

Sex Venues for Gay Men and MSM: How Do They Influence Risk to HIV, and Can We Develop Policy and Interventions to Reduce Transmission?

Speakers:

- William J Woods, PhD, Associate Professor, Center for AIDS Prevention Studies, University of California San Francisco (UCSF)
- Demetre C Daskalakis, MD, Assistant Professor, NYU School of Medicine/NYU Langone Medical Center, Bellevue Hospital Center; Program Director, Men's Sexual Health Project (New York)

William Woods

Dr. Woods' presentation follows his slide presentation (download at

Slide 3. Who Goes? What Goes on at Bathhouses?

To address public policy, our research looks at two questions:

- (1) Who goes to bathhouses (also referred in this talk as sex clubs and/or sex venues)
 - Compare people who go to people who don't go with data from the urban men's health study
- (2) What goes on at bathhouses?
 - Examine data from exit surveys at bathhouses where we ask men to tell us while they were leaving what they did inside

This talk concludes with a discussion of policies that have been tried in response to HIV in the bathhouses.

Slide 4. How do men who go to clubs compare to MSM who don't go?

- Looking at the Urban Men's Health Study, a probability sampling of men who live in particular settings in New York, Los Angeles, Chicago, and San Francisco. The data was collected in 1996/97. One third of the men have gone to a club in the last 6 months. Others might have gone at some point but not in the last 6 months.
- Sex club-goers look different than men who don't go to clubs. They are more likely to be HIV positive and use drugs (Urban Men's Health Study, Binson & Woods, et al., 2001)

Slide 5. Men who report high levels of risk behavior are more likely to go to sex clubs & bathhouses

- Men who report high levels of risk behavior are more likely to go to bathhouse and sex clubs.
- They are more likely to
 - Report unprotected anal intercourse

- Report more sex partners
- Report having group sex.
- Men who engage in high-risk behaviors of various types are more like to go to bathhouses than men who do not.

Slide 6. As such, it's an ideal place to reach high-risk men with HIV prevention

- Bathhouse and sex clubs are an ideal place to reach high-risk men with HIV prevention interventions. That's where men with high-risk behaviors go.
- Bathhouses and clubs are environments where you can be very specific and graphic with prevention campaigns, and the franker content will not offend other community members not present in those venues, who do not want to see graphic representations of men and sex.

Slide 7. Does Bathhouse Facilitate High Risk Sex?

- The Urban Men's Health Study data tell us how men who attend sex clubs are different from those who do not.
- What actually happens in the club? Though the clubs attract men who engage in high-risk behaviors, how much does that behavior actually happen in the club?
- Gathered data via exit survey from a San Francisco sex club. This data is from a single bathhouse, but there are similar patterns in other surveys from other bathhouses done here on the west coast. .
 - Most of the men do not report drug or alcohol use while at the club.
 - Measured that was whether they felt the effects while they were at the club.
 - About 15% of the men reported having use some drug or alcohol in the past 24 hours and reported feeling the effects.
 - Vast majority of men reported only having one partner.
 - Most of the sex in the club was oral sex.
 - Half of the men reported having anal sex, and most reported using a condom.
 - 11% of the men reported unprotected anal during the time that they were there.
 - We asked men about their behavior in the last 3 months.
 - Of the men who reported unprotected anal intercourse it was most likely to have happened at home, as opposed to a bathhouse or in a cruising area.
 - High-risk sex tends to happen at home
 - High-risk sex in the last 3 months is predictive of unprotected anal sex in the bathhouse during that visit. Men who don't engage in high-risk sex otherwise don't come to the bathhouse and find themselves engaging in it. S
 - Some men who reported previously engaging in unprotected anal intercourse did not report engaging in it while at the bathhouse.
- Did the bathhouse facilitate high-risk sex? Most of the data is strongly indicating that the bathhouse itself is not facilitating it. Guys have unprotected anal intercourse with one partner, they tend to have other kinds of sex and engage in more protected behaviors.

Slide 8. Bathhouses attract high-risk men, but most men there are not having high-risk sex

- Bathhouse may be attracting high-risk men or men who engage in high-risk behavior, but men, while at the sex club or bathhouse, are not having high-risk sex.
- Caution: this isn't to say high-risk sex doesn't ever happen at bathhouses or that transmission of HIV never happens at the clubs. The data shows that the vast majority of the behavior

there is not going to lead to transmission. In fact the behavior looks more like the behavior you would find in any number of other settings, like someone's bedroom. The men who are having unprotected anal intercourse tend to have one partner, which is not that different than bringing someone home.

- This is primarily our data but it is not dissimilar from other data collected on the west coast.
- Don't know if there are regional differences in terms of the behaviors that happen in bathhouses.

Slide 9. What policies have been tried?

- Broadly, most health jurisdictions in US and worldwide, don't have policy towards a bathhouse or sex club; and they don't necessarily enforce extant policies.
- In the US. looked at 12 health jurisdictions and did not find one that could operate totally within the state law.
- However local enforcement bodies, police and health department, tend not to enforce state law at the level of trying to close them down.
- Health jurisdictions are busy with other things and tend to let bathhouses operate on their own without much oversight, unless something happens and garners media attention.
- Sydney, Australia tried really novel approaches.
 - A Supreme Court case validated bathhouse's right to exist, and venues began to operate openly.
 - Bathhouse operators work with other stakeholders, such as NGOs and the public health jurisdiction, to develop viable and enforceable health policies
 - NGO certifies the prevention programming of sex clubs, which are featured in advertising and entry signage.
 - Prevention activities in the sex clubs are reviewed every 6 months
 - Policies don't regulate where sex can happen, but specifies instead that if you do have special sex areas, they must provide safer sex materials such as condoms, lube and cleanup stuff right in the area.
 - From reports we're heard very favorable opinions, all the stakeholders felt that everyone was engaged and working together to have a prevention program that was probably making a difference.
 - This novel approach merits attention.

Slide 10. What's been done in USA?

Three major policy approaches:

- Policy #1: close bathhouses.
- Policy #2: regulate set up of sex clubs in terms of public and private space.
- Policy #3: kind of prevention that can be made available to customers.

Slide 11. Closing the baths

- In the 1980's San Francisco, New York, LA, Atlanta all tried to close their clubs with varying successes, but today all of those cities have sex clubs or bathhouses operating in them.
- It was not a policy that worked across the board. While some venues were targeted for closure, others remained open or opened. This policy is very costly and not effective.

- Popular perception is that bathhouses were closed and remained so. When LA bathhouse issues became public in mid 2003, many people were shocked that these places still existed.
- Some public health officials still want to close them down while others think that it's a good place to work with men at risk than other venues such as parks and private parties.
- Closing the baths has not been a smashing success as a policy approach

Slide 12. Structural Regulations

- Structural regulations came out of the attempts to close the clubs
- San Francisco has policy of no private spaces. All sex must be monitorable - another customer, management or the city is required to confirm customers are having safe sex.
- New York has a policy of no sex in public areas – and, one is not allowed to have sex in private either. But private spaces are hidden so no one can see what is going on, so enforcement focuses on prohibiting sex in public areas.
- Los Angeles has a policy where private rooms are allowed but they must have a hole in the door so activities inside could be monitored. Clubs in other health jurisdictions also have this arrangement.
 - Staff doesn't want to look into these windows
 - Patrons cover up windows and the health department stops going to the clubs to make sure that people are monitoring through the windows.
 - In every attempt, we've seen they fell into disuse.
 - This is not a particularly good structural regulation but it is widely used.
 - This is no longer a requirement in LA, and in 2003 LA rolled out a series of new policies, which are a mixture of structural regulations and prevention provisions.
- Data from the Urban Men's' Health and looks at the difference in risk behavior that is reported by men who go to sex clubs in San Francisco, New York, Los Angeles and Chicago. Hypothesized that if these policies made a difference, you'd see difference in the risk behavior that men reported.
 - We didn't find any significant change in the amount of unprotected anal intercourse, number of partners, or going to public places to have sex.
- The paper shows that if there is any effect it is just moving the behavior someplace else, for instance it goes to private parties. Moving the behavior closes the opportunity to target men at higher risk, which is problematic. (Review the paper for some caveats to this finding.)

Slide 13. Prevention Programs

- Information, education and outreach programs are done a lot in bathhouses throughout the country. In the early part of the epidemic, bathhouses were a significant way in which information was spread among the gay community, around what you can and should do about sexual behavior in avoiding HIV.
 - Data collected from 7 bathhouses in LA in 1985/86 report that 86% of men said they got information from the baths that gave them a better understanding of HIV.

- At that time and currently is still an important venue for educating young people who are coming out and don't learn about gay sex and risk behavior high school sex-ed programs.
- Distribution of condoms and lube, like the Sydney example, at the site of sexual activity makes a significant difference in whether men are going to use condoms in the heat of the moment. Information and education and distribution of condoms and lube are very available in clubs across the US and Canada. These are the things that were always available when we contacted clubs.
- HIV and STD testing, special education events and having health educators or counselors onsite for certain hours a week.
 - All very time intensive, expensive and have a high impact for a few people.
 - They are valuable and the feedback is positive when people take advantage of these services.
 - These programs are not changing the environment of the bathhouse or the behavior of the people.
 - These programs are not evaluated, with the exception of HIV/STD testing, so we don't know how well they work or the influence they have.
 - With HIV/STD testing, there is debate about what impact these programs have: does it reach people who would not test elsewhere, people who need to be tested, and people who were recently infected?
 - Some of the data suggests that there are people learning that they are positive.
 - There is data that 3-5% of people who test are positive which is similar to clinics.
 - Some studies report higher rates of identifying people with HIV
- Most policies focus less on what prevention programs needs to happen, but more on structural approach.

Slide 14. Summary

Men with the highest risk behavior go to bathhouses, so it is an ideal place to have HIV/STD prevention work. Most of the men are not engaged in that behavior at the bathhouse, so the best kind of prevention would be something men can take away with them. Not many programs do that...the idea would be that men could take information and condoms with them when they leave.

Q&A / Discussion

Question: In the exit survey, how did you authenticate answers given by the participants because people don't always give true answers to protect their privacy?

Bill: To the privacy point these were totally anonymous. But there was no way to authenticate the behavior that happened in the club because there was nobody walking around to see what people were doing. The best authentication was that the data was same a year later and followed results of other surveys done on the west coast.

Question: Are STD positive tests higher in clubs or baths?

Bill: Don't know – never seen anybody report how the STD rates compare to local clinic data.

Question: Do you know of any clubs requiring educational component before they permit a new member to join or enter?

Bill: There is a requirement in San Francisco that new members have to review guidelines other clubs ask you a question you have to get right before you can join

For more detail on this research, please refer to these references:

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Woods WJ, Erwin K, Lazarus M, Serice H, Grinstead O, Binson D. Building stakeholder partnerships for an on-site HIV testing programme. *Culture, Health & Sexuality*, 2008; 10(3):249-262.

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Demetre Daskalakis

Since 2005 after a brief pilot period funded by the NIH under the NYU center for AIDS research, we established testing venues at the two remaining traditional bathhouses in NYC. Based on data from that effort, we partnered with NYC Health and Hospitals Corporation and the NYU Center for AIDS Research to build the Men's Sexual Health Project. This program extends Bellevue Hospital's license to provide HIV and STD testing from the hospital into the commercial sex venue locations, making the rooms the staff works in their technically diagnostic satellites. We maintain research elements and survey elements so we can gain a high-level of data from the men that we test. We augment our HIV testing to be on standard.

The current program was initially based at the two traditional bathhouses into NYC and in the last two weeks we have extended our license to a third venue, which is a commercial sex club (not a traditional bathhouse). We offer a broad range of HIV testing, including rapid HIV tests with results onsite and pooled plasma viral load, looking for earliest stages of HIV infection. We also use an algorithm to approximately date the HIV positive standard test, so we can deem whether the infection is recent or established. Also, we offer STD testing for syphilis, gonorrhea and Chlamydia (from all appropriate orifices); rapid tests for Chlamydia and gonorrhea, and syphilis results must be reported back later. From 2005 to present, we have performed about 2000 tests among 1400 unique subjects, which implies that we have a clientele with repeat testers.

Characteristics of the Testers

- Initially we tested only patrons of the commercial sex venues.
- We have extended our reach using the Internet to promote the sex venues as walk-in clinical diagnostic sites.
- 35% of the testers were either recruited through our online partner sites, such as Manhunt and Craigslist or through other online advertising. Recruits from the internet are:
 - Generally younger: 40% are 18-29,
 - Less racially diverse than the population meeting at the commercial sex venues.
 - We are more likely to test white non-Hispanic men from the Internet, while from the sex venues are more diverse (51% are not white non-Hispanic in sex venues).
- Level of educational attainment is high.
- Most are employed.
- 23% of the men are not gay-identified; that varies among the venues, with highest being 27%.
- 10-20% of the men are married and are less likely to have been offered or previously tested for HIV. We reach a group of people who are hard to reach, even with the scale up of HIV testing in routine healthcare settings.
- We also found that only 19% of the people we met found partners exclusively at bathhouses.
- Over 80% use other venues; the most popular places were the Internet (second) and popular cruising areas (third).
- We have identified a group of risk takers in multiple environments.
 - 48% of the men we met have reported unprotected anal sex in the 3 months prior to testing.

- In the last two months we began asking where the unsafe sex occurred and over 80% of the men report that it occurred in their home with an Internet partner.
- About 3.5% of the men are newly diagnosed by the testing pilot; of those 40% are acutely infected or recently infected using our other testing
- Although we have not reported on our STD testing to date. Our Chlamydia rate, specifically rectal Chlamydia rate, is 10.5% percent, which mirrors that of City Clinic in San Francisco. Syphilis is the highest outreach-based syphilis rate in the city, 6-7% of newly diagnosed syphilis that we are diagnosing.

Although we have a limited number of people that we are reach day today, compared to who are in the clubs, with our longevity we are testing more and more people who are frequent users of these venues. Can only do 5-8 tests per day, but by being in the venues for several years, the testers meet new people and service repeat clientele.

Men's Sexual Health Project has expanded to a third commercial sex venue, an open area sex club, which in violation of the New York City policy of only tacitly allowing closed sex-area venues. Now work with The Saint-at-Large, a promoter of circuit parties and sponsor of the Black Party, a circuit party with a commercial sex venue all in one place. We were the first to test in the 30 years of that event.

Commercial sex venue owners started a coalition and Men's Sexual Health Project has been asked to be their medical advisor to develop their own strategies for structural interventions within their venues that may or may not include testing depending on their context. The goal is to engage authorities in NYC in advance of any regulation plans with some views from the trenches rather than the folks without experience in commercial sex venues.

We have been very focused on shifting counseling to include safer sex conversations about using condoms but also to address men who do not use condoms. We created an approach to counseling within these venues that people within other communities might not feel is appropriate. But when we meet people who are not going to use condoms or are staunchly not going to shift their behaviors, we do advise them to test for syphilis and other STDs more frequently. We also teach the entire cohort of men that we meet about post exposure prophylaxis.

We moved our testing room at one venue from inside the bathhouse to an adjacent floor because in the basement of that same building is a straight swingers club in an effort to get non-MSM to test with us as well. Not very successful Initially, operators of heterosexual-oriented venues were more concerned with HIV prevention outreach than the individuals who ran the MSM venues. Now the operators are also interested in extending these services into their heterosexual targeted venues.

Q&A / Discussion

Question: Would you advocate for mandatory regulations of Health Educators to be employed at any bathhouse in the USA? Do any of the clubs have responsibility to ensure their patrons sign off as to the risk of having high risk sex while there?

Demetre: I can only speak for my experience the venues I've worked with and a discussion I had with them last night. Mandating the presence of testers, counselors or prevention workers doesn't take into account the context of the individual commercial sex venues. One of the challenging issues is that these clubs or venues or events are not built the same. It is difficult to mandate having a prevention worker at a specific venue. What will happen is that there will be alternative venues that cannot meet that requirement that will then not be under that regulation. There is a shift toward underground with any specific regulation that is a mandate. I found it very heartening that the folks that own these venues are interested in creating a list of bare minimum requirements to maintain the health of their clientele. They have had a shift in their thinking and are interested in looking at HIV/STD prevention much as they would as fire doors in their venue. Just as they would say you have to have working fire doors in your venue they are starting to look at this as an issue of client safety. I can't say mandate one option or another but it's about the context of the individual venue and event.

Question: What are the real chances of turning the Internet from a threat to HIV prevention into an opportunity to disseminate safe sex messages? [The speakers address this from the perspective of how they consider this in their research, since we are not focusing on the internet in this discussion.]

Demetre: Similar to commercial sex venues the Internet does provide a very specific ability to disseminate information. An interesting internet program that has gotten more press comes from NYU, where they created an internet soap opera that was an educational tool about moving through the city, the challenges of being a gay man or an MSM, and what it means transitioning through this place and the risk of unsafe sex. I think the internet does offer a very significant opportunity, just like the venues, if you are not having an educational or health moment when you are online looking for a partner you may not make a "pit stop" at information. At the core, both internet and commercial sex venues are commercial, they like to make money. Things that slow down their clients or give them bad feedback tend to be a barrier...and the Internet has similarly barriers to commercial sex venues.

Question: If the exit surveys in NY or SF were picking up a trend of the use of antivirals as pre-exposure prophylaxis.

Demetre: In NY we ask the question if people were aware of post/pre exposure prophylaxis. 35% ever heard of either intervention. Of the men that heard of post exposure prophylaxis, only 3.5% had actually ever done it and 0% had ever done pre exposure prophylaxis. That compares to SF City Clinic, where their rate of knowledge was 45%.

Bill: I don't have a lot of data on that but PrEP does get a lot of publicity in San Francisco.

Follow-up comment from questioner: we're hearing about it; the guys in clubs are talking about it; and it's coming up in chat rooms. We are considering monitoring if people are actually using antiviral as prophylaxis. We are hearing reports that this might be the case – the “MTV” packs of meth-truvada-viagra.

Demetre: One of the things we are finding in commercial sex venues is that only about 5% of men are reporting meth use within the last 3 months. Having discussed this with the cohort of commercial sex venues owners, meth is happening with a high amount of frequency but at private parties. It has been pushed deeper underground in NYC.

Comment: In Berkeley, CA, we created a collaborative between the bathhouse, AIDS organizations and the LGBT community center. When we did outreach with the baths, we also created a continuum; we would interview folks at the baths, sex clubs and parks, and we were able to hook up some of those men to come to the community center to utilize support groups, mental health, HIV and substance abuse counseling as well. We did not reach huge numbers, but we did give a community opportunity for MSM who didn't identify as gay who may have been leading dual lives.

Question: In terms of testing pilots in bathhouse and sex venues, a question that comes up is about the numbers of individuals being tested. Can you take us through that particular critique and help us understand what kind of impact having a bathhouse testing program has, given that only a certain number of tests can be administered on a given day in those places?

Bill: In our exit survey, we asked if men noticed testing happening and 75% said that they had seen testing happening. 15% of those men said that they had availed themselves to testing at a club, and 26% said they had tested within a month of seeing it. You may only be hitting 12 guys on a night. In the Bay Area, many men are being tested every year (and a number of sex club attendees have already tested positive), but bathhouse testing reaches many over time. The program we evaluated was always full; the need and desire for testing seems unquenchable when it is offered at a club.

Demetre: If you build it, they will come - both from within and outside of the club. With time what I've learned is that the longevity of the program has more impact in terms of testing more of the population or frequent users of the bathhouse. What happens is you start to make an impact and test more frequent bathhouse users, which ultimately allows there to be a conversation about HIV and STD whatever that may do to their risk. When you bring a testing program to that environment other things come with it. NYC has a very well established condom distribution program. A majority of the men tested hated the kind of condom distributed...so with our funding, we provided condoms that were more appealing to people coming to the venue. We have also referred 30-35 people directly from the bathhouse to the emergency room for post-exposure prophylaxis. That has nothing to do with testing, but as a testing program it offers a clinical nuance in the environment and other things come with it. This is a difficult thing to measure (and I wish I could figure out how to

measure it), but it is an important outcome that is separate from the volume of testing that is available.

Bill: we tried to find data to look at the larger impact of testing was on the overall risk behavior in the club. We didn't find much of anything, but we were looking at clubs that already had very low risk behavior. It communicates a lot of things to the guys at the club: the club cares that you are there; the health department cares that you are there to provide the services; and that you are worth taking care of, I hope it communicates to the clientele that they are worth taking care of themselves.

Comment: Clients of my program also complain about the NYC condoms, so we order condoms from NY State, which offers a greater variety.

Demetre: The City of New York has changed their program to have a greater variety available for free.

Jen Hecht, MPH, Education Director, STOP AIDS Project

Jen reviewed

1. Basic information about structural intervention, paradigms for discussing, understanding and classifying structural interventions and
2. STOP AIDS Project approaches to incorporate structural intervention at the local level.

Jen's remarks followed her PowerPoint presentation (download at

Additional remarks follow here, organized by slide number

Slide 2. Background

Factors in addition to individual behavior can affect the HIV risk level of different groups...this is the premise for prioritizing structural intervention.

Slide 4. Definition of Structural Intervention

Within these four domains of intervention, social, political, economic and environmental there is a lot of overlap. Some examples of structural intervention are: designated drivers they use social domain by changing social norms in order to reduce risk of driving while intoxicated. The second example is a banked highways which is an environmental change that reduces the risk of injury from driving too quickly around a curve in a road, once a banked highway is put in place people don't revert back to increased risk; this shows that this type of intervention is stable. Stability is a good test to see if something is a structural intervention.

Slide 5: Paradigms for discussing structural interventions

- Availability: increasing services or facilitators of HIV prevention, for example condom distribution in bars or restricting risky behavior like seatbelt laws.
- Acceptability: focus on social norms making behaviors more or less likely to happen, for example media campaigns that promote the use of designated drivers.

- **Accessibility:** focuses on shifting power and making services available to people who have less power, for example microfinance programs affect power dynamics such that gender and equity in women's economic dependence on men is reduced.
- These interventions can be targeted to individuals, organizations or the environment.
- **Distal v. Proximal Factors**
- By addressing more distal factors such as housing we can have an impact on proximal factors like condom use. This can happen by reducing the likelihood that individuals exchange sex for money, drugs or a place to stay, which in turn can reduce the likelihood of having sex without condoms.

Slide 10: Overview of steps to developing an intervention

On the slide is an example of two different causal pathways that show how gender inequality can lead to unprotected sex

Slide 11:

An example of taking factors from a causal pathway to generate intervention ideas is alcohol. If we were thinking about how alcohol impacts HIV transmission we might think that street vendors can provide food for patrons outside of local bars so that people can sober up before they go home.

Slide 12: Criteria for selecting an intervention

- **Feasibility:** it is important to be aware of how realistic it is to implement a certain intervention. Some ideas may be easy to implement and others may be very difficult
- **Impact:** what will the impact of this intervention be on our overall outcome of reducing HIV transmission?
- **Acceptability:** want to understand if this is something that falls within the social norms of our community and how will the community feel about it?
- **Sustainability:** sustainable with minor cost

Questions:

What do you mean by varied response to HIV, as different socio economic factors play out differently to HIV messages in the targeted groups what may be effective in one part of the country may not be effective in another part?

Jen: Regionally efforts need to be targeted differently based on what is going on there. Our prevention efforts will be specifically targeted to the epidemic in SF. However what I was talking about within varied responses was the necessity to take on individual, community, group, network and structural level interventions, which is true in every region but they will look different in all regions.

What are the specific interventions you will be taking, for example MSM population on Castro Street in SF?

Jen: We are still brainstorming and don't have a response yet but that is something we are working on. AN example could be food vendors outside of bars. We have talked about the high concentration of bars on Castro Street without food places.

Of the different types of interventions how to structural interventions differ from network interventions?

Jen: Structural interventions are broader and can be applied to address network factors. I think of structural interventions that address social, political, economic and environmental factors. Network factors would be on a small scale.

Jen (comment): look up articles and read the book called "Nudge" to see how structural adjustment can play out!

For more detail on this research, please refer to these references:

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