer "Yes" to any of the following questions, please tell us how often the experience has occurred in the last **12 months**.

89. In your **lifetime**:

a. Have you ever had sex with men?

No

Yes → *How many men have you had sex with in the last 12 months?*

_____ (# of men)

b. Have you ever had sex with women?

No

Yes → *How many women have you had sex with in the last 12 months?*

_____ (# of women)

c. Have you ever had vaginal sex?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

d. Have you ever used a condom when having vaginal sex?

No

Yes → *How often in the last 12 months?*

Always

Most of the time

Sometimes

Rarely

Never

e. Have you ever had oral sex?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

89. In your **lifetime**:

f. Have you ever had anal sex?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

g. Have you ever used a condom when having anal sex?

No

Yes → *How often in the last 12 months?*

Always

Most of the time

Sometimes

Rarely

Never

h. Have you ever used a condom to prevent pregnancy?

No

Yes → *How often in the last 12 months?*

Always

Most of the time

Sometimes

Rarely

Never

i. Have you ever used a condom to prevent HIV/AIDS?

No

Yes → *How often in the last 12 months?*

Always

Most of the time

Sometimes

Rarely

Never

j. Have you ever drunk alcohol before having sex?

No

Yes → *How often in the last 12 months?*

Always

Most of the time

Sometimes

Rarely

Never

89. In your **lifetime**:

k. Have you ever used drugs before having sex?

No

Yes → *How often in the last 12 months?*

Always

Most of the time

Sometimes

Rarely

Never

l. Have you ever had sex with someone you just met?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

m. Have you ever had sex with multiple partners at the same time?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

n. Have you ever had sex while in prison, jail, or juvenile hall?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

o. Have you ever injected (i.e. shot up, hit up) street drugs, steroids, or vitamins with a needle?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

p. Have you ever given someone money or drugs to have sex with you?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

89. In your **lifetime**:

q. Have you ever had sex with someone so that they would give you money or drugs?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

r. Have you ever had a sexually transmitted disease (e.g., gonorrhea, syphilis, Chlamydia, genital warts, genital herpes)?

No

Yes → *Have you in the last 12 months?*

Yes, Once

Yes, More than once

No

s. Have you ever shared a needle and/or “works” with someone else?

No

Yes → *How often in the last 12 months?*

Always

Most of the time

Sometimes

Rarely

Never

90. Which of the following drugs have you used in the last 12 months? (Check all that apply)

Heroin

Powder Cocaine

Crack Cocaine

Methamphetamine

Ecstasy

Psychedelics

Marijuana

Inhalants

Other (list) _____

91. Considering all types of alcohol, how many times during the past month did you have 5 or more drinks (*if male*) **or** 4 or more drinks (*if female*) on the same occasion? _____

Please mark how often in the last 12 months you have had sex with people who have the following condition or experience.

92. In the **last 12 months**, have you had sex with someone you think or know:

- a. Had a sexually transmitted disease (e.g., gonorrhea, syphilis, chlamydia, genital warts, genital herpes)?
- Yes, Once
 Yes, More than once
 No
-

- b. Had HIV/AIDS?
- Yes, Once
 Yes, More than once
 No
-

- c. Was in jail, prison, or juvenile hall?.....
- Yes, Once
 Yes, More than once
 No
-

- d. Injected drugs, steroids, or vitamins with a needle?.....
- Yes, Once
 Yes, More than once
 No
-

- e. Shared a needle and/or "works"?.....
- Yes, Once
 Yes, More than once
 No
-

93. a. Have you ever been incarcerated? Yes No

b. If **“Yes”**, where and how much total time did you spend there? (Check all that apply)

	How much total time did you spend there?	
<input type="checkbox"/> County Jail.....	_____	Days / Months / Years (Circle One)
<input type="checkbox"/> Juvenile Hall.....	_____	Days / Months / Years (Circle One)
<input type="checkbox"/> Probation Camp.....	_____	Days / Months / Years (Circle One)
<input type="checkbox"/> Youth Authority.....	_____	Days / Months / Years (Circle One)
<input type="checkbox"/> Prison.....	_____	Days / Months / Years (Circle One)
<input type="checkbox"/> INS Facility.....	_____	Days / Months / Years (Circle One)
<input type="checkbox"/> Other _____	_____	Days / Months / Years (Circle One)

94. a. Have you ever been tattooed? Yes No

b. If **“Yes”**, where did you get your tattoos? (Check all that apply)

<input type="checkbox"/> In prison, jail or juvenile hall	<input type="checkbox"/> At a friend’s house
<input type="checkbox"/> In a tattoo parlor	<input type="checkbox"/> Other _____

95. a. Have you ever had a body piercing? Yes No

b. If **“Yes”**, where did you get your body piercings? (Check all that apply)

<input type="checkbox"/> In prison, jail or juvenile hall	<input type="checkbox"/> At a friend’s house	<input type="checkbox"/> In a jewelry store
<input type="checkbox"/> In a beauty salon/store	<input type="checkbox"/> In a tattoo parlor	<input type="checkbox"/> Other _____

96. Do you know where you would go if you wanted to get an HIV test? Yes No

97. a. Have you been tested for AIDS or HIV?..... Yes No

b. If **“Yes”**, when? _____
(Month, Year)

c. If **“Yes”**, which of the following best describes why you went to get tested?

(If female) You were pregnant.

It was required for employment, insurance or military service.

Someone suggested you should be tested.

You thought you might have HIV/AIDS.

It was part of another medical test.

Other reason _____

d. If **“Yes”**, what were your results?

I was infected with the HIV virus (positive).

I was not infected with the HIV virus (negative).

I don't know.

98. Would you like to be tested for HIV/AIDS?..... Yes No

99. Do you know anyone with HIV/AIDS?..... Yes No

100. How old were you when you first became a member of a gang? _____

Appendix B

Attitudes and Knowledge

ATTITUDES

Please mark whether you “Strongly Agree”, “Agree”, “Disagree” or “Strongly Disagree” by placing an in the appropriate column for each of the following statements.

		Strongly Agree	Agree	Disagree	Strongly Disagree
SE	13. I think I know the facts about HIV/AIDS and how you get it.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	14. With medication, people with HIV/AIDS can still live long and healthy lives.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	15. It doesn't matter if I get HIV/AIDS because I'll probably die young anyway.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	16. I don't have to worry about HIV/AIDS because I'm not gay.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	17. I don't have to worry about HIV/AIDS because I don't share needles and/or "works".....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	18. If I had HIV/AIDS, my family would help me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	19. HIV/AIDS is a conspiracy (plan) against minorities.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PS	20. My friends have changed the way they have sex because of HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	21. The thought of getting HIV/AIDS scares me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SE	22. It's easy to get condoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PV	23. There is a good chance I will get HIV/AIDS during the next five years.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	24. I think HIV/AIDS is a problem in my community.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PS	25. My friends practice "safer" sex.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SE	26. There is still time for me to protect myself against HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PV	27. I am at risk for HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Strongly Agree	Agree	Disagree	Strongly Disagree
PS	28. My friends think that practicing “safer” sex can lower the spread of HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	29. It is important to protect myself from HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PS	30. Using condoms means you really care about someone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PS	31. My friends think that it is too much trouble to use condoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PV	32. My friends are at high risk for HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ST	33. Anyone who gets HIV/AIDS deserves it.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SE	34. I don’t use condoms because sex is better without them.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PV	35. There is a possibility that I have HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PS	36. My friends talk about how to protect themselves from getting HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PV	37. I may have had sex with someone who was at risk for HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	38. People like me do not get HIV infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SE	39. It is a hassle to use condoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PV	40. My sexual activities put me at risk for HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ST	41. HIV/AIDS is a punishment from God.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	42. I am very healthy so my body can fight off an HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SE	43. If I had HIV/AIDS, I would want to know.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SE	44. It’s easy to get clean needles and “works” if you need them.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Strongly Agree	Agree	Disagree	Strongly Disagree
PV	45. I am worried that I might get an HIV infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SE	46. Condoms are irritating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	47. If I had HIV/AIDS, my friends would stay away from me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	48. There is a cure for HIV/AIDS but we are not being told about it.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	49. There should be more information about HIV/AIDS available to the public.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	50. I don't worry about getting HIV/AIDS because if I take medicine, I'll be okay.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	51. If someone gave me HIV/AIDS, I wouldn't care if I gave it to someone else.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ST	52. I would only worry about getting HIV/AIDS if I went to jail.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ST	53. I would kill myself if I found out I had HIV/AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ST	54. If I found out someone had HIV/AIDS, I would stay away from them.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AC	55. If I had HIV/AIDS, there is a place I could go to get treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AC	56. I am able to see a doctor when I get sick.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AC	57. If I had HIV/AIDS, I would get medical care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PV=Perceived Vulnerability
 SE=Self-Efficacy
 PS=Peer Support
 ST=Stigma
 AC=Access to Care

KNOWLEDGE

Please circle "T" if you think the following statement is true. Circle "F" if you think the following statement is false.

- | True | False | |
|------------------------------------|------------------------------------|--|
| T | <input checked="" type="radio"/> F | 58. Most people who develop AIDS eventually get better. |
| <input checked="" type="radio"/> T | F | 59. A baby born to a mother with HIV/AIDS can get HIV/AIDS. |
| <input checked="" type="radio"/> T | F | 60. HIV is carried in the blood. |
| T | <input checked="" type="radio"/> F | 61. Most people who have HIV infection are sick with AIDS. |
| <input checked="" type="radio"/> T | F | 62. HIV/AIDS is carried in men's cum (semen). |
| <input checked="" type="radio"/> T | F | 63. AIDS weakens the body's ability to fight off disease. |
| T | <input checked="" type="radio"/> F | 64. People have been known to get HIV and develop AIDS from toilet seats. |
| T | <input checked="" type="radio"/> F | 65. If the HIV test comes out negative, it means that the person has AIDS. |
| <input checked="" type="radio"/> T | F | 66. You can die from AIDS. |
| T | <input checked="" type="radio"/> F | 67. Men have a higher chance of getting AIDS from having sex with a woman than from having sex with a man. |
| <input checked="" type="radio"/> T | F | 68. Using a condom will lower the chance of getting AIDS. |
| T | <input checked="" type="radio"/> F | 69. It is safe to have sexual intercourse without a condom with a person who shoots drugs as long as <u>you</u> don't shoot drugs. |
| <input checked="" type="radio"/> T | F | 70. People of any race can get HIV and develop AIDS. |
| T | <input checked="" type="radio"/> F | 71. People have been known to get HIV and develop AIDS by tongue kissing a person who is infected with HIV/AIDS. |
| T | <input checked="" type="radio"/> F | 72. Lambskin condoms are better than latex condoms for preventing HIV infection. |
| T | <input checked="" type="radio"/> F | 73. People usually become very sick with AIDS a few days after being infected with HIV. |

- T F 74. It is safer not to have sexual intercourse at all than to have sexual intercourse using a condom.
- T F 75. Pregnant women are safe from getting HIV infection.
- T F 76. A vaccine has recently been developed that prevents people from getting HIV infection (which can lead to AIDS).
- T F 77. HIV can be passed by an infected person who doesn't look sick.
- T F 78. People have been known to get HIV and develop AIDS by eating at a restaurant where a worker has AIDS.
- T F 79. You can get HIV and eventually AIDS through an open cut or wound.
- T F 80. You are safe from AIDS if you have oral sex (with mouth to penis or mouth to vagina) without a condom.
- T F 81. Anal (rear end) sex without a condom is one of the safer sexual practices.
- T F 82. You can get HIV and eventually AIDS by donating blood.
- T F 83. Using drugs like marijuana, alcohol, cocaine and crack makes it more likely that you may have unsafe sex.
- T F 84. You can get HIV/AIDS by getting tested for it.
- T F 85. You can get HIV/AIDS from sharing needles and "works".
- T F 86. You cannot get HIV/AIDS from getting a tattoo.
- T F 87. With treatment, babies of HIV/AIDS mothers can be born without HIV/AIDS.
- T F 88. You can get HIV/AIDS from having your body pierced.

Appendix C

Training Manual

Pilot Study on HIV Among Gang Members

**AIDS Coordinator's Office
Department on Disability
City of Los Angeles**

FIELD STAFF TRAINING MANUAL

**Vital Research, LLC
March 2005**

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Appendixes

Appendix A	Master Supply List
Appendix B	Copy of Interviewer Agreement

INTRODUCTION

Thank you for playing an important role in the Pilot Study on HIV Among Gang Members!

The purpose of this training manual is to:

- Orient you to the study and its purpose
- Describe structured interviewing techniques
- Familiarize you with the survey instrument
- Provide detailed instructions on procedures

WHY IS THIS STUDY BEING CONDUCTED?

This research study is being conducted on behalf of the AIDS Coordinator's Office, Department on Disability of the City of Los Angeles. The study is designed to describe the:

- Opinions and beliefs of active Gang Members about HIV/AIDS
- Knowledge level of active Gang Members about HIV/AIDS
- Number and type of risk behaviors that active Gang Members have that expose them to HIV/AIDS
- Percent of active Gang Members who are HIV positive (have HIV/AIDS)

The information collected will be used by the City of Los Angeles to learn more about HIV and Gang Members in order to help Gang Members get educated, tested, and treated for HIV/AIDS. The study will also help Gang Members, their families, and friends become more aware of the risk of HIV/AIDS and make better choices in protecting themselves and their communities.

WHO IS INVOLVED IN THIS STUDY?

1. AIDS Coordinator's Office, Department on Disability of the City of Los Angeles

The AIDS Coordinator's Office commissioned this research study to learn more about HIV and Gang Members. The AIDS Coordinator's Office develops and manages contracts with community-based organizations to provide AIDS education and prevention services, with special outreach to the populations hardest hit by the epidemic.

2. Vital Research, LLC

Our company was chosen by the AIDS Coordinator's Office to conduct the Pilot Study on HIV Among Gang Members. In addition to designing the survey instrument, analyzing results, and coordinating with the Minority AIDS Project (MAP) for HIV testing of Gang Members, we are responsible for data collection, which involves training you and providing you with all the materials that you need to gather the data. Added to our project staff are Bill Martinez, Study Coordinator, and Les De'Morst, Field Coordinator.

3. Minority AIDS Project

Minority AIDS Project (MAP) provides educational and other HIV/AIDS-related support services. MAP will be administering HIV tests for Gang Members who participate in this study. MAP is also responsible for providing you with HIV/AIDS education that you can use in the field.

4. Interviewers

You are a vital part of the research process. Because you have knowledge about and access to the special population under study, you will be instrumental in collecting the data for this pilot.

WHAT IS YOUR ROLE IN THIS STUDY?

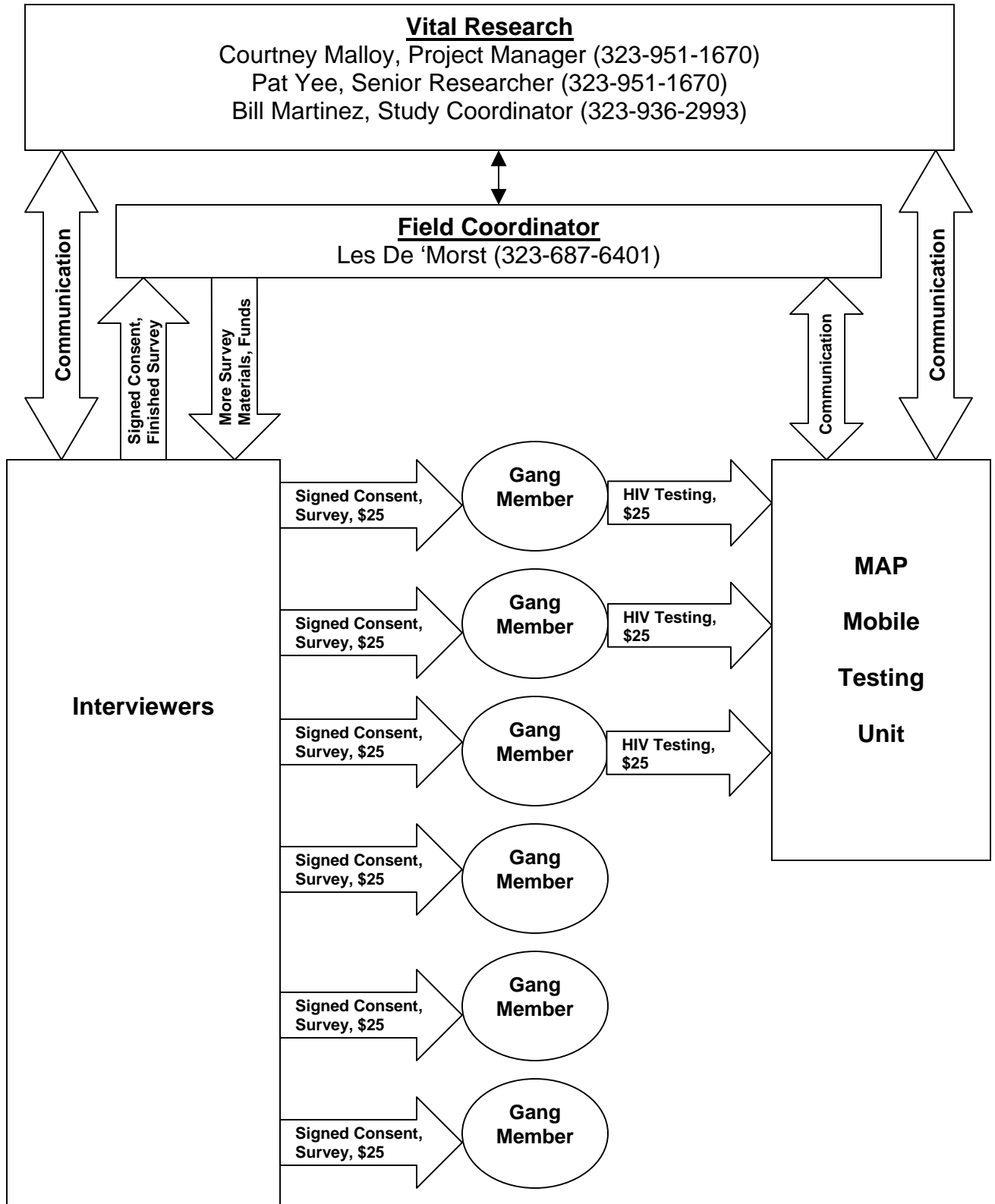
Your role in this study is to help collect data. The data that need to be collected are completed surveys and HIV test results. You will be educated about HIV/AIDS and trained to:

1. Recruit 300 active Gang Members
2. Obtain signed consents from the participants
3. Interview participants, who will receive \$25.00 to complete the survey about HIV knowledge, beliefs, opinions, and risk behaviors
4. Help 150 out of the 300 participants, who will receive another \$25.00, to be tested for HIV

Figure 1 presents an overview of how the interviewing and HIV testing process will work.

- After this training, you will start out with a set of five consent forms, five surveys, appointment cards, and a \$125.00 check (enough funds for five participants, who will receive \$25.00 each for finished interviews).
- You will recruit, obtain signed consent forms, and conduct interviews with active Gang Members, ages 18-24.
- You will give out \$25.00 in cash to each participant who has completed the survey.
- You will work with the Field Coordinator to coordinate MAP Mobile Unit HIV testing.
- You will turn in all completed surveys and consent forms to the Field Coordinator, who will turn them in to Vital Research.
- You will receive from the Field Coordinator, as needed, more survey materials and funds for completed surveys.
- You can discuss any questions, problems or issues in the field with the Vital Research Project Manager.

Figure 1. Overview of the Data Collection Process



WHAT ARE THE STEPS TO COLLECTING DATA EFFECTIVELY?

- 1. Review your training materials.** You will be given several resources including:
 - a training manual
 - copies of the survey
 - the interviewer's survey
 - copies of the consent form
- 2. Take all supplies and materials with you when you are interviewing.** Make sure you take everything listed on the Master Supply List (See Appendix A).
- 3. Recruit participants for the study.** Make sure you recruit only “active” Gang Members between the ages of 18 and 24 for the study. Explain the purpose of the study and what they will be asked to do. **(SEE PAGE 9)**
- 4. Select an appropriate place to conduct your interview.** Be sure to select a place that will make the participant feel comfortable. It is usually best to conduct interviews in quiet, private locations. **(SEE PAGE 11)**
- 5. Get consent from the participant.** The participant **must** sign the consent form before you conduct the survey **and** before they are tested. After they sign the beige form, collect it from them and give them a copy of the blue version to keep. **(SEE PAGE 10)**
- 6. Conduct the interview.** Conduct the one-on-one structured interview.
 - Be sure that the participant completes the identification **code box** at the top of the survey.
 - Read the questions exactly as they are on your version of the survey
 - Use the prompts and additional explanations, as you need them. **(SEE PAGES 13-29)**
- 7. Conclude the interview.** After you have finished the interview,
 - Give **each** participant an orange card for HIV testing even if you have not yet scheduled your Mobile Unit.
 - **Be sure you or the participant writes the identification code from the top of the survey in the code boxes on the orange card.**
 - The participant should seal their completed survey in the envelope.
 - Review the correct answers to the knowledge test with the participant.
 - Give the participant the \$25.00 incentive. **(SEE PAGE 29)**

- 8. After the participant has left, write down neighborhood on the outside of the envelope.** This will help us track how many interviews are being completed in certain areas.
- 9. Work with the Field Coordinator to schedule MAP Mobile Unit Testing.** Contact the Field Coordinator to schedule your testing date and location. Be sure to tell the participants about the date and location at the interview (if you know) or within a couple days of the interview. **(SEE PAGE 30)**
- 10. Follow up with the appropriate participants on the day of Mobile Testing.** Participants will feel more comfortable and be more likely to go to the Mobile Unit for testing if you go with them, take them, or meet them there. **(SEE PAGE 30)**
- 11. Contact the Field Coordinator to turn in surveys and get more materials.** Periodically, the Field Coordinator will contact you to collect any completed surveys and consent forms. When you have completed all your surveys, contact the Field Coordinator and he will provide you with additional data collection materials.

How to Select Participants to Interview

The Recruiting Criteria

For this study, you will be recruiting participants who meet the following criteria:

1. Between the ages of **18 and 24**.
2. **“Active”** Gang Members. This means that the participant is actively involved in the gang lifestyle right now.
3. Living in **Los Angeles**.

According to interviewers in this project, an active Gang Member is someone who:

1. **“Looks like” a Gang Member** (e.g., wears certain colors; wears white t-shirts; has tattoos of street names, street numbers, gang names; carries weapons);

And

2. **“Acts like” a Gang Member** (e.g., engages in criminal activities such as selling drugs, murder, robbery, or extortion on behalf of the gang; actively protects and provides for a gang/neighborhood; feels responsible for and committed to a gang/neighborhood).

Note: The gang member must be someone that you **personally** know is an “active” gang member. Do not interview someone just because they are friends with a gang member that you know or because they are referred to you.

In addition, we want a sample that will closely match the race/ethnic and gender make-up of Gang Members in Los Angeles. We will keep you updated on data collection progress throughout the study so you know how many participants to continue to recruit.

How to Recruit Participants

1. Explain the purpose of the pilot study.

- To learn more about what they think, know, and believe about HIV/AIDS.

2. Explain that that the study involves two parts.

- An interview with questions about their HIV/AIDS knowledge, opinions, and behavior. The interview will take about 60 minutes.
- An optional HIV test at a Mobile Testing Unit in the local area which will take about 1 to 1½ hours.

3. Tell them that their survey responses and HIV test are anonymous.

- Their name will not be on the survey or their HIV test results. The survey and test results will be identified by a unique code that cannot be traced back to them.

4. Tell them that they will be paid for their participation.

- They will receive \$25.00 when they complete the interview.
- They will receive \$25.00 after they complete the HIV test at the Mobile Unit.

5. Ask them if they would be willing to participate.

- If they are willing to complete the survey, either proceed with the consent form and immediately conduct the interview or set up a time and place to consent and conduct the interview.
- If they are willing to participate in the optional HIV test, be sure they are tested AFTER you complete the survey.

How to Consent Participants

This study asks participants to answer sensitive questions about their beliefs and behaviors. In addition, they may undergo a medical test to determine HIV status. For these reasons, we must get consent from participants before conducting the interviews **and** before they are tested for HIV.

The consent form is 5 pages. Four pages provide detailed information about the study, and the fifth page is a signature page. After the participant has read the consent form, have them sign the signature page. Only **AFTER** they have signed the consent can you start the interview.

Consenting Procedures

1. Read through the beige consent form with the participant. (Use your highlighted version to emphasize the key points.)
2. Emphasize that participation is voluntary; they can withdraw from the study at any time.
3. Ask them if they understand the form and if they have any questions.
4. Let them know they can contact Vital Research or the AIDS Coordinator's Office if they have questions later on.
5. If they agree to participate, ask them to print and sign their name on the signature page.
6. Collect the beige form, and give them a copy of the blue version.
7. You should also print and sign your name as the Person Obtaining Consent on the beige form.

How to Create a Good Interview Environment

1. Choose an Appropriate Place

- Privacy: Since some of the questions are sensitive, the best way to get honest and accurate answers is by trying to do the interview in private.
- Quiet: If possible, select a location where there are few distractions. Make sure you can be heard above any noise or music.
- Safety: Choose a familiar location where both you and the participant feel safe.
- Positioning:
 - Face the participant away from distracting activities
 - Make sure the participant has eye contact with you
 - At the same time, make sure you cannot see the participant's answers if he/she would like to keep the answers confidential

2. Establish a Good Interviewing Relationship

A. Explain why the survey is important and worthwhile

Make sure the participant understands:

- What is expected of him/her during the interview
- What is the purpose of the interview
- How the information will be used

B. Develop a positive relationship:

- Warmth and respectfulness: Let the participant know that you are genuinely interested in what he/she has to say
- A permissive atmosphere: The participant should feel completely free to express any feeling or viewpoint. By your attitude and behavior, you demonstrate that no answer is out of place.
- Be objective: The participant should feel comfortable talking to you and know you are not judging them.
- Be neutral: Never state your ideas, reactions, or preferences.

3. Develop the Characteristics of a Successful Interviewer

- Maintain your role in this study as an Interviewer, not counselor or therapist; while you can be empathic and show genuine interest, do not get personally involved (at this point).
- Never talk about anything you see or hear while conducting the interview with anybody other than Vital Research staff. Any concerns, problems or issues may be discussed in private with the Vital Research Project Manager.
- Be willing to follow procedures accurately and follow through.

How to Conduct the Interview

1. Overview of the Survey

The survey asks participants about HIV opinions, beliefs, knowledge, and risk behaviors. The survey also includes a few demographic questions.

Section A: Demographic Information

- Race/Ethnicity
- Gender
- Age
- Marital Status/Children
- Educational Background
- Work Background

Section B: Attitudes

- Beliefs about HIV/AIDS
- Perceived Threat of HIV/AIDS
- Self-Efficacy (ability to protect against HIV/AIDS)
- Peer Support

Section C: HIV/AIDS Knowledge Test

- Medical/Scientific Knowledge
- Knowledge of Risk Behaviors and Prevention
- Knowledge of Transmission of HIV/AIDS

Section D: Risk Behaviors

- Sexual Behavior
- Condom Use
- Alcohol/Drug Use
- Needle Use
- Tattooing/Body-Piercing
- Incarceration
- STD/HIV Status

2. Conducting the Structured Interview

You will be conducting *structured* one-on-one interviews. This means you will be reading the survey questions and answer options word-for-word from your special version of the survey. The participant will mark his/her answers on his/her own copy of the survey. When the participant has completed the survey:

- Place the survey in a Vital Research Business Reply envelope
- Seal immediately
- Turn the envelopes in to the Field Coordinator.

Your version of the survey is the same as the participant's version, except for 1) additional instructions that you will read in ***bold italics*** and 2) extra prompts or explanations that are in ***(parentheses and bold italics)*** in case the participant needs further explanations. Try to read the questions exactly as they are on the survey and use prompts and examples if needed.

First, read the directions and ask the participant if he/she understand them. Pace your reading to be sure the participant has enough time to read silently along with you and answer the question on their survey form. The survey takes about 60 minutes to finish.

To start the interview:

1. Give a survey and pencil to the participant.
2. Make sure the participant completes the Identification Box in the upper right hand corner on the first page.
3. Read the directions out loud. Check to make sure the participant understands them.
4. Begin the interview.

How to Help Participants Get Tested for HIV

The second part of the study is getting participants tested for HIV at MAP Mobile Units. We need about half of the participants you interview to be tested.

Key Things to Remember About HIV Testing

1. The testing is both anonymous and confidential.
2. The Mobile Units will be scheduled in public places so that participants can safely go without others knowing that they are getting an HIV test.
3. Be sure that participants understand the study has two parts: 1) the survey; and 2) the optional HIV test. They will receive \$25.00 cash for each part. When participants agree to participate in the survey, also ask them at that time if they will be tested. If they are not sure about whether they would like to participate in testing, ask them again when you conduct the survey.
4. Participants can only take the HIV test **AFTER** they complete the survey. This is important because they will receive HIV/AIDS education when they are tested. We want their survey answers to reflect their knowledge and opinions before testing and education.
5. When you administer the survey, give each participant an orange card for HIV testing even if you have not yet scheduled your Mobile Unit. Be sure you or the participant writes the code from the top of the survey in the code boxes on the orange card. Participants will need to bring the card with them in order to receive the \$25.00 cash incentive.

Scheduling

- Contact Les **at least 4 days** in advance to schedule your testing date. When you call to schedule, provide the following information:
 - Requested date and time
 - Requested location
 - Number of participants to test (Be as accurate as possible; MAP needs to know so they can prepare for your tests)
 - Names of participants
- MAP will do their very best to accommodate your schedule; however, remember they have other clients to test and other time commitments to honor.

Changes or Cancellations

- Call Les **at least 24 hours** in advance if you need to change or cancel your testing date.

On the Testing Day

- If you have any problems **on the day of testing** and need to be in touch with someone, call Kevin Williams at MAP (323-936-4949 x115).
- Try to reserve a parking location for the mobile unit somewhere near your gang intervention agency (e.g., on the property, in the parking lot, in a loading zone).
- Be sure that you **and** all of the people scheduled for testing arrive at the testing location on time.

NOTES & QUESTIONS

APPENDIXES

Appendix A
Master Supply List

Master Supply List

- Training Manual
- Laminated Answer Sheet
- Laminated Interviewer Guide
- Consent Forms to Obtain Signatures (Beige)
- Consent Forms to Give to Participants (Light Blue)
- Your Version of the Consent Form with highlighting (White)
- Your Version of the Survey (White)
- Surveys for the Participants (Yellow)
- Appointment Cards (Orange)
- Pencils (2)
- Cash to Use for the Incentive

Appendix B

Copy of Interviewer Agreement

Pilot Study on HIV Among Gang Members

INTERVIEWER AGREEMENT

As an interviewer for the Pilot Study on HIV Among Gang Members, I agree to do the following:

- Recruit and consent active Gang Members between the ages of 18 and 24 to participate in this study.
- Conduct structured one-on-one interviews with study participants.
- Provide the \$25.00 incentive to each participant I interview. In the event that I do not recruit the number of participants that I have received incentives for, I will return the remaining money to Vital Research.
- Work with the Field Coordinator to schedule Mobile Unit Testing.
- Help participants who agree to take the HIV test by meeting them at the Mobile Unit or going with them to the Mobile Unit.
- Turn in all completed consent forms and surveys to the Field Coordinator.

Vital Research agrees to do the following:

- Provide you with all the materials you need to collect data for the study.
- Provide you with a check in advance that you can use to provide cash incentives to participants.
- Pay you an honorarium of \$50.00 for attending the training session.
- Pay you a stipend of \$15.00 per survey completed.

(Signature of Interviewer)

(Date)

(Signature of Vital Research Representative)

(Date)