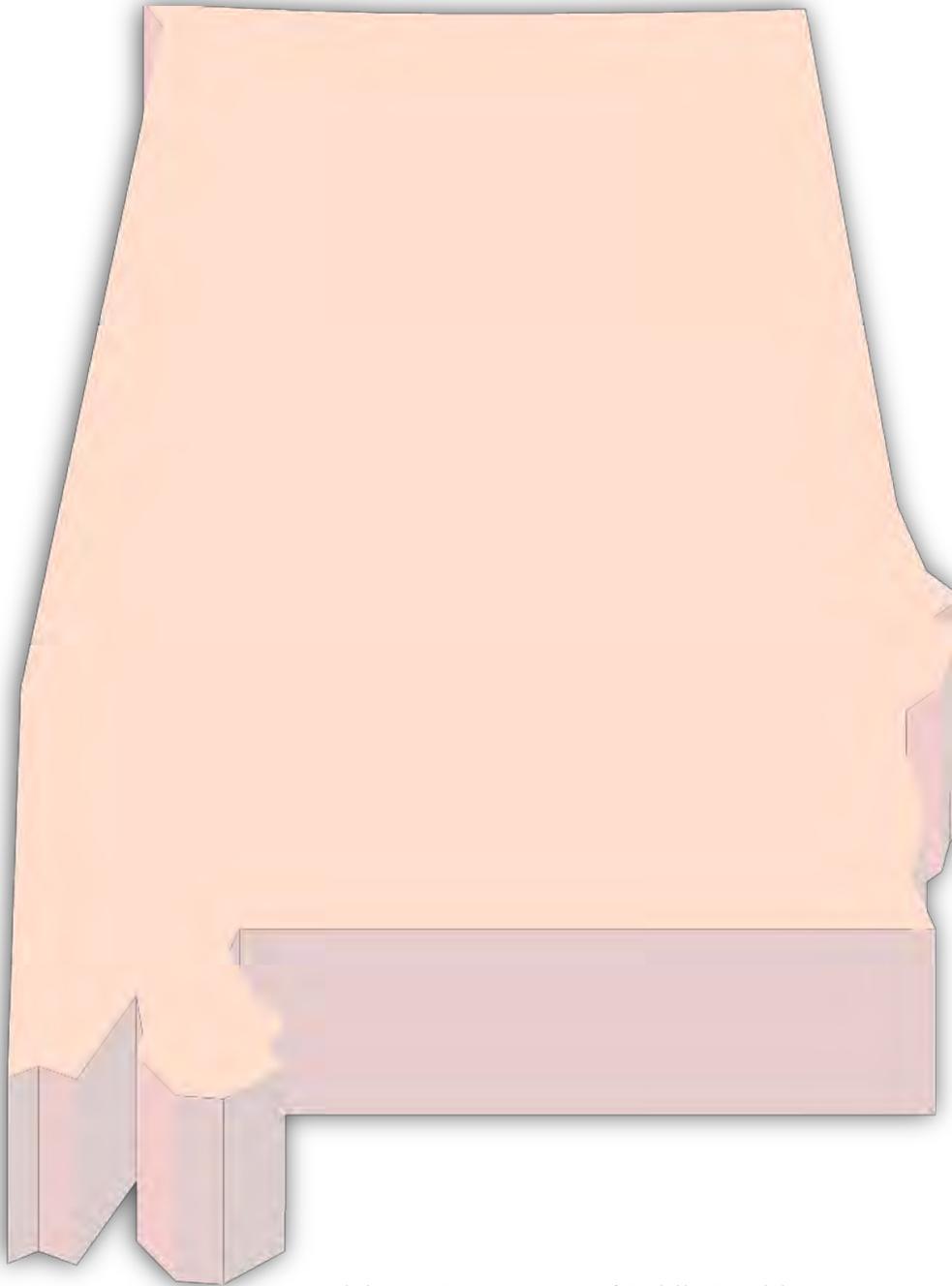


Alabama
2012-2016 Statewide Jurisdictional HIV Prevention Plan



Alabama Department of Public Health
Division of HIV/AIDS Prevention and Control



know.
manage.
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Executive Summary

The 2012 Jurisdictional HIV Prevention Plan (HPP) for Alabama demonstrates the collaboration between the HIV Prevention Planning Group (HPPG) and the Alabama Department of Public Health (ADPH), Division of HIV/AIDS Prevention and Control (DHPC). The HPPG is the statewide HIV Prevention Planning Group. The DHPC uses the HPP to guide programs and allocate resources for HIV prevention throughout the state.

The HPP proposes interventions to reduce the burden of HIV in Alabama based on the latest approaches, programs and/or models as recommended by the Centers for Disease Control and Prevention (CDC) and other national agencies. Federal partners such as the National Alliance of State and Territorial AIDS Directors (NASTAD), Southern AIDS Coalition (SAC), Health Resources and Services Administration (HRSA) and the Office of National AIDS Policy (ONP) offer science-based data and recommendations supported by capacity-building assistance to strengthen the State's program development activities.

This process involves the identification and engagement of stakeholders and other HIV service providers to develop a results-oriented process for a seamless approach to providing HIV services. The HPP is designed to, (1) strengthen coordination and integration of local HIV core and support services; (2) improve linkages between service providers; and, (3) encourage linkages and collaboration between prevention and direct care providers. Ultimately, the HPP is intended to expand the capacity of prevention and care services to implement high quality, scientifically-sound, culturally competent, scalable services that reach individuals at highest risk and those disproportionately affected by HIV.

The HPP is a living document with goals, objectives and specific tasks in alignment with the current Funding Opportunity Announcement (FOA) PS12-1201, and the National HIV/AIDS Strategy (NHAS). The HPP will be reviewed yearly and revised as needed as the five-year project period unfolds to respond to the changing needs of our target populations.

The shift of the NHAS to identify HIV positive persons, their partners, and other high-risk individuals demands that the HPP remain flexible. The NHAS encourages leadership for improved dynamic service delivery from all providers, despite less emphasis on primary prevention. The DHPC is committed to providing capacity-building assistance for specialized programs that demonstrate the potential for the greatest impact on individuals, groups, institutions, at-risk populations, and communities in need.

This HPP is the result of the commitment of diverse Alabamians to prevent the advancement of HIV infection. The primary goal of The HPP is to provide HIV prevention and care in order to reduce new infection, increase access to care, and reduce health-related disparities in Alabama.

I. Introduction

A. Overview of Alabama's HIV Prevention and Control Program

The ADPH divides the State into eleven Public Health Areas (PHA) (see Appendix A) to facilitate coordination, supervision, and development of public health services. Ranging in size from one to eight counties, the areas are determined primarily by population. The most populous counties, Jefferson and Mobile, are the only single-county PHAs. Each area has a regional office responsible for developing and managing local programs of public health services to meet the needs of that particular area. Each of Alabama's 67 counties has at least one county health department.

The DHPC which operates under the auspices of the Bureau of Communicable Disease is responsible for planning, organizing, and implementing HIV/AIDS project activities and initiatives for Alabama. The Division has six branches: Administration, Communication and Training, Direct Care and Services, Prevention Planning and Development, Evaluation and Quality Management and Surveillance.

Since 1988, all 67 county health departments in Alabama have offered voluntary and confidential HIV counseling and testing to individuals seeking STD, TB, Maternity, and Family Planning services. Counseling, testing, referral and partner notification (CTRPN) services are under the direction and administration of the Division of STD Control. Public health nurses are trained to perform both HIV pre-test and post-test counseling. Disease Intervention Specialists (DIS) perform counseling, make referrals to social and medical services, and perform partner notification activities for those who test positive. DIS refer and counsel HIV negative clients who have specific issues that need to be addressed.

All eleven of the State's Public Health Areas have an Area STD Program Manager and an Area HIV Prevention Coordinator. STD Program Managers are responsible for implementing and managing HIV CTRPN and STD programs for their assigned area. HIV Prevention Coordinators are responsible for coordinating activities related to HIV prevention, including coordinating and collaborating with stakeholders in the community. Coordinators, along with community volunteers, have served as co-chairs for the former regional Community Planning Groups (CPG).

Due to the success of the past regional CPG and the desire of members to remain connected, the groups were reformed with changes in their collaboration activity roles and responsibilities. These groups were renamed HIV Prevention Networks (HPN). Network representatives now serve on the Alabama HIV Prevention Planning Group (HPPG). Many STD managers and staff have been active members of community planning from the beginning, and continue to play major roles in the process.

B. HIV Prevention Planning Group Process

The DHPC is responsible for development of the Alabama HIV Prevention Plan (HPP). In 2003, the current HPPG process transitioned from multiple CPGs to one formal statewide body. The HPPG consists of 33 members representing a wide range of those affected/infected and other key stakeholders. During the five-year (2012-2016) project period, the DHPC and the HPPG will initiate and expand new opportunities for community engagement.

The HPPG's purpose is to develop and implement both community engagement and the statewide jurisdictional plan. The DHPC and other HIV service partners use the HPP as a framework to: (1) ensure prevention and care activities are in alignment with the National HIV/AIDS Strategy (NHAS); and, (2) promote the execution of High Impact Prevention (HIP) programs and activities, and monitor progress within Alabama's communities. Ongoing collaboration with partner organizations beyond HPP development will have a multiplier effect in expanding efforts to prevent new HIV infections and linkages to services.

From September 2011- August 2012, the HPPG convened to identify populations with the greatest burden and risk for HIV utilizing current data sources, such as the HIV Epidemiological Profile and Arc10 GIS software. Based on these and other sources, the HPPG re-evaluated the current plan, reviewed existing resources and determined the current needs, gaps, prevention activities/interventions, goals, and objectives.

Committees were created and tasks were assigned. The HPPG members actively participated in the development and refinement of Alabama's HPP. A Steering Committee comprised of HPPG members, stakeholders, service providers, consumers, DHPC staff, and other community members met five times to oversee the development of the five-year plan. Drafts of the revised HPP were reviewed by the HPPG for comments and recommendations in July 2012. The HPPG provided a letter of concurrence at the August HPPG meeting. The final approved HPP will be available on the DHPC website at <http://www.adph.org/aids/>.

The Alabama 2012-2016 HIV Prevention Plan will foster a process that encourages parity, inclusion, and representation among HPPG members and the HIV community. Strong partnerships and increased coordination across HIV programs will strengthen strategies to reduce rates of new HIV infections in Alabama.

C. Cross Program Collaboration

In 1994, the HIV, STD, and TB Programs of the ADPH began an organized effort to work together cooperatively. Currently, the DHPC and the STD Division central office staffs work together to assure continuity of services and achievement of goals and objectives for HIV/STD prevention and control. Representatives from both programs have been cross-trained in HIV and STD issues and screening methods. Regular meetings occur to review activities, discuss progress, and plan future collaborative efforts. Disease Intervention Specialists (DIS) participate in the community planning process.

In 2011, the Viral Hepatitis program joined the DHPC. Through funding from the CDC, the Viral Hepatitis Prevention Program Coordinator will collaborate with the DHPC to integrate hepatitis activities focusing on high-risk groups such as persons with a history of incarceration, persons with a history of illicit drug use, and persons with a history of multiple sexual partners. During the next three years, the Viral Hepatitis core activities will include community education with a focus on Alabama's inmates. Promotional awareness, professional training, and capacity building will be primary tools used to prevent and control viral hepatitis throughout the state.

All programs share responsibility for the collection and analysis of HIV counseling and testing data. Counseling, Testing, Referral and Partner Notification (CTRPN) services are performed by

the STD Program for clients who test positive for HIV in both public and private health care settings. In addition, clients who test positive for HIV are referred for a tuberculin skin test. HIV/AIDS-related reports are forwarded from the STD Division to the HIV/AIDS Surveillance Branch for data entry and analysis.

HIV and STD prevention programs will continue to work closely to plan and implement strategies for HIV prevention through early detection and treatment of STD. Proposed strategies include refinement of counseling and testing activities, data gathering techniques for HIV/STD risk assessment, and inclusion of community-based ASOs in cross-program training.

II. Alabama Epidemiological Profile

A. Overall Trends

One point two million (1,200,000) people in the United States are living with HIV infection. The CDC estimated that 20% of these people are unaware of their infection. Between 1982 and 2011, 17,839 cases of HIV infection were reported to the ADPH. At the end of 2011, 64% (11,342) were known to be living. An additional 2,000 to 4,000 Alabama residents are projected to be infected and unaware of their positive HIV status. The HIV epidemic in Alabama is classified as one of moderate magnitude when compared to the experience of other states. During 2011, 706 newly diagnosed HIV infections were reported in Alabama.

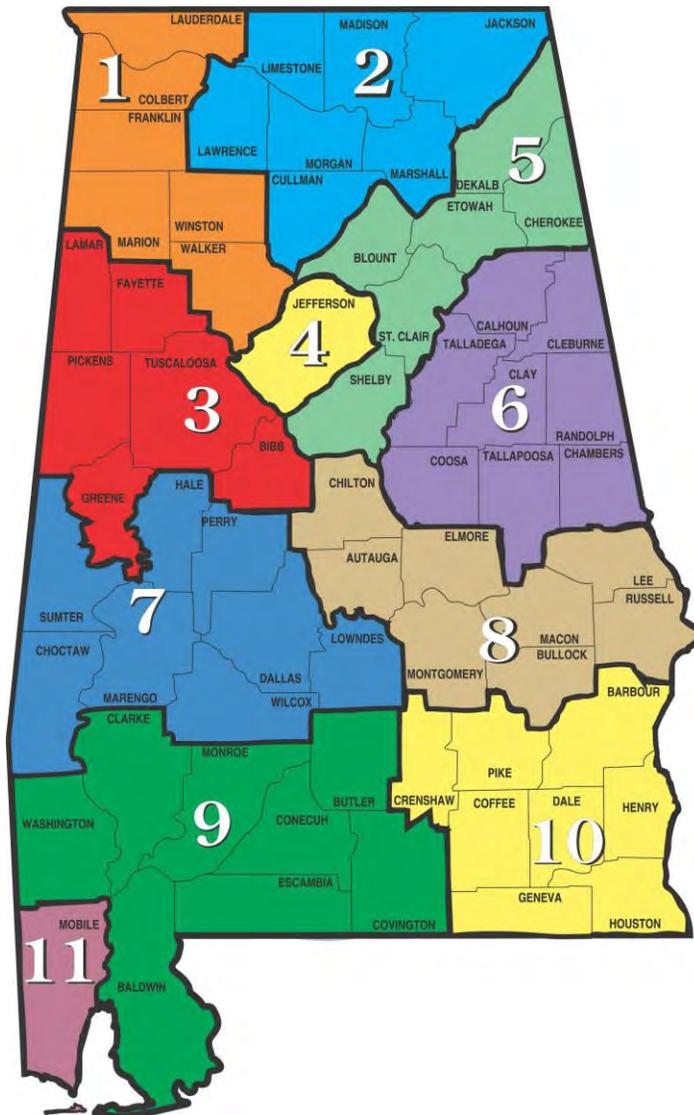
Following the 2010 decennial census, the United States Census Bureau reported 4,779,736 persons reside in Alabama. The majority of residents (62%) were between the ages of 18 and 54 years, 24% were younger than 18 years, and 14% were 65 or older (median age = 37.8). The incidence and prevalence of HIV infection in Alabama is highest among individuals aged 13 to 44 years, with 76% of newly diagnosed HIV infections and 81% of prevalent cases occurring in this age group during 2011. Males accounted for three-quarters (76%) of incident cases in 2011, with African-American (AF-AM) males representing one-half (50%) of all newly diagnosed HIV cases. White males represented another 21% of 2011 incident HIV infections. AF-AM females followed closely, representing 19%.

New infections are disproportionately occurring in Alabama's AF-AM population. Although AF-AMs comprised only 26% of the state's population in 2011, they represented 69% of newly diagnosed HIV infections. The rate of HIV/AIDS diagnosed among AF-AMs (38.4 per 100,000) was more than seven times higher than among Whites (5.3 per 100,000). AF-AM males represented 66% of all cases diagnosed in males during 2011. The rate of newly diagnosed HIV infections in AF-AM males (60.2 per 100,000) was more than six times higher than White males (9.1 per 100,000). A similar trend was seen among AF-AM females, with 78% (131) of all incident diagnoses in females represented by this group. The rate of HIV incidence in AF-AM females (19.4 per 100,000) was eight times higher than White females (1.6 per 100,000) and two times higher than White males (9.1 per 100,000).

Alabama's population can be divided into three geographic groupings: major urban centers (>200,000 population), minor urban centers (100,000-200,000 population), and rural areas (<100,000 population). Major urban centers include Jefferson, Madison, Mobile, and Montgomery Counties. In 2010, these major urban centers represented 34% (1,635,632) of the

State's total population and 61% (10,597) of cumulative HIV cases reported to ADPH. Minor urban centers include eight counties and comprised 24% (1,156,292) of the State's population and 14% (2437) of cumulative HIV cases. Rural areas accounted for 25% (4256) of cumulative HIV cases. Alabama is considered primarily rural with 55 of the 67 counties located outside of the State's major and minor urban population centers (Figure 1).

[Figure 1] Alabama Public Health Area Map



Source: Alabama Department of Public Health

Following the 2010 census, nationally, Alabama ranked 42nd in per capita income with 23% of the population living in poverty. Alabama's agricultural Black Belt region across the central part of the State has the highest poverty and unemployment rates in the State. The region also encounters disproportionately high rates of HIV infection. Though only representing 13% of Alabama's total population, the Black Belt region reported 23% (3574) of all incident cases in 2010. Statewide, the rate of incident HIV infections per 100,000 persons was highest in

Lowndes (53.1), Montgomery (38.4), Hale (38.1), Chambers (35.1), Jefferson (31.4), and Conecuh (30.2) counties.

HIV clinics and service organizations apply to ADPH for Ryan White funding to provide priority core service and support services, with appropriate justification based on Health Resources and Services Administration (HRSA) guidelines. Funding decisions are made using a formula based on Alabama's current service utilization, unmet need, and data provided in the HIV Integrated Epidemiologic Profile. Social workers, case managers and clinicians employed in Ryan White funded HIV clinics and service organizations are responsible for coordinating direct care and service delivery. The majority of HIV care providers and services are located in Alabama's major urban centers. However, alternate care and services are offered at satellite clinics located in many rural areas across the state.

People living with HIV infection are experiencing increased longevity due primarily to positive HIV/AIDS treatment outcomes. As of December 2010, ADAP offered medication services with an enrollment cap of 1700 and a waiting list of 200-300 clients was required. The ADAP formulary offers 72 medications, and includes at least one drug from each class of HIV medications. In addition, a limited number of medications to treat opportunistic infections are available through ADAP. In FY 2011, additional federal funding allowed the cap to be removed and currently enrollment has increased to over 1850, with an average medication pick-up rate of approximately 85%. Alabama's public health care system and resources are significantly stressed as the care and service needs of people living with HIV infection in Alabama's urban and rural areas continues to increase.

The HIV epidemic affects persons in all gender, age, race, ethnicity, and socioeconomic groups in every county in Alabama. However, the effect has not been the same for all groups. Recent trends suggest a shift in the HIV epidemic toward AF-AMs and high-risk heterosexual activity. With the number of deaths among people diagnosed with HIV continuing to decline and the number of people living with HIV continuing to increase, the importance of identifying populations most affected and at risk for HIV infection is paramount. Alabama must be diligent in planning effective HIV prevention and care efforts with the allocation of limited resources.

B. HIV Prevention Planning Group - Epidemiologic Committee

The HIV Integrated Epi-Profile provides information about the current HIV/AIDS epidemic in Alabama. This profile describes the socio-demographic, economic and geographic characteristics of people living with and at-risk for HIV infection in Alabama. The profile is a resource for guiding prevention interventions and service delivery efforts to justify and obtain funding for implementation of prevention and service programs, and to improve and evaluate HIV-related programs and policies in Alabama.

C. Data Sources

To better serve local communities, the Epidemiologic Committee of the HPPG collaborated with the HIV Surveillance staff to analyze and improve the impact of prevention efforts within Alabama utilizing the following data sources:

a. Enhanced Referral Tracking System (ERTS)

The DHPC's ERTS database provides significant data in determining the demographics and

geographical location of HIV positive residents aware of their HIV status and not in-care.

b. America’s Health Rankings

The United Health Foundation partners with the American Public Health Association and Partnership for Prevention to publish America’s Health Rankings, which provide the longest running state-by-state analysis of the nation’s health.

c. Auburn University at Montgomery (AUM) Center for Demographic Research

The Auburn University at Montgomery (AUM) Center for Demographic Research conducts high quality research on population topics, and provides demographic data, research results, and guidance to Alabama's citizens, businesses, non-profit organizations, and public agencies.

d. Birth and Death Data

The ADPH Center for Health Statistics receives information on all births and deaths occurring in Alabama. Birth certificates include demographic information about newborns and parents, including insurance status, prenatal care, prenatal risk factors, maternal morbidity, mode of delivery, pregnancy history, and clinical characteristics of the newborn. Death certificates include demographics, underlying cause of death, and contribution of selected factors to death. The data can be used to determine the number of deaths related to HIV across the State or in a specific area. Deaths resulting from AIDS or whose underlying cause was HIV infection may be under reported on a death certificate. Clinical information related to HIV status may be missing.

e. Direct Care Update Report

The HIV Direct Care and Services Branch oversees Alabama’s Ryan White Part B program activities, including medical and social services, medical and non-medical case management, and ADAP. HIV direct care and service providers apply for Ryan White funding through the DHPC to provide defined core medical and support services to the HIV positive patient population. ADAP’s goal is to reduce associated morbidity and mortality among HIV infected persons by delaying the progression of HIV disease through prevention and treatment.

f. HIV Surveillance Data

The ADPH has been collecting confidential AIDS and HIV information since 1982 and 1987, respectively. Standardized case report forms are used to collect socio-demographic information, mode of exposure, laboratory and clinical information, and vital statistics. HIV data may underestimate the number of recently infected individuals as many people have not been tested and are unaware of their status. In addition, newly diagnosed cases may be reported to the health department at any point during the clinical spectrum of disease. Therefore, HIV surveillance data provides an estimate of the number of persons known to be infected with HIV.

g. Kaiser Family Foundation

The Kaiser Family Foundation is a non-profit, privately operating foundation focusing on the major health care issues facing the United States, as well as the nation’s role in global health policy. The Foundation serves as a non-partisan source of facts, information, and analysis for policymakers, the media, the health care community, and the public. The Foundation provides free, up-to-date, and easy-to-use health data for all 50 states. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

h. Sexually Transmitted Disease (STD) Case Reporting

The Division of STD Control conducts statewide surveillance to determine the number of reported STD cases and to monitor trends. Services provided include partner counseling and notification, referral services for examination, treatment, and social services. STD data is widely available at the state and local level and serve as surrogate markers for unsafe sexual practices and demonstrate the prevalence of changes in specific behaviors because of shorter incubation periods between exposure and infection. Chlamydia, gonorrhea, HIV, and syphilis are reportable STDs in Alabama. Certain STDs (e.g., ulcerative syphilis) can facilitate the transmission or acquisition of HIV infection. Changes in STD trends may indicate changes in characteristics of persons who are at-risk for HIV, may delay testing, or who are not tested at all.

i. United States Census Bureau

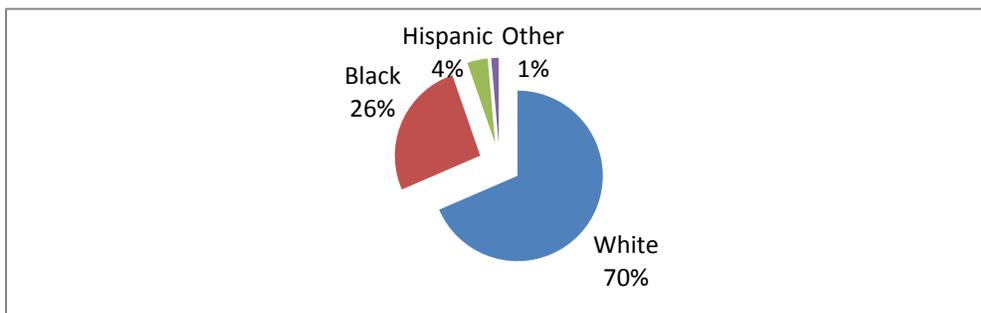
The Census Bureau collects and provides information about the people and economy of the United States. The Census Bureau's website (<http://www.census.gov/>) includes data on demographic characteristics of the population, family structure, educational attainment, income level, housing status, and the proportion of persons who live at or below the federal poverty level. State and county-specific data (e.g. reports on population changes) are easily accessible, and links to other websites with census information are included.

j. Youth Risk Behavior Surveillance Survey (YRBSS)

The Youth Risk Behavior Surveillance Survey (YRBSS) is a self-administered questionnaire given every two years to a representative sample of high school students (grades 9 to 12) at State and local levels. In Alabama, the survey is administered at the State level and includes questions related to sexual behavior and drug use. The YRBSS is a standardized questionnaire, so comparisons can be made across participating jurisdictions. Jurisdictions have the ability to add questions of local interest. A limitation of the YRBSS project is the potential for under or over reporting as the survey relies upon self-reported information. Another limitation is data are representative only of adolescents enrolled in school and cannot be generalized to all adolescents. A third limitation significant to HIV risk factor assessment is that the survey does not include questions about homosexual or bisexual behavior.

Based on these data sources, the HPPG Epi Committee compiled, analyzed, and presents the following data to determine cost-effective and scalable interventions targeted to the appropriate populations in the appropriate geographic areas to develop this 2012-2016 HIV Prevention Plan.

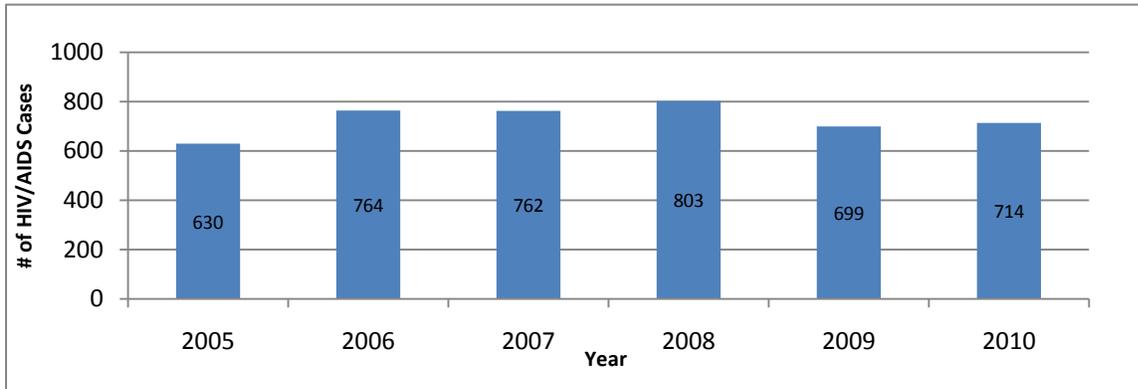
[Figure 2] Alabama Population, 2010



Source: <http://quickfacts.census.gov/qfd/state>

According to the US Census Bureau, in 2010 the population of Alabama was 4,779,736. Of the population, 70% are white, 26% are black, 4% are Hispanic, and 1% is constituted of “other”.

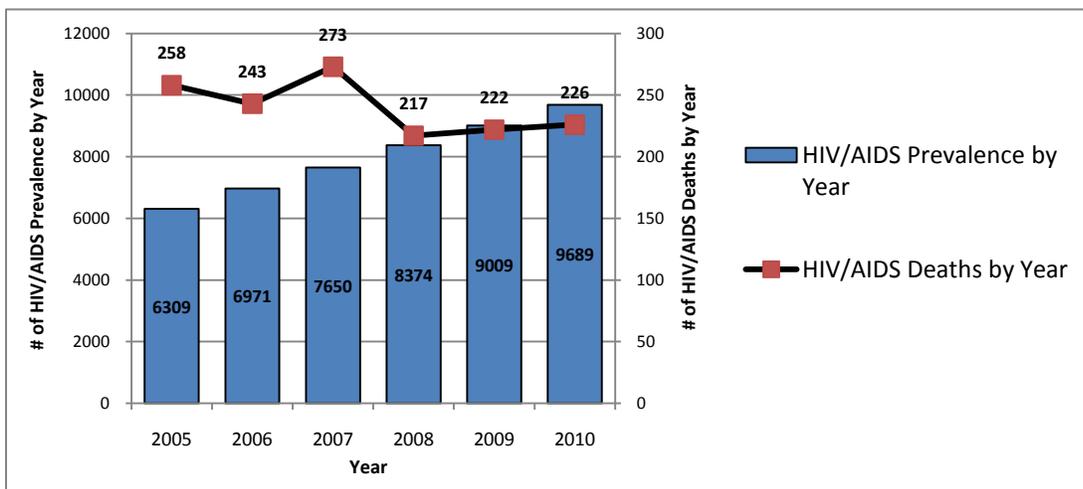
[Figure 3] Alabama 2005-2010: HIV/AIDS Cases by Year of Diagnosis



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

In the above chart, HIV/AIDS cases are charted by year of diagnosis. In 2008, Alabama reached an all-time high with 803 reported cases. Although there was a small decline the following year, numbers for 2009 and 2010 indicate that the cases may increase again in future years.

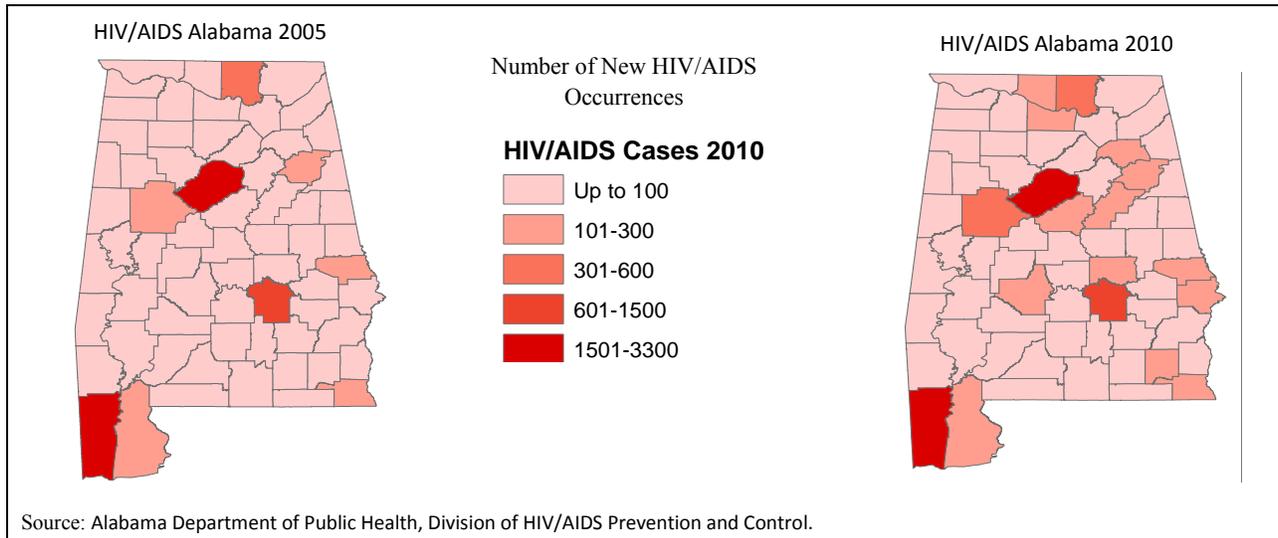
[Figure 4] Alabama 2005-2010: HIV/AIDS Prevalence Compared with Deaths by Year



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

In the above chart, the number of prevalent cases of HIV/AIDS is mapped. Figure 4 demonstrates the number of people living with HIV/AIDS that are potentially eligible for Direct Care Services in Alabama. As people living with HIV are living longer, Alabama’s public health care system and resources are significantly stressed as their care and service needs continues to increase in all areas of the State.

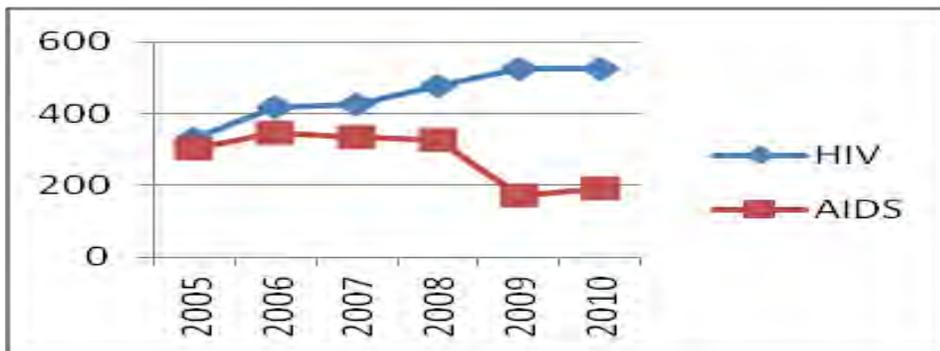
[Figure 5] Alabama 2005-2010: HIV/AIDS Cases Trend By Year of Diagnosis per County: (People Living with HIV/AIDS by County)



In Figure 5, the HIV/AIDS epidemic trend is mapped over a 6-year period. While it appears that HIV/AIDS diagnoses as a whole have decreased, counties with higher population experienced a significant increase in persons reported living with the disease. New prevention measures are needed to address these larger counties and their surrounding areas to decrease future infections.

With the development of Highly Active Antiretroviral Therapy (HAART), persons found HIV positive are able to live longer and more productively than those who were diagnosed HIV positive early in the epidemic. Figure 5 shows the decrease in deaths of people living with HIV/AIDS from 2005 – 2010.

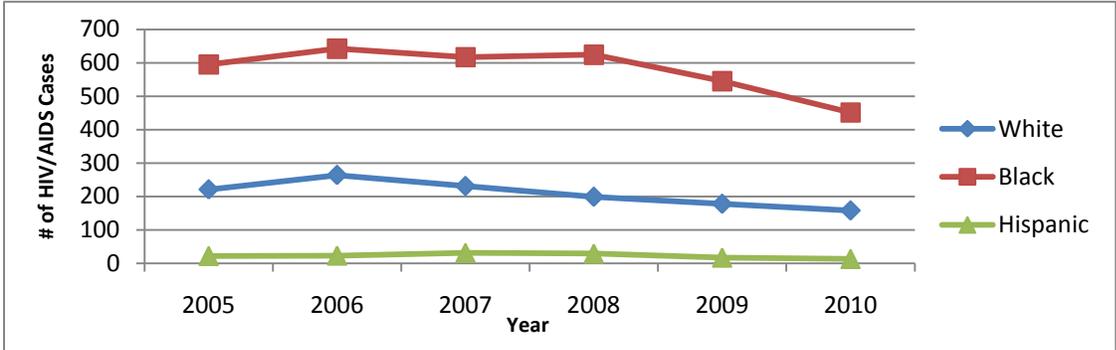
[Figure 6] Alabama 2005-2010: HIV/AIDS Cases by Disease Status and Year of Diagnosis



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

Beginning with the first diagnosis of HIV/AIDS in Alabama residency in 1982, the number of persons diagnosed with AIDS has historically superseded the number of persons diagnosed with HIV. Clearly demonstrated by Figure 6, this is not currently the case. The number of AIDS diagnoses has decreased, while the number of people diagnosed with HIV has increased.

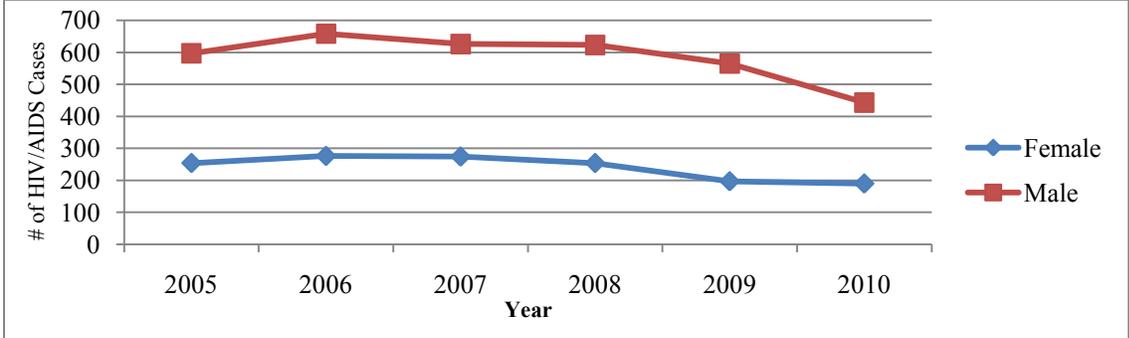
[Figure 7] Alabama 2005-2010: HIV/AIDS Cases by Race/Ethnicity and Year of Diagnosis



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

Figure 7 depicts the over-all decrease in HIV/AIDS cases as shown in Figure 2. However, in this chart one can identify to which race/ethnicity the highest risk of becoming HIV/AIDS positive belongs. The black community has the highest risk population within the state of Alabama followed by the white community with the second highest risk population, and the Hispanic community with the lowest at risk population.

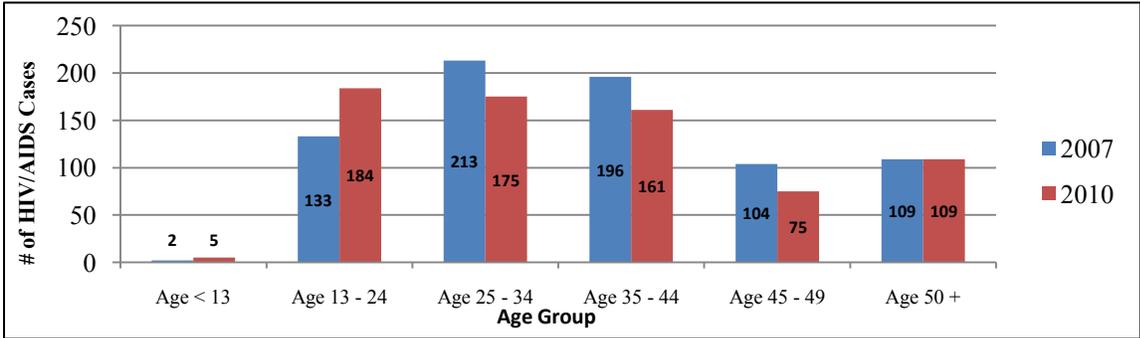
[Figure 8] Alabama 2005-2010: HIV/AIDS Cases by Gender & Year of Diagnosis



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

Figure 8, shows males are bearing a doubled burden of HIV/AIDS, when compared to women. In 2010, based on the latest available data, the number of males affected are double that of females. Females have held consistently between 200-250 cases annually for the 6-year period.

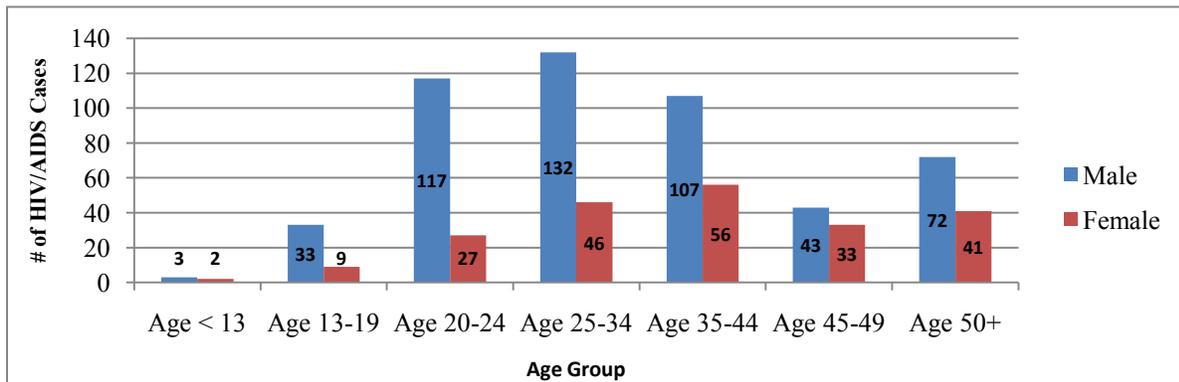
[Figure 9] Alabama 2007 and 2010: HIV/AIDS Cases by Age Group



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

In Figure 9, the number of diagnosed cases for each age group is shown for 2007 and 2010. Based on these data, the age groups that should be closely monitored are 13-24, 25-34, and 35-44. When compared with 2007 data, cases within age group 13-24 have significantly increased, while cases within age groups 25-34, 35-44, and 45-49 have decreased, and cases within age group 50+ are unchanged.

[Figure 10] Alabama HIV/AIDS Cases by Gender and Age Groups, 2010



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

In Figure 10, more males are demonstrated to be infected across all age groups in 2010.

[Figure 11] Alabama HIV/AIDS Cases by Ethnicity and Age Groups, 2010

Race/Ethnicity	<13	13-24	25-34	35-44	45-49	50+	Unknown
White	1	32	37	51	20	23	1
Black	3	142	127	102	53	82	4
Hispanic	0	3	5	7	0	1	0
Asian	0	0	0	1	0	0	0
American Indian/ Alaska Native	0	0	0	0	0	0	0
Pacific Islander	0	0	0	0	0	0	0
Multi-Race	1	7	5	0	1	3	0
Unknown	0	0	1	0	1	0	0
Total	5	184	175	161	75	109	5

Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

Figure 11 shows the age stratified by race/ethnicity variables compared for 2010. The Black ethnicity groups in the 13-24 age groups have the highest number of cases. The 25-34 year old groups and 35-44 age groups follow.

C. HIV/AIDS Cases by Exposure Category

[Figure 12] Alabama HIV/AIDS Cases by Exposure Category, 2010

Subpopulation Prioritization				
Risk Population	Subpopulation	Total Population	Avgas Yearly Cases 2005-2010	Avgas Yearly Rate/100,000
MSM	Black	35,077	209	596
Avg Yearly New Dx: 327	Hispanic	5,503	9	166
Avg Rate/100,000: 229	White	102,112	98	96
	13-19	17,048	23	136
	20-24	11,894	63	526
	25+	106,606	242	227
	HIV +			
FSM	Black	483,399	159	33
Avg Yearly New Dx: 203	Hispanic	50,983	5	9
Avg Rate/100,000: 11	White	1,250,329	34	3
	13-19	230,138	15	7
	20-24	167,802	29	17
	25+	1,666,607	159	10
	HIV +			
MSF	Black	434,267	66	15
Avg Yearly New Dx: 81	Hispanic	68,134	3	4
Avg Rate/100,000: 5	White	1,264,175	10	1
	13-19	211,055	2	1
	20-24	147,250	9	6
	25+	1,319,814	70	5
	HIV +			
M/IDU	Black	692	29	4,247
Avg Yearly New Dx: 45	Hispanic	109	0	227
Avg Rate/100,000: 1655	White	2,013	13	626
	13-19	336	1	193
	20-24	235	2	1,052
	25+	2,102	41	1,953
	HIV +			
F/IDU	Black	813	20	2,468
Avg Yearly New Dx: 36	Hispanic	86	1	951
Avg Rate/100,000: 1227	White	2,007	14	684
	13-19	322	1	314
	20-24	235	5	1,926
	25+	2,333	30	1,295
	HIV +			
MSM/IDU	Black	49	15	30,848
Avg Yearly New Dx: 29	Hispanic	8	0	3,089
Avg Rate/100,000: 15,023	White	143	13	8,811
	13-19	24	1	2,705
	20-24	17	2	14,540
	25+	149	26	17,198
	HIV +			
Rate/100,000 greater than average rate				

Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

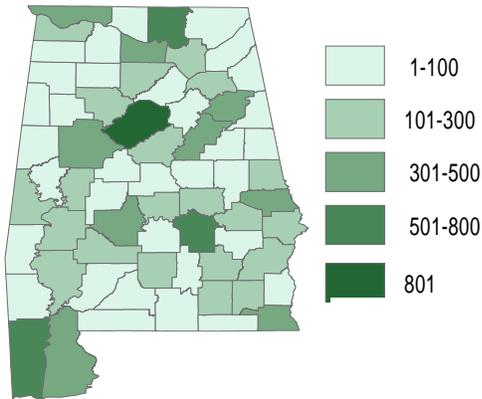
In Figure 12, the top six exposure categories are shown. The categories determined to be at highest risk were obtained by comparing the percentage of the total that the category contributed to the total and sorting out the top six.

D. Surrogate Markers for HIV Infection

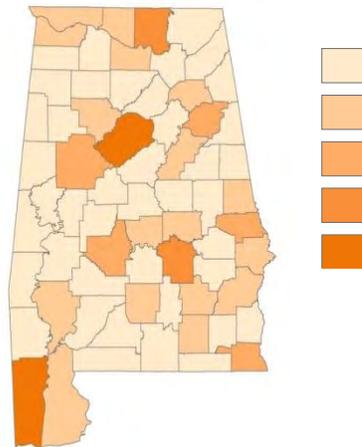
STD rates can be used as surrogate markers for HIV. These maps show Chlamydia, gonorrhea, syphilis, and Teen Pregnancy numbers are highest in Jefferson (Birmingham), Montgomery, Madison (Huntsville), and Mobile Counties. Shown below is a direct relationship between the amounts of occurrences of a specific phenomenon and the number of HIV/AIDS cases reported.

To effectively reduce the occurrence of HIV/AIDS, the surrogate markers must be closely monitored and attempts at reduction in their occurrence must be taken. In order to counteract a future rise in HIV/AIDS, the counties with a high number of occurrences must receive a focus.

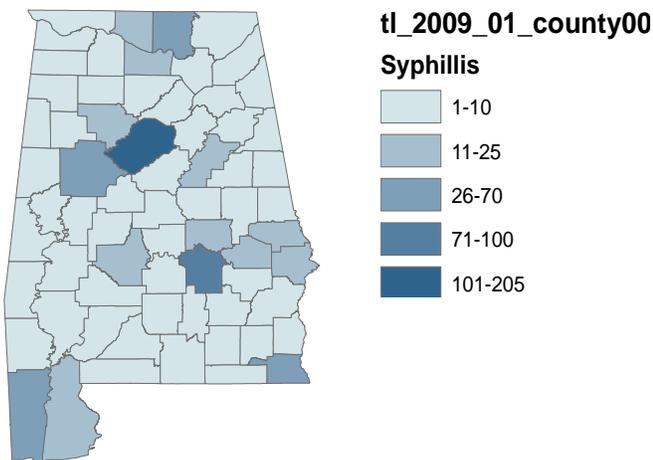
Chlamydia Cases 2010



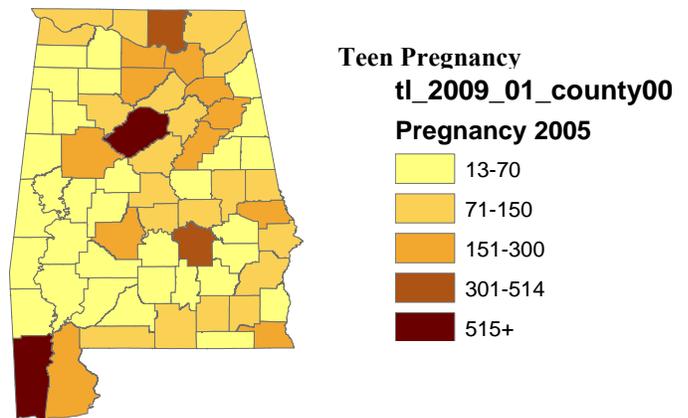
Gonorrhea Cases 2010



Syphilis Cases 2010



Teen Pregnancy Cases 2010



III. Capacity of the Division of HIV/AIDS Prevention and Control (DHPC)

A. Background and Need

Alabama continues to experience an HIV/AIDS epidemic of moderate magnitude when contrasted with the experience of other states. The HIV epidemic affects persons in all gender, age, race, ethnicity, and socioeconomic groups in every county in Alabama.

Recent trends suggest a shift in the HIV epidemic toward Black males and Black females with heterosexual activity. With the number of deaths among people diagnosed with HIV continuing to decline and the number of people living with HIV continuing to increase, the importance of identifying populations most affected and at risk for HIV infection is paramount. To plan for HIV prevention services and to allocate limited resources as the epidemic continues to change and the number of persons living with HIV/AIDS continues to increase, it is extremely important to identify those populations most affected and most at risk for HIV infection.

Between 1982 and 2011, a total of 17,839 Alabama residents had been diagnosed with HIV/AIDS and reported to the Alabama Department of Public Health (ADPH). At the end of 2011, 64% (11,342) were known to be living. Currently 33.78% of the prevalent HIV/AIDS cases are between the ages 25-34 years and 28.06% live in Public Health Area IV (see Appendix A). Alabama does not have any metropolitan divisions that have at least 30% of the persons living with HIV. During 2011, 706 Alabamians were diagnosed and reported to ADPH with HIV infection. 72% of new infections are occurring in Alabama's Black population and 50% are reported in people under the age of 34. In 2011, Black males represented 67% of the HIV/AIDS cases diagnosed among males. The rate of HIV/AIDS diagnosed among Black males at 60.2/100,000 was more than six times higher than White males at 9.1/100,000. The proportion of HIV/AIDS diagnosed among females has been stable over the past four years.

In 2011, Black females accounted for 78% of the HIV/AIDS cases diagnosed among females. The rate of HIV/AIDS diagnosis for Black females of 19.4 per 100,000 was higher than both White females at 1.6 per 100,000 and White males at 9.1 per 100,000. Among Blacks in 2011, heterosexual sex and male-to-male sex (69.9%) were predominate modes of exposure (excluding no identified risk). Among Whites, predominate mode of exposure reported was male-to-male sex (60.7%). Since the early years in the HIV epidemic, the Division of HIV/AIDS Prevention and Control (DHPC) has nurtured its relationships with state and community partners to gain acceptance as a recognized leader and partner in reducing the spread of HIV disease. The system of HIV/AIDS programs in Alabama is supported through a network of services statewide. The Alabama Department of Public Health (ADPH) through the DHPC sets program policy and provides guidance, technical assistance and financial support to twelve AIDS community-based and services organizations; the University of Alabama medical and hospital systems; the University of South Alabama medical and hospital systems; the Alabama Primary Care Association with clinic affiliates; fifteen Historically Black Colleges and Universities; the STD program of the ADPH; numerous other public and private partnerships, and the eleven regional ADPH offices.

CDC mandates HIV Prevention Planning (HPP) process under the direction of the DHPC. The HPP process has provided a solid foundation for the state's prevention efforts since 1992. The participation of "community" represents a wide range of those affected/infected, agency representatives and other interested individuals partnering with the State and local health departments to address the epidemic in Alabama maximizing the effectiveness of current prevention and care programs activities and strategies. The HPG has evolved into the current 33 elected member infrastructure for the direction of prevention program activities statewide.

The DHPC not only involves consumers through the HPG process, but continues to support the Alabama Consumer Advisory Board (ACAB) which sponsors an annual conference targeting HIV consumers and other participants statewide. In 2010, 62 consumers attended the one-day conference. Another consumer-driven prevention and care service, offered by DHPC since 2005 focuses on connecting PLWHA (persons living with HIV/AIDS) and their partners, and high-risk negatives to care, as well as retaining and reengagement of clients for services. Seven contracted Peer Mentors work closely with regional HPCs and ASO statewide. Peer Mentors are HIV-positive individuals whose mature handling of their own disease is a model for others.

Even with the monitored programs in place, gaps in services still remain to identify individuals who are at greatest risk of infection; unaware of their positive serostatus; and, PLWHAs not "in care". The DHPC attempts to narrow these gaps by increasing the provision of test kits to approved providers; implementing a legislatively mandated reporting requirement for viral loads and CD4 counts to identify HIV positive individuals; expanding linkage services to further track clients beyond the first "kept" appointment; enhancing post-test education of HIV positive clients and their partners; expanding HIV awareness, education and testing to populations living in high-risk environments to prevent new infections; improving access to services in rural areas of the state; and, supporting more coordination of services such as transportation, housing, and other daily living needs of HIV positive clients.

The DHPC senior and mid-level staff has over 30 years of service in the HIV/AIDS field. Since funding prevention and care services is becoming more synchronized at the federal level, the roles of the DHPC staff are coordinated more at the state level using a team approach in program development. The staff expertise includes the disciplines of Public Health Epidemiology, Health Administration, Health Behavior, Education, Nursing, Legal, Social Work, Health Information and Technology, Behavioral Science, and School Health Education. These individuals assist with grant preparation, program development and organization, monitoring and evaluation, and quality assessment and improvement. This collaborative team approach opens communication across program lines. Our team actions further ensure a commitment towards health equity and a commitment to structuring a statewide seamless system of programs and services for those we serve in Alabama.

The HIV Prevention program of the DHPC has the experience, expertise, and existing capacity to provide services that address the HIV epidemic within Alabama. The DHPC has six branches: Administration, Communications and Training, Prevention Planning and Development, Direct Care and Services, including the ADAP, Surveillance, and Quality Management and Evaluation.

DHPC has committed to five primary long-range goals which are consistent with the goals of the National HIV/AIDS Strategy (See Appendix B for Statewide goals and objectives).

1. Reduce the incidence of new HIV infections in Alabama: Counseling, testing and partner services (CTPRS) is a shared responsibility of the STD Division and the DHPC. The HIV surveillance branch works closely with the HIV Planning Groups (HPG) and staff to improve the understanding of epi-profile data trends and implications for targeted services. The coordination and delivery of services is assured by communication, planning, and resource sharing across programs and divisions.

2. Improve public understanding of, involvement in, and support for HIV prevention: The HPG process assures community engagement and is an effective mechanism for input and participation by a diverse group of individuals statewide for HIV prevention and direct care services delivery. The HPG and its HIV Prevention Plan are valued as the “go to” body to get relevant and accurate information. Accountability and reporting to the HPG by funded agencies is a requirement of grantees. HIV Program Coordinators are strategically located statewide to network with agencies and expand collaborative prevention efforts.

3. Prevent/reduce behaviors that transmit HIV: Since 1997, the HIV Division has offered funding opportunities to community-based agencies for implementation of prevention interventions using traditional Diffusion of Effective Behavioral Interventions (DEBIs). To be funded, projects must be based on the Epi profile, consistent with the State Comprehensive plan and include an HIV Counseling, Testing and Referral component.

4. Increase individual knowledge of serostatus and improve referral to appropriate prevention and treatment services: The DIS staff of the STD Division provides one-on-one counseling with clients who seek services in public health clinics. The DHPC funds a Post-test Education and Counseling project through ASOs which allows follow-up for two years after a positive test and assures referral for clients to partner, medical and social services.

Two other programs developed by the DHPC are the ERTS program and the Peer Mentor/Educator program. Based on newly reported HIV infections as documented by the HIV Surveillance program, the HPCs follow-up with clients to verify and document that the clients are referred and attend a first appointment with a medical provider. The Peer Mentor program is an intensive client support service established in 2004. Currently, eight peer mentors are funded through DHPC to provide extensive outreach, referral, and education in high-risk communities, as well as support to HIV/AIDS clinics statewide.

5. Develop partnerships for HIV prevention: The Division’s collaborative partnerships for prevention include numerous governmental and community-based organizations. Post-secondary educational institutions are valuable resources which support and validate program efforts. In 2010, DHPC implemented the Enhanced HIV Testing initiative in the UAB Emergency Department and in the Alabama Primary Health Care network clinics. A major collaboration of DHPC is to provide capacity-building support to the Alabama Statewide Consumer Advisory Board (ACAB). A DHPC staff liaison is assigned to assist the ACAB.

B. Existing Resources; Prevention Services; Care & Treatment Services; and, how the services, interventions, and strategies are currently being used.

Services include fostering linkages throughout the State among prevention programs, direct care services providers, consumer advisory groups, non-traditional community-based organizations, and ASOs. Other special services include:

1. Statewide Peer Mentoring Program: The program consists of peer mentors representing Public Health Areas throughout Alabama. The program aims to identify HIV positive persons in the community who are not receiving prevention and direct care services. The Peer Mentors provide education and outreach services to infected persons, and offer referrals and linkages to medical/dental care, consumer advocacy groups, inpatient/outpatient substance abuse treatment, emergency and transitional housing, case management, and secondary prevention counseling. The peer mentors work with local medical clinics, ASOs, and CBOs that provide HIV specific services to infected persons and high-risk negative individuals.

2. Alabama Statewide Consumer Advisory Board (ACAB): The ACAB consists of consumers throughout the State who represent various Public Health Areas. Each consumer participates in their local consumer group to brainstorm ideas, discuss community needs, advocate for medical/dental and social services, and offer support to newly diagnosed persons. The ACAB provides a voice for consumer issues to be expressed at the state level. This allows an opportunity for consumer participation and input in state-level community planning, primary and secondary prevention activities, and direct care services.

3. Funded Projects: The DHPC provides HIV prevention funding to support primary and secondary education and outreach activities. Since 1997, the DHPC has funded projects that responded to a competitive Request for Proposals. Funded agencies were those who presented unique and innovative strategies for responding to the prioritized risk populations in the eleven Public Health Areas. Currently, there are seven CBOs throughout the State that receive CDC federal funding through the ADPH.

4. Enhanced Referral Tracking System: The ERTS has eleven HPCs, divided by regions, who track and link newly reported HIV cases into care. ERTS has been fully implemented since January 2005, and has been presented at several national conferences as a model for other states to mimic. The ERTS program will continue to follow-up and verify that clients have entered care. With the continued increase in new HIV cases, the HPCs maintain strong collaborations with DIS, ASOs, and Peer Mentors. HIV/AIDS service providers have multiple contracts that provide a comprehensive range of social and clinical services. Some of these services include medical and dental care, case management, housing assistance, post-test counseling, prevention education, screening, and community street outreach.

5. FOCUS Program: The FOCUS program engages school systems statewide to incorporate the program as a class credit course, a core youth auxiliary, or other mechanism to teach HIV prevention, community planning, and risk behavior subjects to students. All students are invited to participate in this peer learning and teaching model.

6. Adult Viral Hepatitis Prevention: The goals of Adult Viral Hepatitis Prevention is to decrease the incidence of new infections of hepatitis A virus (HAV), hepatitis B virus (HBV) and hepatitis C virus (HCV) (primary prevention), as well as, decreasing risks for chronic liver disease, including cirrhosis and liver cancer, in persons with chronic HBV infection or chronic HCV infection (secondary prevention). These goals are accomplished by promoting awareness of the disease and collaborating with State and local partners to increase services and activities.

Via integration and collaboration the ADPH has worked on integration activities such as identifying public health and clinical activities in which hepatitis B vaccination and counseling should be incorporated; ensuring training and updates for health care professionals in settings that serve adults at risk for hepatitis A, B, or C; identifying the resources for hepatitis A and hepatitis B vaccination for at-risk persons; identifying clinics and facilities with the capacity to administer hepatitis A and B vaccine to at-risk adults; conducting community outreach for citizens who need prevention education; and, identifying some sources for appropriate medical referral of HCV positive persons.

7. Expanded HIV Testing Initiative: Under the *Expanded HIV Testing Initiative*, the University of Alabama at Birmingham Hospital Emergency Department (UAB-ED) has begun offering “opt out” HIV rapid testing during all three shifts of the ED. This expansion in testing exposes individuals from all socio-economic, educational, and racial backgrounds to HIV testing. Individuals who do not have health insurance and use the ED for ongoing treatment and care are now able to test for HIV on a routine basis. Since testing began in August 2011, the ED has conducted over 1200/week tests with 12 being positive HIV cases.

Alabama’s Expanded HIV Testing Initiative (ETI) includes comprehensive HIV/STD testing events at HBCUs within the state. These non health-care venues have been chosen as sites with a high-risk demographic within the rural and metropolitan south based on age (18-24) and race (AF-AM) in addition to high-risk behaviors (heterosexual, MSM, and MSM/W). Alabama targeted 15 HBCUs as testing venues during the three year expanded testing initiative. HBCUs located in counties with the highest HIV incidence based on 2009 statistics were targeted the first year. These included Montgomery County (41/100,000/yr), Mobile County (28/100,000/yr), Jefferson County (30/100,000/yr), and Macon County (45/100,000/yr). The DHPC data and QBM management staff estimates the expanded testing initiative will increase testing in Alabama by 30%.

8. Pregnancy Improvement Project: The DHPC and the UAB Family Clinic will collaborate through a new strategy called *The Pregnancy Improvement Project (PIP)* to create a web page that will provide prenatal updates, statistics, CDC recommendations, and treatment guidelines. A toll free number will be placed on the web page with HIV prenatal experts answering the calls five days per week. Private providers will have access to web resources and professional consultations. Social marketing of the PIP project will include grass roots delivery of educational items to physician offices, professional conferences and training, professional newsletters and web sites.

9. Bureau of Clinical Laboratories (BCL): HIV confirmatory tests are provided by the BCL. This provides a quicker turnaround time for reporting to providers. The BCL participates in

proficiency testing for all analyses. The positive lab tests are assigned the same day they are received by DIS. The fieldwork on each case begins within two days. The standard is 30 days to close a case. However, partner identification and notification may be extended beyond 30 days.

Effective, June 30, 2011 a revised public health law was implemented requiring laboratory reporting of CD4 counts and viral load. The CD4 and viral load results will be used to estimate linkage and retention in care, community viral load, quality of care, and to provide feedback of results to providers and patients, as requested. The ERTS program will include CD4 counts and viral load as evidence of HIV infection in tracking activities. Patients identified with CD4 counts that have no documented HIV medical care will be tracked identically as clients with a positive Western Blot.

10. Alabama AIDS Drug Assistance Program (ADAP): The goal of the ADAP is to reduce associated morbidity and mortality among HIV infected persons by delaying the progression of HIV disease through prevention and treatment of HIV complications. ADAP, in collaboration with community health care providers, is committed to providing HIV medications to low income and uninsured residents living with HIV in an effort to increase life expectancy and to improve quality of life. Case management services continue to play a major role in Alabama's efforts to increase access to care and ADAP medications with a focus on the underserved minority and hard-to-reach populations.

HIV positive residents access the ADAP through an application process initiated by their social worker/case manager or clinician. Ryan White funded care and service agencies receive funding to provide transportation services for clients who live in rural areas to ensure access to HIV clinic appointments and ADAP medications. Because of increased utilization of ADAP, the program implemented an enrollment cap in FY2011 and reinstated a waiting list since first eliminating it in 2006. New applications are placed at the end of the ADAP waiting list until a slot opens on active ADAP. Individuals are moved off the ADAP waiting list to active status on a first-come, first-served basis. While waiting to be placed on active ADAP, the applicant's caseworker will apply to Pharmaceutical Assistance Programs (PAP) on behalf of the applicant to begin medications until a slot is available on active ADAP.

HIV medications are added to the ADAP formulary when FDA approved, and the National ADAP Crisis Task Force price negotiations are complete. The ADAP Coordinator surveys HIV clinicians and social workers seeking input regarding medication needs of their patients/clients. If the consensus is to add the medication to the formulary, the ADAP Coordinator contacts the Central Pharmacy requesting cost information and availability of the medication from the wholesaler. The Division Director completes a cost analysis and makes the decision to add a medication to the formulary based on results of the physicians' survey and budget projections.

ADAP sponsors a Medicare Part D cost assistance plan (MEDCAP) that assists HIV positive individuals with Medicare Part D. HIV positive individuals on MEDCAP usually do not qualify for low-income subsidy assistance to pay for the cost of co-pays or monthly premiums and would otherwise qualify for enrolment in ADAP for medications.

11. The ADAP Adherence Project: ADAP staff will continue an active approach to cost containment and will include the following quality measures: (1) Monitoring monthly drug utilization; (2) Monitoring monthly drug costs to ensure ADAP consistently receives accurate drug pricing; (3) Monitoring monthly medication pickups to improve medication adherence; (4) Complete regular ADAP medication inventories at all clinics to decrease program costs by decreasing medication waste; (5) Improve the current Client Satisfaction Survey to collect significant client data to impact improvement decisions; (6) Implement the data collection system to integrate data systems across programs by 2012; and, (7) Implement the electronic ADAP application and e-prescription process. ADAP will continue to monitor the centralized eligibility determination process to ensure client eligibility and to improve the Client Eligibility Review and application process.

12. Ryan White Direct Care: Since 1990, the DHPC has funded, through the Ryan White formula grant, 18-25 service providers to support medical and social services, medical case management, and support services as approved by HRSA.

13. Post-test Education, Counseling and Referral Project: Since 1996, this statewide project has been funded to provide HIV/AIDS education and information to clients testing positive for HIV. In 2005, eligibility criteria were expanded to include persons who are determined to be at high-risk. Five to six sessions can be conducted for individuals who meet the project requirements.

14. AIDS Alabama, Housing for HIV positives: Housing and supportive services include availability of multiple apartment complexes which house individuals living with HIV, case management, and transportation to medical and social service appointments.

15. ASONA: AIDS Service Organizations of Alabama is a Statewide association of 11 ASOs that offer social services, financial aid, non-medical case management, advocacy, legal and multiple other services to meet the needs of persons living with HIV/AIDS. ADPH provides financial support as available.

16. Access to Care Initiative: Alabama eHealth, an Access to Care Initiative of Medical AIDS Outreach of Alabama, is funded by AIDS United and the Social Innovation Fund and is completing the first year of a three-year Access to Care grant in collaboration with AIDS Action Coalition of Alabama, and Whatley Health Services. The project implements telemedicine clinics at three remote, rural clinic sites during the first year and will be expanded to additional rural sites in subsequent years. The project offers improved access to care for rural patients in Alabama, reduces the burden of transportation barriers, and leverages the expertise of HIV specialty providers.

C. Gaps

Even with the DHPC programs in place, gaps in services still remain across all regions in the State. These include funding and access to dental care, transportation, mental health services, substance abuse treatment, support groups, follow-up counseling, and referral to services. Other gaps include access to clinical drug, vaccine trials, dentists, nutritional counseling and supplements, nursing home and long-term care, and primary and secondary prevention education

and information. Since Alabama is predominantly rural, transportation is a constant barrier to accessing medical care.

Therefore, access to quality treatment for HIV presents more of a challenge for those who live in rural areas of the State. Clients may be forced access resources in poor and compromised health care systems. HIV care and services occur primarily outside of the State's private medical sector. Clients often rely on local health departments or RW funded care or service agencies. Most county health departments are not equipped to handle complex diseases like HIV due to a lack of physician coverage. If a rural area is fortunate enough to have a clinician, he or she often lacks the expertise to treat HIV disease. Limited financial resources and inadequate health insurance are serious challenges for both urban and rural residents to accessing HIV care and services. Uninsured individuals have reported a decrease in access to routine and preventive care, health information, and use of private doctors and outpatient clinics. Individuals who are eligible for Medicaid reported difficulty in locating a medical provider who accepts new Medicaid clients. This creates a significant barrier to equal access to medical care across Alabama for a large number of residents who rely on Medicaid to pay for medical care.

The DHPC attempts to narrow these gaps by the following steps: 1) increasing the provision of test kits to approved providers; 2) disseminating information about women and perinatal care to providers especially physicians; 3) implementing a legislatively mandated reporting requirement for viral loads and CD4 counts to identify HIV positive individuals; 4) expanding linkage services to further track clients beyond the first "kept" appointment; 5) enhancing post-test education of HIV positive clients and their partners; 6) expanding HIV awareness by providing education and testing to populations living in high-risk environments to prevent new infections; 7) improving access to services in rural areas of the state; and, 8) supporting more coordination of services such as transportation, housing, and other daily living needs of HIV positive clients.

1. Gap Analysis Conclusion:

The HPPG Needs Assessment Committee concurred on the following:

1. The first conclusion is that "the community still needs basic HIV information." It was said in a focus group, "Just because we work with it (HIV and AIDS) all the time doesn't mean that everybody in Alabama knows even the simple facts about AIDS." Some ASOs, CBOs, and public health staff stated in several focus group reports that basic information is provided, but it varies by geographic area with some regions providing more effective prevention education than others. The challenge is to ensure all-encompassing HIV education throughout the state.
2. A similar concept related to the first conclusion is that these community focus group participants want more HIV prevention messages on billboards, and public service announcements that engender HIV and AIDS awareness. A notable strength from this conclusion is that our billboards and haul-ads were remembered and quoted by participants, yet some areas of the state are not reached with this information.
3. The members on the committee agreed that there is a gap within the community, such as identifying available services for HIV education, testing and treatment, lack of community involvement, communication barriers between providers and availability of prevention services for MSM, Heterosexuals, and Injection Drug Users across Alabama.
4. Participants convey that ASOs and Community-Based Organizations in Alabama need to do more prevention activities for the HIV positive community. For example, provide supports

services, effective behavior interventions, address stigma, and invest in the client outreach within the local community.

2. Focus Group Demographics

The information gathered from FOCUS Group participants reflects their opinions, ideas and prevention needs within the following populations: MSM, Heterosexuals, IDU, Youth and Substance Abusers from various locations across the state. Input from these individuals contributed to identifying groups.

A general description of the 2012 Alabama Needs Assessment cohort is as follows:

- Seven Focus Groups were conducted among the Alabama Substance Abuse Community with 60 participants (this includes 22 males and 38 females, one bi-ethnic, 23 AF-AMs and 36 Caucasians ranging from ages 19–51) from Public Health Areas 3, 7, 9 and 11 (See Appendix A, Figure 1).
- Two Focus Groups were held with Men who have Sex with Men with 16 participants (this includes 12 AF-AMs and 4 Caucasians ranging from ages 19-50). These Focus Groups were held in PHA's 1, 2 and 7.
- Two Focus Groups were held in PHA 3 & 10 with 12 heterosexual women representing a rural housing authority and healthcare professionals. Nine were AF-AM and three were Caucasian, ranging in age from 20-60.
- One Focus Group was held with IDU's with a total of eight participants of which five were female and three were male (this includes three AF-AMs and five Caucasians ranging between ages 25 and 60) in PHA 6.
- Two Focus Groups were held with youth ranging between ages 14-18 in PHA 3 and & 11. There were a total of 107 students that identified their following ethnicities: AF-AM, Caucasian, Hispanic and Bi-Ethnic.

3. Youth Risk Behavior Survey (YRBS)

Schools play a critical role in promoting the health and safety of young people and helping them establish lifelong healthy behaviors. Each school day, Alabama's schools provide an opportunity for more than 850,000 students to learn about the dangers of unhealthy behaviors and practice the skills that promote a healthy lifestyle. Unhealthy behaviors are often established during childhood and persist into adulthood.

The CDC's YRBS is the only surveillance system designed to monitor a wide range of priority health risk behaviors among representative samples of high school students at the national, state, and local levels.

National, state, and large urban school district surveys are conducted every two years among high school students throughout the United States. These surveys monitor priority health risk behaviors including unintentional injuries and violence; tobacco, alcohol, and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection; unhealthy dietary behaviors; and, physical inactivity. These surveys also monitor obesity and asthma among students.

The 2011 Alabama Youth Risk Behavior Survey indicates that among high school students:

Sexual Risk Behaviors

- 58% ever had sexual intercourse.
- 10% had sexual intercourse for the first time before age 13 years.
- 23% had sexual intercourse with four or more persons during their life.
- 44% had sexual intercourse with at least one person during the three months before the survey.
- 43% did not use a condom during last sexual intercourse.
- 4% were never taught in school about AIDS or HIV infection.

www.cdc.gov/yrbs

The 2010 Alabama School Health Profiles indicates that among high schools:

Health Education

- 75% taught eight key topics including pregnancy, HIV, or other STD prevention topics in a required course.
- 29% taught four key topics related to condom use in a required course.
- 84% taught how to access valid and reliable health information, products, or services related to HIV, other STDs, and pregnancy in a required course.
- 49% had a lead health education teacher who received professional development during the 2 years before the survey on HIV prevention.
- 25% had a lead health education teacher who received professional development during the 2 years before the survey on pregnancy prevention.
-

Health Services

- 66% had a full-time registered nurse who provides health services to students at school.

Supportive Policies

- 23% had a gay/straight alliance or similar club.
- 3% provided curricula or supplementary materials and engaged in five practices related to lesbian, gay, bisexual, transgendered, or questioning (LGBTQ) youth.
-

Family Involvement

- 39% provided parents and families health information to increase parent and family knowledge of HIV prevention, STD prevention, or teen pregnancy prevention.

http://www.cdc.gov/healthyyouth/yrbs/pdf/hiv/al_hiv_combo.pdf

IV. Prevention Activities and Strategies

The DHPC partnered with ASOs and CBOs to further expand treatment and prevention services beyond the scope of the health department. The following projects are prevention and treatment activities and strategies being conducted around the state. These projects support the goals of the National HIV/AIDS Strategy (NHAS).



1. Know. Manage. Live: Know. Manage. Live. "It's more than a motto - it's a formula for beating HIV and AIDS. This campaign was developed to address the CDC Prevention Expanded Testing Initiative. The goal of this project is to expand rapid HIV testing activities in disproportionately affected populations across the state. Alabama has expanded rapid testing in Primary Care Centers, HBCUs, and the UAB, the largest emergency department. For more information on how you can know, manage and live your best life through education, counseling, testing, and linkage to care check out the videos located on our website at www.adph.org/aids/, courtesy of the Greater Than AIDS campaign developed as part of the U.S. Centers for Disease Control and Prevention Act Against AIDS effort.

2. Counseling, Testing, Referral, and Partner Notification (CTRPN): These services are accomplished by joint effort of the DHPC and the Division of STD. Public Health nurses in all health department clinics are trained to perform HIV pre-test counseling, obtain the test specimen, and submit to the BCL. Nurses also give results and post-test counsel clients testing negative. All DIS are trained to perform pre- and post-test counseling, make referrals to social and medical services, and perform partner notification activities for those who test positive. DIS also make referrals and counsel clients who test negative for HIV but are considered high-risk or have specific issues to be discussed. All STD managers are responsible for implementing and managing HIV CTRPN and STD programs. HPCs are responsible for coordinating activities related to HIV prevention, including coordinating and collaborating with individuals in the community involved in activities related to HIV/AIDS

3. Statewide Peer Mentoring Program: The program consists of peer mentors representing Public Health Areas throughout Alabama. The program aims to identify HIV positive persons in the community who are not receiving prevention and direct care services. The Peer Mentors provide education and outreach services to infected persons, and offer referrals and linkages to medical/dental care, consumer advocacy groups, inpatient/outpatient substance abuse treatment, emergency and transitional housing, case management, and secondary prevention counseling. The peer mentors work with local medical clinics, ASOs, and CBOs that provide HIV specific services to infected persons and high risk negative individuals.

4. The Pregnancy Improvement Project (PIP): The DHPC and the UAB Family Health Clinic will collaborate through a new strategy called **PIP** to create a web page that will provide prenatal updates, statistics, CDC recommendations, and treatment guidelines. A 1-800 number will be placed on the web page at www.adph.org/aids with HIV perinatal experts answering the

calls five days per week. Private providers will have access to web resources and brief surveys for determining needs and cultural competency to more effectively work with pregnant women.

5. Enhanced Referral Tracking System (ERTS): An outreach and referral service that focuses on early treatment access for newly identified HIV positive individuals in Alabama.

6. HIV/AIDS Statewide Calendar: Centralized listing of all events related to HIV/AIDS in the State. All request for an event to be added to the calendar, is done by completing an HIV/AIDS Statewide Events form located at www.adph.org/aids. Approved requests are processed within two business days of the request.

A. Proposed Prevention and Treatment Activities

The following proposals are potential future activities that the DHPC, in collaboration with key stakeholders, is considering for implementation. The goal is to provide testing, referral, retention and re-engagement services to persons living with HIV, particularly minorities. These plans are tentative and are subject to change.

1. Tele-health Training Center: A proposed initiative to fund a teaching program directed toward medical providers. The goal would be to partner with the MAO tele-health project to offer improved access to care for rural patients in Alabama, potentially reducing the burden of transportation barriers, and leveraging the expertise of HIV specialty providers.

2. Tele-health Services: A proposed initiative to expand tele-health services to Lowndes by partnering with MAO and Health Services Inc.

3. Expanded Community Patient Navigator: A proposed initiative to establish a seamless system to link, retain, and re-engage people to continuous and coordinated quality care. The idea is to provide easier access to services for persons newly reported with HIV, particularly minorities. The plan includes collaborating with the ASOs to employ one or two "patient navigators" to connect HIV positive persons to prevention and treatment services.

B. Scalability of Activities in Alabama

The DHPC continues to scale up services. Scalability of activities references the ability to reach a significant portion of those in need, cost-effectively through a combination of effective interventions, demonstrating a population level impact. ADPH will continue to provide the public with information and education as preventive tools against new HIV infections. The ultimate goal of ADPH is to break down barriers to care and treatment by educating more Alabamians on HIV prevention and care services, increasing testing, and reduce stigma and discrimination associated with HIV/AIDS in all communities.

The plan to meet this goal is through the use of social media, printed materials, videos, and training activities. Such activities will include on demand webcasts, webinars, pamphlets, satellite conferences, video conferences, health fairs, and HPPG meetings. These activities are especially designed to engage all medical providers, care givers, educators, social workers/case managers, emergency medical service workers, correctional facility staffs, law enforcement personnel, youth, pastors or faith-based community leaders, the MSM population, African-

American communities, federally funded clinics, college campuses, mental health and substance abuse providers, and people infected/affected by HIV/AIDS.

HIV activities can be posted to the statewide calendar of events page to promote events hosted or sponsored by the DHPC and/or its partnering agencies. ADPH web pages and social networking sites will promote public awareness and service activities. Public awareness promotions will be combined with social marketing efforts for consistent messaging and public attention. Alabama has also created a Governor's Task Force on HIV/AIDS to engage high-ranking officials in the fight against HIV/AIDS.

C. Treatment as Prevention

The most significant change that has taken place in HIV prevention and in the thinking and strategies of many public health workers and prevention advocates is a much greater emphasis on the role of HIV treatment as a method of HIV prevention. DPHC has addressed the four steps necessary for making treatment-as-prevention work. These conditions are testing, linkage to care, proportions of persons on therapy, and the proportion failing therapy.

1. Testing

An increased proportion of the population, especially high-risk populations, need to be tested to diagnose the maximum number of previously undiagnosed people. Testing also needs to be frequent enough in populations with very high HIV incidence for recent infections to be diagnosed before the infected person transmits infecting to others. The DIS staff of the STD Division provides one-on-one counseling with clients that seek services in public health clinics. The DHPC funds a Post-test Education and counseling project through ASOs which allows follow-up for two years after a positive test and assures referral for clients to partner services and medical and social services.

2. Linkage to care/proportions of persons on therapy

Medical systems must be in place to ensure that the lowest possible number of people drop out of care. A high proportion of HIV patients have to be on antiretroviral therapy for treatment to have an measurable effect on transmission rates. Drug access and cost will clearly influence how many patients are on therapy. Suboptimal treatment regimens and levels of support produce prevention failure as well as treatment failure. Maximizing the proportion of HIV infected on therapy may be affected by intensifying the follow-up of existing patients. Part of the increase in the proportion of people on ARVs will be achieved by re-contacting people who are on treatment interruptions and persuading them to re-engage in therapy.

Two programs to address these concerns were developed by the DHPC. These programs are the ERTS program and the Peer Mentor/Educator program. Based on newly reported HIV infections, as documented by the HIV Surveillance program, the HPCs follow up clients to verify and document the clients are referred and attend a first appointment with a medical provider. The Peer program is an intensive client support service established in 2005. Currently, eight peer mentors are funded through DHPC to provide extensive outreach, referral, and education in high-risk communities, as well as support to HIV/AIDS clinics statewide

The DHPC provides HIV prevention funding to support primary and secondary education and outreach activities. Since 1997, the Division has funded agencies that responded to a competitive Request for Proposals. Funded agencies were those who presented unique and innovative strategies for responding to the prioritized risk populations in the eleven Public Health Areas. Currently, there are seven CBOs throughout the State that receive CDC federal funding through the DHPC.

3. Proportion failing therapy

Even if the majority of patients are on therapy, the effect of treatment on prevention will clearly be compromised if there is a high level of therapeutic failure. The ERTS program has proven effective in reconnecting previous HIV positive individuals with the medical follow-up needed for effective management of their disease process.

For treatment-as-prevention to work there needs to be an unprecedented high rate of success in all steps from increasing HIV testing to increasing the proportion of people on ARVs who have an undetectable viral load.

V. Engagement Plan

A. Background

The HPPG was formerly established in 2003. Prior to the establishment of a statewide body, there were eleven regional/area groups throughout the state. Established in 1994, these groups worked independently but reported to the DHPC. Each group wrote individual HIV Plans which were integrated into the State Plan and portions of each Area Plan were included as attachments.

The regional/area groups were tasked with identifying individuals to serve on the local committee. Members were recruited who reflected the face of HIV in the state. Others recruited included health department staff, especially social workers and TB/STD disease intervention specialists. Community leaders from faith-based organizations, business, education, government, non-government, minorities, non-professionals, students, Lesbian, Bisexual, Gay, Transgender (LBGT) and those who had an interest in HIV were also asked to serve.

State meetings were held periodically with the health department regional/area coordinators, Division staff, other key stakeholder's statewide working in ASOs/CBOs and those with an interest in HIV.

B. Membership

As the State's vision emerged, a statewide body was formed with the regional/area coordinators and a least one-community member from each region serves as a voting member and additional individuals serve as members at-large. Meetings are held quarterly at the state level.

Community members are chosen based on their HIV status, race/ethnicity, gender, sexual orientation, expertise and dedication to the mission and vision set forth. An ad hoc committee (Selection) reviews applications and enlists the input from the regional/area coordinators before the final decision is made. Members are oriented at the local and State level. Participation in the local planning groups is the first criteria for membership. Bylaws are required for each group.

Additional training for DEBI and EBI interventions, such as S.I.S.T.A, EMPOWERment, Community Promise, and Voices/Voces serve to promote additional community involvement, especially with the ASOs/CBOs, their clients, and the high-risk communities. This helps to reduce the number of new infections which complements the *National HIV/AIDS Strategy*.

These programs are funded by the State and are monitored and evaluated. Depending on evaluation results, the DHPC decides whether or not to continue funding through the current cycle and/or future funding cycles.

C. Collaboration

HIV service providers and other stakeholders participate at the local and State level in the coordination and collaboration for prevention, care and treatment. Each regional/area coordinator is encouraged to work closely with the ASOs/CBOs in their area. This is done by inviting them to local network meetings and making occasional visits to clinics. Collaboration with community projects such as health fairs, educational trainings and other events is encouraged.

Agencies may request their assistance from Peer Mentors in transporting clients, speaking with new clients about the disease process from a personal level, medication compliance issues and re-engaging patients who need to be linked to care. The Peers assists the regional/area coordinators with speaking engagements, community events, health fairs and with ERTS.

The FOCUS coordinator, who is an at-large member of the HPPG, serves as a liaison with the high school systems and works to establish programs in all schools. Statewide teacher trainings are held during the summer and youth rallies are held annually. The State Board of Education is also represented on the HPPG.

Members network with fraternal, religious and civic organizations and participate in activities to promote HIV education and testing. Many have outreach programs in the local youth detention centers, group homes, city/county jails and prisons.

Primary care centers, HBCUs and UAB Emergency Department are the newest partners in prevention and testing. ADPH provides training, materials, testing and assistance, as needed. The primary care centers are receiving training which allows them to deliver quality HIV/AIDS testing and services and to include HIV/AIDS in all wellness activities.

The HBCU Initiative includes counseling, testing, and linkage to care for college students. It also provides increased awareness of HIV/AIDS to student organizations and on-campus health services staff, enabling them to deliver prevention messages campus-wide. UAB's ED is currently using opt-out testing, which is a recommendation from CDC, to test all patients who visit the ED. All patients who test positive are linked into care at the UAB 1917 Clinic or other area infectious disease specialists.

DHPC and the HPPG will monitor the progress of the new partners through an evaluation process. This process will include data which indicates the number of persons who were provided HIV/AIDS education, testing, treatment and linkage to care. The Communication Branch of DHPC will review all program related materials for content, accuracy, and

appropriateness. This yearly review will ensure that updates are provided as needed. Using a bi-yearly Rapid Testing Statistical Report, the Communications Branch will monitor the quantity of rapid tests performed by all DHPC partners.

The engagement process achieved a more coordinated, collaborative and seamless approach to accessing HIV services for the highest risk populations. The favorable relationship between the health department, CBOs/ASOs and the community at large has been instrumental in determining the needs of the populations at highest risk. They work together to ensure that HIV-positive individuals are linked to care, returned to care and offered case management to assist with other needs such as transportation, housing and other medical services. The partner relationship will be maintained through continued relationship-building efforts. The HPPG, HPCs, Peer Mentors, ASOs, CBOs, and FOCUS Program will continue to collaborate with faith based organizations, community organizations, gatekeepers for the MSM population, public and private schools, AF-AMs, medical providers, and PLWHAs.

DHPC and partners will have ongoing public awareness activities to promote services available for citizens of Alabama. DHPC will continue to provide the public with information and education as preventive tools against new HIV infections. The ultimate goal of ADPH is to break down barriers by educating more Alabamians on HIV prevention, increasing testing, and reducing stigma and discrimination associated with HIV/AIDS in all communities. This goal will be obtained through the use of social media, printed materials, videos and training activities; including traditional media (pamphlets, brochures, etc.) and new media (on-demand webcasts, webinars, satellite and video conferences, etc.) as well as in-person promotions (health fairs, education sessions and HPPG meetings).

These activities are especially designed to engage medical providers, caregivers, educators, social workers/case managers, emergency medical service workers, correctional facility staff, law enforcement personnel, youth, Pastors or faith-based leaders, the MSM population, African-American communities, Federally-funded clinics, college campuses, mental health and substance abuse providers and people infected/affected by HIV/AIDS.

DHPC will continue to provide printed materials, access to videos and webcasts, and testing supplies to our partners which include the funded projects, ASOs, CBOs, Peer Mentors, physicians and the FOCUS Program. These partners have easy access to materials/supplies by on-line ordering and free viewing of webcasts on-demand.

DHPC has created an HIV statewide calendar of events to promote events hosted or sponsored by the Department and/or its partnering agencies on ADPH web pages and social networking sites for public awareness and service activities. Public awareness promotions will be combined with social marketing efforts for consistent messaging and public attention. Alabama has also created a Governor's Task Force on HIV/AIDS to engage high-ranking officials in the fight against HIV/AIDS.

Input from HPPG members and other stakeholders is continuous in that they are members of the local and statewide group. The community co-chair and another community member served with six area coordinators as "champions" in completing the jurisdictional plan. At the regional/area level and at the State level, adherence to PIR (parity, inclusion and representation)

is monitored. Members are encouraged to ensure their voices are heard and that their voices are equal to each voice at the table. Capacity-building programs are presented to educate and empower all members. When funding permits, these programs and trainings are offered locally, statewide and nationally.

Surveillance and service data/indicators utilized to inform and monitor the development and implementation of the jurisdictional plan is contained in the Epi-Profile. Partnering with a college intern, the HPCs and the Division staff were able to provide additional resources that are an integral part of the current Epi-Profile.

D. Challenges

Funding is a major concern with most agencies in the State. Many organizations cannot allow employees the time off to attend local network meetings and the one-day per quarter to attend the statewide meeting. Volunteer or non-traditionally employed members often cite finances and lack of transportation as barriers. HIV is no longer perceived as the „death sentence’ that it was three decades ago. Many feel that the advances made in medical treatment and pharmacological therapy no longer require that the “old messages” specific to public health continue. Although activism, advocacy and other altruistic attitudes with regard to HIV are thankfully on the rise, apathy is still alive in the South.

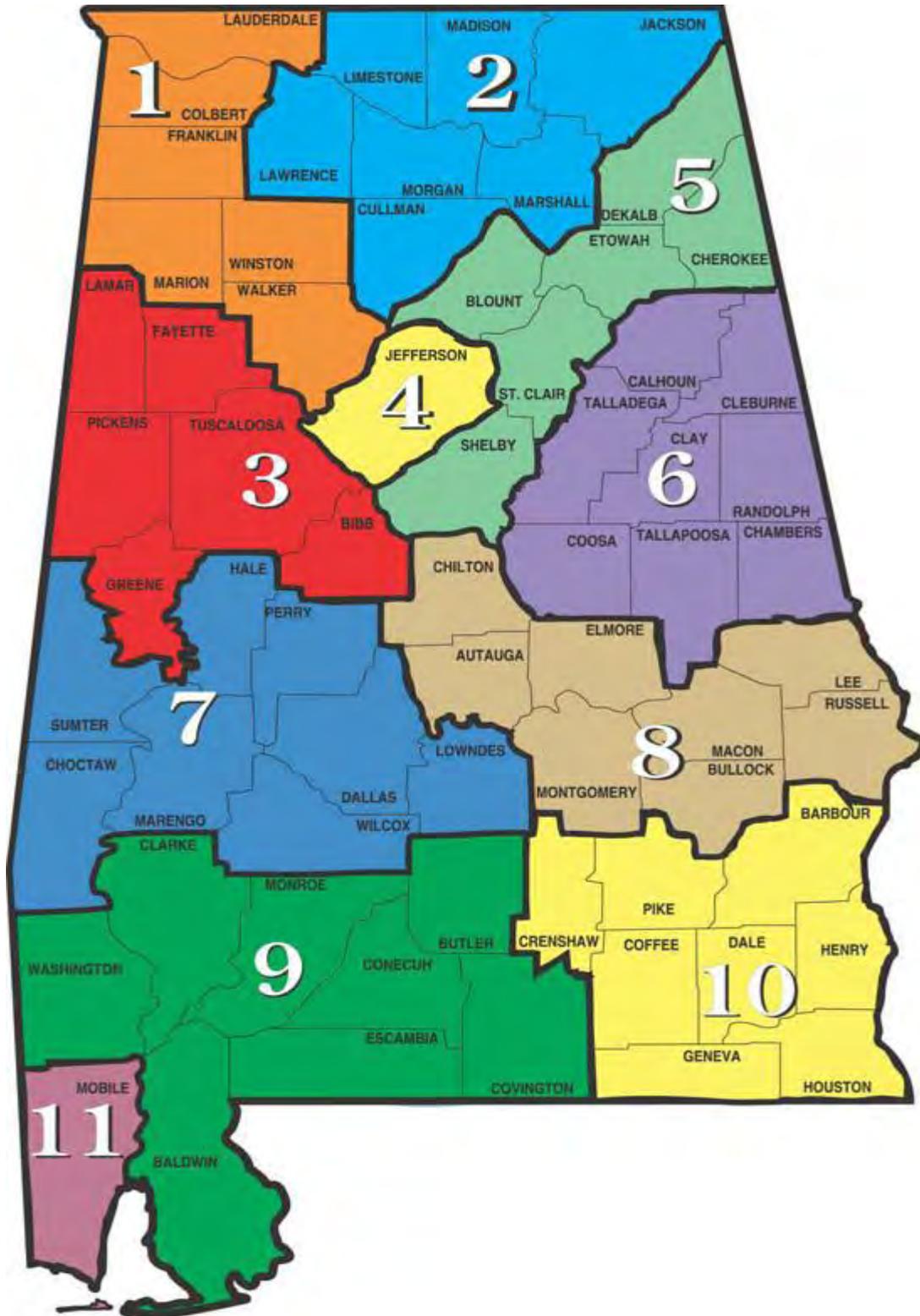
VI. Appendices

Appendix A Alabama Public Health Area Map A

Appendix B Alabama Statewide Goals and Objectives

Appendix C Glossary of Terms

APPENDIX A



APPENDIX B

Statewide HIV Prevention Plan Goals & Objectives

Long-Range Goals and Objectives

Overall programmatic goals for 2012 through 2016 include:

1. Reduce the incidence of new HIV infections in Alabama.
2. Improve public understanding of, involvement in, and support for HIV prevention.
3. Prevent/reduce behaviors that transmit HIV.
4. Increase individual knowledge of serostatus and improve referrals to appropriate prevention and treatment providers.
5. Develop partnerships for HIV prevention.

B. HIV Prevention Program Specific Plans-FY 2012

1. HIV Testing

GOAL 1: Reduce the HIV incidence in Alabama by 3% annually through 2016.

Objective 1: By December 2012, all counseling and testing sites will achieve a 1% rate of newly identified HIV positive tests annually.

Objective 2: By December 2012, routine testing in new health care settings under the Expanded Testing Initiative (ETI) will achieve a 1.0% rate of newly identified HIV-positive tests.

Objective 3: By December 2012, ETI targeted testing in non-health care settings will achieve a 1.0% rate of newly identified HIV-positive tests.

Objective 4: By December 2012, 50 ETI testing sites will be operational.

Objective 5: By December 2012, at least 85% of persons who test positive for HIV will receive their test results in health department STD clinics.

Objective 6: By December 2012, the five state funded organizations will document quarterly testing and referral services offered in conjunction with each prevention intervention.

Objective 7: By December 2012, reduce or maintain a <1% perinatal transmission rate through the strategy proposed in the Pregnancy Improvement Project (PIP) targeting providers.

GOAL 2: By 2016, achieve greater health equity for those age 13 to 40 by reducing HIV related health disparities in six underserved Public Health Areas (PHA) through greater availability and access to more HIV prevention and care services.

Objective 1: By July 2012 provide quarterly routine testing, opt-out and pregnancy guideline information to physicians and providers of pregnancy care for women and their infants.

Objective 2: By December 2012, target five schools in the Black Belt impoverished region to become new FOCUS program sites for HIV education, testing awareness and other integrated risk reduction for adolescents, 14 – 19 years old, primarily AF-AM youth.

Objective 3: By December 2012, document monthly HIV testing and referrals for those 12 -19 years of age at a special adolescent sexual health clinic in partnership with a Black Belt pediatric medical practice in Selma, Alabama.

Objective 4: By December 2012, ten newly identified primary care/rural clinics in underserved PHAs will offer routine HIV rapid testing.

Objective 5: By December 2012, the DHPC will convene up to three meetings with health care partners to improve service coordination.

2. Comprehensive Prevention with Positives

GOAL: By 2016, the DHPC will expand a system to optimize health outcomes and increase access to care by linking at least 80% of persons receiving HIV positive tests results to medical care and assuring clients attend a first medical appointment.

Objective 1: By December 2012, the 50 ETI sites will document medical appointments made for newly identified HIV-positive persons within 72 hours.

Objective 2: By December 2012, increase to 70% clients documented through the Enhanced Referral Tracking System (ERTS) and confirmed “in care” by attending the first appointment.

Objective 3: By July 2012, the DHPC will pilot *The Linkage Care* (TLC) system, a new service at five selected health department locations, to link, using a 3 month, 6 month, and 1 year marker, and retain newly identified positive persons to care.

Objective 4: By December 2012, post-test counseling sessions will be contracted with ASOs to provide up to four sessions for newly identified positives and high-risk negatives.

Objective 5: By December 2012, at least 75% of persons who receive their HIV positive test results will be referred and linked to health department Partner Services.

Objective 6: By December 2012, document PIP technical assistance to at least 50 OB/GYN providers.

Objective 7: By October 2012, implement a competitive RFP process to distribute prevention funds up to seven organizations providing AIDS services for behavioral, structural or biomedical interventions.

Objective 8: By December 2012, 65% of minority persons reported as HIV-positive and living in Alabama will be receiving medical treatment and care.

Objective 9: By June 2012, collaborate with the HIV Surveillance Division to use a mapping method to assist DHPC programs and the HPPG in strategically targeting program and services based on sound data.

3. Condom Distribution

GOAL: To increase condom distribution in Alabama.

Objective 1: By December 2012, distribute 300 cases of male condoms and 1500 bags of female condoms to selected providers.

Objective 2: By December 2012, increase condom distribution sites by 50%.

4. Policy Initiatives

GOAL: By December 2016, document policy initiatives for the DHPC program.

Objective 1: By December 2012, document completion of confidentiality and security training and/or forms by essential staff and other specified DHPC providers.

Objective 2: By December 2012, document dissemination of updated policies on HIV reporting requirements to providers.

Objective 3: By January 2012, HPPG policy changes will be distributed to all 33 members at the first meeting.

Objective 4: By December 2012, 27 health care provider sites must complete program audits to maintain approval status according to the DHPC testing policy.

Objective 5: By December 2012, the Alabama Drug Reimbursement Program (ADAP) will make policy changes to comply with the federal standards for eligibility.

Objective 6: By June 2012, a DHPC strategic plan will combine prevention and care core elements into a single plan.

5. Evidence-based HIV Prevention Intervention for HIV-negative persons

GOAL: By October 2012, implement a competitive RFP process for behavioral, structural or biomedical interventions to distribute prevention funds to organizations providing HIV/AIDS services.

Objective 1: By November 2012, complete a RFP selection process to fund up to seven providers.

Objective 2: By May 2013, maintain the FOCUS youth rally in the northern region and continue operation of the established FOCUS program sites.

Objective 3: By May 2013, the expanded FOCUS program will identify at least five new schools to implement FOCUS and participate in a Black Belt region youth rally.

6. Social Marketing, Media, and Mobilization

GOAL: By 2016, a social marketing and mobilization plan will provide strategies for implementation by the DHPC and other community partners.

Objective 1: By June 2012, the HPPG will include a social marketing and mobilization plan for target audiences in the HPP.

Objective 2: Beginning January 2012, the ETI will initiate up to two promotional activities for the HBCU, primary care and Emergency Department.

Objective 3: Beginning October 2011, HIV reporting requirement materials will be developed for dissemination to reporters statewide.

Objective 4: Beginning January 2012, launch a PIP notification campaign to over 100 health care providers.

Objective 5: By July 2012, target social marketing to professionals and potential clients for TLC program.

Objective 6: Beginning January 2012, the FOCUS contractor will develop a targeted marketing plan for the Black Belt region.

7. Jurisdictional HIV Planning

GOAL: By September 2012, the HPPG will update the Alabama HIV Prevention Plan.

Goal 1: By December 2016, develop new partnerships for HIV Prevention, while supporting the continued growth of long-term partnerships.

Objective 1: By September 2012, the HPPG will respond to any follow-up requests from disseminated perinatal resource kits.

GOAL 2: By December 2014, utilize a network of capacity-building and technical assistance providers acceptable to CDC and HPPG.

Objective 2: By September 2013, the HPPG will conduct one combined capacity building training for HIV & Other STD's, TB, Hepatitis A-C, and invite STD division staff to support integration of activities and provide cross training for personnel. In addition to that training we would like to have additional CB (Capacity Building) trainings combined into our HPPG agendas as time allows highlighting the needs, gaps and epi profile.

Objective 3: By May 2014, promote capacity building by conducting combined training for community partners (including PLWH) with the State entities listed in Objective 1.

Objective 4: By September 30, 2014, we would like to offer capacity building training, meetings and workshops to the medical community to encourage routine HIV testing and participation with PCRS.

Objective 5: By December 2014, collaborate with the Peer Mentors, Alabama Consumer Advisory Board and with nontraditional programs (ex. Mental Health, Substance Abuse Programs, Incarcerated Men, Motherhood and Fatherhood Initiative) to elicit and address their training needs.

Goal 3: By December 2017, ADPH will monitor, evaluate, and provide quality assurance for Programs.

Objective 6: By January 2017, continue regular and rapid test training, protocol development, and technical support for agencies that need/request it.

Objective 7: By March 2017, provide cross training for personnel listed in Objective 1.

Objective 8: By June 2017, Central Office Staff, HIV Coordinators, and community Co-chairs will be given the priority to participate in national meetings that support CDC's strategies.

Objective 9: By June 30, 2017, utilize CDC's CRIS system (Capacity Building Request Information System) for requesting prevention training and support.

Objective 10: By September 2017, identify other consultants through the national capacity-building network and key organizations to provide technical assistance to support prevention planning.

Objective 11: By September 30, 2017, provide quality orientation, ongoing training, and mentoring for members of the Community Planning Group.

Objective 12: By December 15, 2017, utilize evidence-based (EBI) modules when providing specialized intervention training.

Objective 13: By December 30, 2017, elicit collaboration with nontraditional community partners in order to expand outreach to more high-risk people.

Our committee would also like to address some additional topics for possible Capacity Building Trainings for HPPG and for us to share in our PHA's (Public Health Areas): Women's Infection Rates & Lack of Resources, MSM's Younger vs. Older & Lack of Resources, Stigma & Discrimination in the Community and among Providers.

Objective 14: By November 2012, up to 75 HPPG members and staff will attend the bi-annual HIV Prevention Leadership Institute.

8. Capacity Building and Technical Assistance

GOAL 1: By December 2016, utilize a network of capacity-building (C.B.) and technical assistance (T.A.) providers acceptable to the CDC and the DHPC.

Objective 1: By January 2012, the DHPC will develop a C.B. and T.A. plan with projected dates, audiences, locations and services requested/needed.

Objective 2: By June 2012, the HPPG will submit a capacity-building plan.

Objective 3: During 2012, provide up to three training courses for Peer Mentors, HPPG and ACAB members.

GOAL 2: Build ACAB capacity to collect, analyze, interpret and present consumer input.

Objective 1: By February 2012, ACAB members will collect and compile data from at least 250 consumers who represent the geographic and demographic face of HIV in Alabama.

Objective 2: By February 24, 2012, the ACAB will analyze and interpret CNA data.

Objective 3: By March 2012, the ACAB will present CNA data to the HPPG.

9. Program Planning, Monitoring and Evaluation, and Quality Assurance

GOAL 1: ADPH will monitor and report routine, rapid, and expanded testing data by venue and positivity rate to measure targeted community prevention activities.

Objective 1: By October 1, 2011, create a SAS program that reports CTS testing events by venue and positivity rate by county.

Objective 2: By January 31, 2012, produce the first quarterly report that documents CTS testing data by venue, positivity rate, and test type (i.e. routine, rapid, and expanded).

Objective 3: By July 31, 2012, use quarterly CTS testing reports to analyze effectiveness of targeted community prevention activities.

GOAL 2: ADPH will ensure that clients testing positive for HIV are linked to appropriate medical care and treatment and prevention services.

Objective 1: During 2012, quarterly reports and program audits will document testing data and referral activities for all funded organizations.

Objective 2: During 2012, track new HIV positive cases to ensure that a minimum of 70% of clients meet their first medical appointment.

Objective 3: During 2012, ERTS data on new HIV cases will be collected monthly as submitted by 11 regional HIV Program Coordinators.

Objective 4: During 2012, the ERTS Program Manager will provide a contact list of “unreported or previously unknown HIV-positive” to the HIV Program Coordinators every two months to document referrals and entry into HIV-related medical care.

GOAL 4: By 2016 monitor the capacity of HIV/AIDS programs and partners to provide prevention services to HIV-infected persons.

Objective 1: During 2012, capacity-building programs will be evaluated for relevance and responsiveness to the target audience needs.

Objective 2: During 2012, Peer Mentors will create, distribute or evaluate at least one tool to reinforce prevention messages.

Objective 3: By March 2012, the DHPC Data Manager will implement a data program for TLC use to monitor client retention up to one year.

Appendix C

Glossary and Terms

AIDS Action Coalition (AAC)

Alabama Drug Assistance Program (ADAP): The program that provides medications for HIV-positive clients, based on income and medical eligibility

Alabama Department of Public Health (ADPH): Division of State government that deals with the health concerns of the general public; locally referred to as the health department. Abbreviations also include PHD, HD, DPH, and DOH.

AIDS Service Organization (ASO): An organization that provides HIV/AIDS related services such as care, case management and referral to persons living with HIV/AIDS.

AIDS Service Organization Network of Alabama (ASONA): A Statewide association of 11 ASOs who offers: social services, financial aid, non-medical case management, advocacy, legal and multiple other services to meet the needs of persons living with HIV/AIDS. Financial support is provided by ADPH as available.

Birmingham AIDS Outreach (BAO)

Capacity Building: Process to increase the skills, infrastructure, and resources of individuals, organizations, and communities. Capacity building is a key strategy for the promotion, delivery, and sustainability of HIV prevention programs. As a result of capacity building on HIV prevention programs, the programs will (1) operate optimally and (2) increase their capacity to effectively deliver evidence-based

interventions and core public health strategies for HIV prevention.

Capacity Building Assistance (CBA): Provision is made available through a variety of methods including training, technical assistance (TA), and technology transfer to individuals, organizations, and communities. CBA is provided directly to communities, prevention planning groups, community-based organizations, and health departments.

CARE Act: Ryan White Comprehensive AIDS Resources Emergency. Federal legislation that addresses the needs of persons in the United States living with HIV/AIDS, and their families. The original CARE Act was enacted in 1990.

Community Based Organization (CBO): An organization that is based and focused on services for the general population, such as a community health center.

Centers for Disease Control and Prevention (CDC): The lead federal agency for protecting the health and safety of people, for providing credible information to enhance health decisions, and promoting health strong partnerships. Based in Atlanta Georgia, this agency of the U.S. Department of Health and Human Services serves as a national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

Collaboration: Working with another person, organization, or group for mutual benefit by exchanging information, sharing

resources, or enhancing the other's captivity-often to achieve a common goal or purpose.

Community Member(s): (1) consumers /members of the priority population that are receiving services or (2) people who are "non: affiliated" with organizations but are infected or affected by HIV and have a passion to address HIV.

Comprehensive Program, Monitoring and evaluation (M&E), and quality assurance (QA) plan, referred to as the

Comprehensive Program Plan: A document that details goals and SMART objectives for the proposed HIV program components and activities, the strategies to monitor and evaluate implementation and outcomes, and the set of activities carried out to define, design, assess, monitor, and improve the quality of HIV prevention services and activities.

Concurrence: Refers to the HPG's agreement that the HPG has reviewed the jurisdictional HIV Prevention Plan that is to be submitted to CDC by the health department and concurs that the jurisdictional HIV Prevention Plan includes existing prevention programmatic resources to be allocated locally to the areas with the greatest HIV disease burden.

Condom Distribution: Act of giving or delivering condoms to people.

Consumer Advisory Board (CAB)

Cooperative agreement: A financial assistance mechanism that may be used instead of a grant when the awarding office anticipates substantial federal programmatic involvement with the recipient.

Coordination: Aligning process, services, or systems to achieve increased efficiencies, benefits, or improved outcomes. Examples of coordination may include sharing information-such as progress reports-with state and local health departments, or structuring prevention delivery systems to reduce duplication of effort.

Cost analysis: Breakdown and verification of cost data, including evaluating specific elements of costs and examining them to determine the necessity, reasonableness, and allocability of the costs reflected in the budget and their allowability pursuant to the applicable cost principles.

Cost-effectiveness: the relative costs and effectiveness of proposed strategies and intervention, either demonstrated or probable.

Counseling and Testing: A process through which an individual receives information about HIV transmission and prevention, information about HIV tests and the meaning of tests results, HIV prevention counseling to reduce their risk for transmitting or acquiring HIV, and is provided testing to detect the presence of HIV antibodies.

Counseling, Testing and Referral (CTR)

Culturally appropriate: Conforming to a culture's acceptable expressions and standards of behavior and thoughts. Interventions and educational materials are most likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot testing them.

Diffusion of Effective Behavioral Interventions (DEBI)

Disease Intervention Specialist (DIS): local, area or state disease control specialist who works in STD, TB, Immunizations or HIV.

Diversity: Individual differences along the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, health or disease status, or other ideologies. The concept of diversity encompasses acceptance, respect, and understanding that each individual is unique.

Division of HIV Prevention and Control (DHPC)

Engagement Plan: A plan used to identify strategies for increasing coordination between HIV programs of the state, jurisdiction, and tribal communities for the purpose of applying a collective vision for the benefit of the overall jurisdiction. Steps for engagement should include determining the goals of the plan and whom to engage, developing engagement strategies for new partnering agencies, prioritizing engagement activities, creating an implementation plan, monitoring progress, and maintaining the partner relationships.

Epidemic: The rapid spread, growth, or occurrence of cases of an illness, health-related behavior, or other health related events in the community or region in excess of normal expectation.

Epidemiological profile: A document that describes the HIV/AIDS epidemic within various populations and identifies characteristics of both HIV-infected and HIV-negative persons in defined geographic areas. It is composed of information gathered to describe the effect of HIV/AIDS on an area in terms of sociodemographic, geographic, behavioral, and clinical

characteristics. The epidemiological profile serves as the scientific basis of the identification and prioritization of HIV prevention and care needs in any given jurisdiction.

Evidence-based Behavioral Interventions (EBI): Interventions relevant to HIV risk reduction that has been tested using a methodologically rigorous design, and have been shown to be effective in a research setting.

Enhanced Referral Tracking System (ERTS)

FOCUS GROUP: The name applied when discussions are held to elicit consumer opinions.

FOCUS PROGRAM: The name of an HIV prevention school curriculum.

Funding Opportunity Announcement (FOA): A CDC announcement in the Federal Register describing the amount of funding available for a particular public health goal and soliciting applications for funding. The funding opportunity announcement describes required activities and asks the applicant to describe how will carry out the required activities.

Gay and Lesbian Alliance Against Defamation (GLAAD)

Gay, Lesbian, and Straight Education Network (GLSEN)

Health Education/Risk Reduction (HE/RR): Organized efforts to reach people at increased risk of becoming HIV-infected or, if already infected, of transmitting the virus to others. The goal is to reduce the spread of infection. Activities range from

individual HIV prevention counseling to broad, community-based interventions.

High Impact prevention: By using combinations of scientifically proven, cost effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to increase the impact of prevention efforts-an essential step in achieving the goals of NHAS. This approach is designed to maximize the impact of prevention efforts for the country and specific jurisdictions by decreasing incidence and increasing health equity.

High-risk Individual: Someone who has had unprotected sex or has shared injecting equipment in a high-prevalence setting or with a person who is living with HIV.

HIV Planning Group: The official HIV planning body that follows the HIV Planning Guidance to inform the development or update of the health department's jurisdictional HIV Prevention Plan that will contribute to the reduction of HIV infection in the jurisdiction.

HIV Prevention Plan (HPP): The cyclical, evidence-based planning process in which authority for identifying priorities for funding HIV prevention programs is vested in one or more planning groups in a state or local health department that receives HIV prevention funds from CDC.

Housing Opportunities for People with AIDS (HOPWA)

Human Rights Campaign (HRC)

Health Resources and Services

Administration (HRSA): Directs programs that improve the nation's health by

expanding access to comprehensive, quality health care for all Americans.

Injection Drug User (IDU): Someone who uses a needle to inject drugs into his or her body.

Lesbian, Gay, Bisexual, Transgender (LGBT)

Medical AIDS Outreach (MAO)

Men who have sex with men (MSM): Men who report sexual contact with other men (that is, homosexual contact) and men who report sexual contact with both men and women (that is, bisexual contact), whether or not they identify as "gay".

Met/Unmet Need: A met need is a need with a specific target population for HIV prevention services that is currently being addressed through existing HIV prevention resources. These resources are available to, appropriate for, accessible to that population. For example, a project area with an organization for African-American gay, bisexual, lesbian, and transgender individuals may meet the HIV/ADIS education needs of African-American men who have sex with men through outreach, public information, and group counseling efforts. An unmet need is a requirement for HIV prevention services within a specific target population that is not being addressed through existing HIV prevention services and activities-either because no services are available or because available services are either inappropriate for, or inaccessible to, the target population. For example, a project area lacking Spanish-language HIV counseling and testing services will not meet the needs of Latinos with limited English proficiency.

National Alliance of State and Territorial AIDS Directors (NASTAD):

National HIV/AIDS Strategy (NHAS): To accomplish these goals, we must undertake a more coordinated national response to the HIV epidemic. The Strategy is intended to be a concise plan that will identify a set of priorities and strategic action steps tied to measurable outcomes.

NMAC: National Minority AIDS Council

Non-concurrence: The HPG disagrees that the Jurisdictional HIV Prevention Plan

Non-healthcare Setting: A setting in which neither medical diagnostic nor treatment services are provided, but health screening may be provided.

Opt-out HIV Testing Approach: Testing approach in which a person is notified that a test will be performed unless he or she declines or defers testing. Testing is presented so that the person would be expected to understand the default is that a test will be done unless he or she declines.

Parity: The ability of HIV Prevention Planning Group (HPPG) members to equally participate and carry out planning tasks or duties in the planning process. To achieve parity, representatives should be provided with opportunities for orientation and skills building to participate in the planning process and have an equal voice in voting and other decision-making activities.

Partner Services (PS): A systematic approach to notifying sex and needle-sharing partners of HIV: infected persons of their possible exposure to HIV so they can be offered HIV testing and learn their status, or, if already infected, prevent transmission to others. PS helps partners gain earlier

access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Perinatal Transmission: HIV transmission from mother to child during pregnancy, labor and delivery, or breastfeeding.

PLWHA: A person or persons living with HIV or AIDS.

Prevalence: The total number of cases of a disease in a given population at a particular point and time. For HIV/AIDS surveillance, prevalence refers to living persons with HIV disease, regardless of time of infection or diagnosis date. Prevalence does not give an indication of how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk that an individual will have a disease at a point in time.

Prevention Evaluation and Monitoring System (PEMS): A CDC designed program that is used to evaluate and monitor current HIV Intervention Programs.

Prevention Program: An organized effort to design and implement one or more interventions to achieve a set of predetermined goals, for example, to increase condom use with non-steady partners.

Prevention Services: Interventions, strategies, programs, and structures designed to change behavior that may lead to HIV infection or other diseases. Examples of HIV prevention services include street outreach, educational sessions, condom distribution, and mentoring and counseling programs.

Priority Population: A population identified through the epidemiologic profile

and community services assessment that requires prevention efforts due to high rates of HIV infection and the presence of risky behavior.

Refers to parity, inclusion and representation (PIR): see CDC glossary for more

Risk Factors: Are based on observations of behaviors and contexts in which HIV is likely to be transmitted (e.g., lifetime number of sex partners, crack use, environmental factors like membership in a demographic group highly impacted by HIV, using old expired-date condoms, internet use, etc.). Influencing factors of behavioral risk refers to associations with risk or risk correlates and risk contexts, not behavioral determinants.

Rural: An area with a population of less than 2,500 located outside of a larger urban area.

RFP: Request for Proposal

Scalable: Interventions or combinations of interventions that can reach a significant portion of those in need, in a cost efficient manner, and demonstrate population-level impact.

Seroprevalence: The number of people in a population who test HIV positive based on serology (blood serum) specimen. Seroprevalence is often presented as a percentage of the total number of specimens tested or as a rate per 1,000 persons tested.

Socioeconomic status (SES): A description of person's societal status using factors or measurements such as income levels, relationships to the national poverty line, educational achievement, neighborhood of residence, or home ownership.

Stakeholder: A person or representative who has a personal or professional experience, skills, resources or expertise in HIV.

SEATEC: Southeast AIDS Training and Education Center

Social Determinants of Health (SDH): The complex, integrated, and overlapping social structures and economic systems that include the social environment, physical environment, and health services; structural and societal factors that are responsible for most health inequities. SDH are shaped by the distribution of money, power and resources at global, national, and local levels, which are themselves influenced by policy choices. Five determinants of population health are generally recognized in the scientific literature: biology and genetics (e.g., sex), individual behavior (e.g., alcohol or injection drug-use, unprotected sex, smoking), social environment (e.g., discrimination, income, education level, marital status), physical environment (e.g., place of residence, crowding conditions, built environment [i.e., buildings, spaces, transportation systems, and products that are created or modified by people]), and health services (e.g., access to and quality of care, insurance status).

Social marketing: The use of marketing theory, skills, and practice to: achieve social change, promote the general health, raise awareness and induce changes in behavior.

South Alabama CARES: Community AIDS Resources, Education and Support; Formerly named MASS (Mobile AIDS Support Services)

Target populations: Populations that are the focus of HIV prevention efforts because they have high rates of HIV infection and

high levels of risky behavior. Groups are often identified by using a combination of behavioral risk factors and demographic characteristics.

Telemedicine: The use of telecommunication and information technologies in order to provide clinical health care at a distance. It helps eliminate distance barriers and can improve access to medical services that would often not be consistently available in distant rural communities. It is also used to save lives in critical care and emergency situations.

Transgender-Female to Male (FTM): An individual who's physical or birth sex is female but whose gender expression and/or gender identity is male.

Transgender-Male to Female (MTF): An individual who's physical or birth sex is male but whose gender expression and/or gender identity is female.

Transmission Risk: A behavior that places the priority population at potential risk for HIV infection or transmission.

