

HIV Integrated Epidemiological Profile

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EXECUTIVE SUMMARY

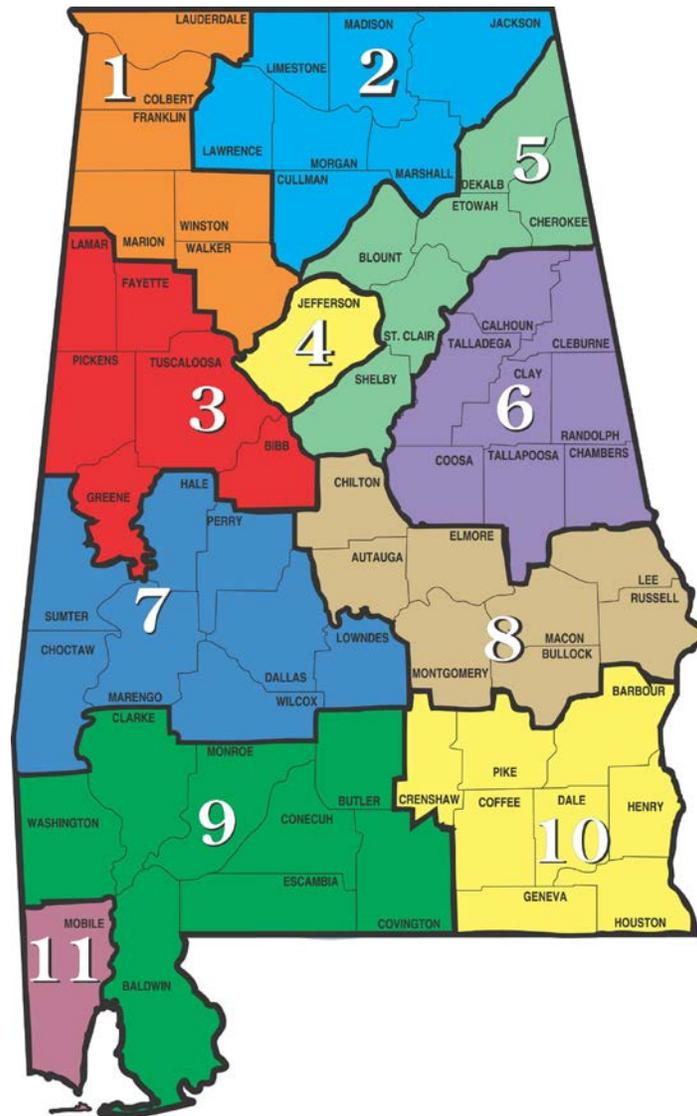
One point two million (1,200,000) people in the United States are living with HIV infection. The Centers for Disease Control and Prevention (CDC) estimate that 20% of these people are unaware of their infection. Between 1982 and 2011, a total of 17,839 cases of HIV infection were reported to the Alabama Department of Public Health (ADPH). At the end of 2011, 64% (11,342) were known to be living. An additional 2,000 to 4,000 Alabama residents are likely infected and unaware of their positive HIV status. During 2011, just over 700 newly diagnosed HIV infections were reported in Alabama. The HIV epidemic in Alabama is classified as one of moderate magnitude when compared to the experience of other states.

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 males representing one-half (50%) of all newly diagnosed HIV infections. White males represented another 21% of 2011 incident HIV infections; African American females followed closely representing 19%.

New infections are disproportionately occurring in Alabama's African American population. Although African Americans comprised only 26% of the state's population in 2011, they represented 69% of newly diagnosed HIV infections. The rate of HIV diagnosed among African Americans (38.4 per 100,000) was more than seven times higher than among Whites (5.3 per 100,000). The rate of newly diagnosed HIV infections in African American males (60.2 per 100,000) was more than six times higher than White males (9.1 per 100,000). Sixty-six percent of males diagnosed with HIV in 2011 were African American. A similar trend was seen among females, with 78% (131) of all incident diagnoses in females occurring in African Americans. The rate of HIV incidence in African American females (19.4 per 100,000) was eight times higher than White females (1.6 per 100,000) and 2 times higher than White males (9.1 per 100,000).

Alabama's population can be divided into 3 geographical 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, Alabama ranked 42nd nationally in per capita income with 23% of the population living in poverty. Alabama’s agricultural Black Belt region has the highest poverty and unemployment rates in the state. Strikingly, 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 defined core service priorities and support services, with appropriate justification based on United States 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, Alabama's AIDS Drug Assistance Program (ADAP) offers medication services with an enrollment cap of 1700; restrictions apply, and a waiting list is currently enforced. The ADAP formulary offers 72 medications, and includes at least one drug from each class of HIV medications. In addition, medications to treat opportunistic infections are available through ADAP. Average enrollment in fiscal year 2011 exceeded the 1700 enrollment cap at 1758 enrollees, 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 African Americans 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.

INTRODUCTION

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

The profile is divided into five key sections:

- I. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE GENERAL POPULATION
- II. SCOPE OF THE HIV EPIDEMIC
- III. INDICATORS OF RISK FOR HIV INFECTION
- IV. PATTERNS OF UTILIZATION OF HIV SERVICES
- V. CHARACTERISTICS OF HIV POSITIVE PERSONS WHO ARE NOT IN CARE

DATA SOURCES

Data was compiled from a variety of sources. Anyone citing or interpreting data should acknowledge all data sources have strengths and limitations.

Alabama's Enhanced Referral Tracking System (ERTS)

The ADPH Enhanced Referral Tracking System (ERTS) provides significant data in determining the demographics and geographical location of HIV positive Alabama residents aware of their HIV status and not in care.

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.

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.

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 the newborn 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.

Direct Care Update Report

The ADPH HIV/AIDS 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 Alabama's AIDS Drug Assistance Program (ADAP). Alabama's HIV care and service providers apply for Ryan White funding through the ADPH 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.

HIV Surveillance Data

The Alabama Department of Public Health (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.

Kaiser Family Foundation

The Kaiser Family Foundation is a non-profit, private 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.

Sexually Transmitted Disease (STD) Case Reporting

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

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.

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.

I. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE GENERAL POPULATION

A. HIGHLIGHTS

Population

The U.S. Census Bureau reported 4,779,736 persons resided in Alabama in 2010. Alabama is composed of 67 counties, ranging in population from 9,045 to 658,466 in Greene and Jefferson Counties, respectively. Alabama is considered largely rural, but does have four major urban centers located in Jefferson, Madison, Montgomery and Mobile Counties and one large metropolitan statistical area that represents 24% (1,128,047) of Alabama's total population and includes seven adjacent counties (Bibb, Blount, Chilton, Jefferson, St. Clair, Shelby and Walker Counties).

Public Health Structure

Alabama is divided into eleven geographically distinct public health areas (PHAs) with the two most populous counties representing single PHAs (Figure 1). The remaining PHAs encompass six to eight counties each. Seven of Alabama's 19 Black Belt counties comprise PHA 7. Each area has authority to provide core public health services to the community including HIV counseling and testing, sexually transmitted disease (STD) screening and treatment, maternal and child health, vaccine preventable immunizations, family planning, home health services, and adult health clinics.

Demographic Composition

The 2010 U.S. Census Bureau reports 70% of Alabama residents are White, not Hispanic (Table 1). Non-Hispanic African Americans compose about one-quarter (26%) of the population in Alabama. The remainder of the population identified themselves as Hispanic (2%), Asian (1%), or Native American (<1%). The racial and ethnic distribution is the same when assessed by gender.

Table 1. Distribution of General Population by Race/Ethnicity and Sex, Alabama 2010

| Race/Ethnicity | Males | | Females | | Total Population | |
|--------------------------------|-------------|-------|-------------|-------|------------------|-------|
| | N=2,323,317 | % | N=2,461,981 | % | N=4,785,298 | % |
| White, not Hispanic | 1656912 | 71.3% | 1707553 | 69.4% | 3364465 | 70.3% |
| African American, not Hispanic | 588483 | 25.3% | 673858 | 27.4% | 1262341 | 26.4% |
| Hispanic | 34703 | 1.5% | 35271 | 1.4% | 69974 | 1.5% |
| Native American | 16854 | 0.7% | 16154 | 0.7% | 33008 | 0.7% |
| Asian | 26365 | 1.1% | 29145 | 1.2% | 55510 | 1.2% |

Source: 2010 United States Census Bureau.

Note: Percentages may not sum 100% due to rounding.

Approximately one-half (53%) of Alabama residents are between the ages of 25 and 64 years (Table 2). Twenty-six percent are 25 to 44 years and 27% are 45 to 64 years. One-third of residents (34%) are younger than 25 years with 15 to 24 year olds representing 15%, 5 to 14 years old representing 14%, and children less than 5 years old representing 7%. The remainder of Alabama residents is aged 65 years or older (14%). The female to male ratio in Alabama is 1:1.

Table 2. Distribution of General Population by Age Group and Sex, Alabama 2010

| Age Group (years) | Males | | Females | | Total Population | |
|-------------------|-------------|-------|-------------|-------|------------------|-------|
| | N=2,320,188 | % | N=2,461,981 | % | N=4,785,298 | % |
| <5 | 155196 | 6.7% | 149644 | 6.1% | 304840 | 6.4% |
| 5-14 | 320516 | 13.8% | 306923 | 12.5% | 627439 | 13.1% |
| 15-24 | 342342 | 14.8% | 335763 | 13.6% | 678105 | 14.2% |
| 25-44 | 604687 | 26.1% | 624560 | 25.4% | 1229247 | 25.7% |
| 45-64 | 620967 | 26.8% | 664878 | 27.0% | 1285845 | 26.9% |
| ≥65 | 279609 | 12.1% | 380213 | 15.4% | 659822 | 13.8% |

Source: 2010 United States Census Bureau.

Note: Percentages may not sum 100% due to rounding.

Poverty, Income, and Education

According to the 2010 U.S. Census Bureau, Alabama is the tenth most poverty stricken state in the nation. Seventeen percent of Alabama residents live below the federal poverty level (Table 3). One-quarter (25%) of children less than 18 years, 16% of adults aged 18 to 64 years, and 10% of the elderly aged 65 years and older live below the federal poverty level. Fifteen percent of all families and 45% of families with a female head of household and no husband present have incomes below the poverty level. Average personal income in Alabama is \$22,984 and the median household income is \$42,081.

Table 3. Socioeconomic Characteristics of the General Population, Alabama and the United States 2010

| Characteristic | Alabama | United States |
|--|----------|---------------|
| Income | | |
| Average Per Capita Income | \$22,984 | \$27,334 |
| Median Household Income | \$42,081 | \$51,914 |
| Federal Poverty Level | | |
| Individuals | 17.3% | 15.1% |
| Families | 15.4% | 11.7% |
| Female HOH†, no husband present | 45.1% | 42.2% |
| Federal Poverty Level by Age Group (years) | | |
| <18 | 24.8% | 22.0% |
| 18-64 | 15.9% | 13.7% |
| ≥65 | 10.3% | 9.0% |

Source: 2010 Current Population Survey, United States Census Bureau.

Note: Percentages may not sum 100% due to rounding. †HOH – Head of Household

The most common level of education attained in Alabama among people aged 25 years and older is a high school diploma or its equivalent (30%), according to 2010 U.S. Census reports (Table 4). Another 25% of residents aged 25 years and older fail to graduate high school with 6% reporting less than a ninth grade education. Assessing Alabama's four most populous counties (>200,000 population) shows roughly the same education distribution.

Table 4. Distribution of the Population ≥25 Years of Age by Educational Attainment for Counties of >200,000 Population, Alabama 2010

| Education | Jefferson N=658,466 | Madison N=334,811 | Mobile N=412,992 | Montgomery N=229,363 | Alabama N=4,779,736 |
|------------------------------------|------------------------|----------------------|---------------------|-------------------------|------------------------|
| High School Graduate or Equivalent | 28.1% | 22.2% | 34.3% | 27.5% | 30.4% |
| Some College | 22.7% | 21.5% | 20.9% | 21.1% | 20.5% |
| Associate's Degree | 7.0% | 6.7% | 7.3% | 5.5% | 5.4% |
| Bachelor's Degree | 18.1% | 23.9% | 13.1% | 18.2% | 12.2% |
| Graduate or Professional Degree | 10.7% | 13.5% | 6.7% | 12.3% | 6.9% |

Source: 2010 Site and County Quick facts for Alabama, United States Census Bureau.

Note: Percentages may not sum 100% due to rounding.

B. DEMOGRAPHICS

The 2010 U.S. Census Bureau reports the population of Alabama is 4,779,736 persons (Table 2). The female to male ratio is 1:1 and the majority of the population between 25 and 64 years old (53%). The proportion of women age 65 years or older was significantly higher than that of their male counterparts (58% to 42%, respectively). The 2000 U.S. Census expanded the collection of race and ethnicity information to allow persons the opportunity to report belonging to more than one race, as well as to report Hispanic ethnicity. Despite this expansion, 70% of Alabama's population reported themselves as White, not Hispanic in the 2010 U.S. Census (Table 1). African American, not Hispanic comprised 26% of the population, with Hispanics, Native Americans, and Asians constituting approximately 3% of the total population.

Alabama is divided into eleven PHAs for the purpose of public health planning and disease intervention (Figure 1). PHA 2 has the largest combined population with 798,074 residents while PHA 4 (Jefferson County) has the second largest population with 658,466 residents (Table 5). PHA 7 has the smallest population with only 141,789 residents and is part of the agricultural Black Belt region. PHA 7 has the lowest percentage of White residents (34%) and the highest percentage of African American residents (51%) in Alabama. Statewide, the number of persons reported as White ranges from 34% in PHA 7 to 86% in PHA 1. Alabama's African American population ranges from only 8% in PHAs 1 and 5 to 51%, in PHA 7. Hispanics comprise between 1% and 6% of Alabama's population.

Table 5. Distribution of General Population by Race/Ethnicity and Public Health Area, Alabama 2010

| Public Health Area (PHA) | White | % | Black | % | Hispanic | % | Other | % | Total | % |
|--------------------------|---------|------|--------|------|----------|-----|--------|-----|---------|------|
| PHA 1 | 260144 | 86.4 | 24281 | 8.1 | 10463 | 3.5 | 6236 | 2.1 | 301124 | 6.3 |
| PHA 2 | 606127 | 75.9 | 111824 | 14.0 | 45756 | 5.7 | 34367 | 4.3 | 798074 | 16.7 |
| PHA 3 | 183765 | 66.1 | 81536 | 29.3 | 7121 | 2.6 | 5745 | 2.1 | 278167 | 5.8 |
| PHA 4 | 340213 | 51.7 | 275511 | 41.8 | 25488 | 3.9 | 17254 | 2.6 | 658466 | 13.8 |
| PHA 5 | 444985 | 82.8 | 46379 | 8.6 | 31366 | 5.8 | 14798 | 2.8 | 537528 | 11.2 |
| PHA 6 | 239121 | 70.3 | 48085 | 14.1 | 8727 | 2.6 | 7114 | 2.1 | 340050 | 7.1 |
| PHA 7 | 48593 | 34.3 | 71934 | 50.7 | 1233 | 0.9 | 1326 | 0.9 | 141789 | 3.0 |
| PHA 8 | 356247 | 56.3 | 86522 | 13.7 | 22699 | 3.6 | 20118 | 3.2 | 632440 | 13.2 |
| PHA 9 | 263566 | 73.4 | 60262 | 16.8 | 10187 | 2.8 | 11050 | 3.1 | 359006 | 7.5 |
| PHA 10 | 217737 | 68.0 | 41302 | 12.9 | 12626 | 3.9 | 10407 | 3.3 | 320100 | 6.7 |
| PHA 11 | 243904 | 59.1 | 142272 | 34.4 | 9936 | 2.4 | 16880 | 4.1 | 412992 | 8.6 |
| Total | 3204402 | 67.0 | 989908 | 20.7 | 185602 | 3.9 | 145295 | 3.0 | 4779736 | 100 |

Source: 2011 Auburn University at Montgomery Center for Demographic Research.

Note: Percentages may not sum 100% due to rounding.

According to 2010 U.S. Census statistics, the distribution of race/ethnicity varies in Alabama's four major urban centers, defined as counties with populations >200,000 (Table 6). In Madison County, 66% of the population indicates their race/ethnicity as White, not Hispanic, compared with 59% in Mobile County, 52% in Jefferson County, and 38% in Montgomery County. Montgomery County reports the highest percent of African American, not Hispanics (55%), followed by Jefferson County (42%), Mobile County (35%), and Madison County (24%). Madison County reports the highest Hispanic population (5%).

Table 6. Distribution of General Population by Race/Ethnicity for Counties of >200,000 Population, Alabama 2010

| Race/Ethnicity | Jefferson County N=658,466 | | Madison County N=334,811 | | Mobile County N=412,992 | | Montgomery County N=229,363 | | Alabama N=4,779,736 | |
|---------------------|-------------------------------|--|-----------------------------|--|----------------------------|--|--------------------------------|--|------------------------|--|
| | | | | | | | | | | |
| White, not Hispanic | 51.7% | | 66.1% | | 59.1% | | 38.4% | | 67.0% | |
| Black, not Hispanic | 41.8% | | 23.8% | | 34.5% | | 54.5% | | 20.7% | |
| Hispanic | 3.9% | | 4.6% | | 2.4% | | 3.6% | | 3.9% | |
| Other | 1.7% | | 5.5% | | 4.1% | | 3.5% | | 3.0% | |

Source: 2011 Auburn University at Montgomery Center for Demographic Research.

Note: Percentages may not sum 100% due to rounding.

C. SOCIOECONOMIC STATUS

Alabama is the tenth most poverty stricken state in the nation with 17% of Alabama residents live below the federal poverty level (Table 3). In 2008, the rate of Alabamians living below poverty level decreased with age, with the highest proportion of persons living below the poverty level being less than 25 years old and the lowest proportion being 65 or older (Table 7). Analyses of Alabama's four most populous counties mirror this trend with Mobile and Montgomery Counties displaying the highest poverty rates in persons less than 25 years. In each of the four most populous counties and statewide, more women than men live below federal poverty level in all age groups.

Table 7. Rate of People Living Below the Poverty Level by Age Group and Sex for Counties of >200,000 Population, Alabama 2008

| Age Group (years) | Jefferson County | | Madison County | | Mobile County | | Montgomery County | | Alabama | |
|----------------------|------------------|--------|----------------|--------|---------------|--------|-------------------|--------|---------|--------|
| | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| <25 | 6.6 | 6.4 | 6.4 | 5.3 | 8.7 | 10.4 | 8.7 | 10.0 | 7.4 | 7.7 |
| 25-44 | 2.0 | 3.7 | 2.3 | 2.4 | 3.4 | 5.4 | 1.9 | 4.3 | 2.8 | 4.3 |
| 45-64 | 2.3 | 2.9 | 1.2 | 1.8 | 2.8 | 3.8 | 2.7 | 3.6 | 2.4 | 3.3 |
| ≥65 | 0.8 | 1.8 | 0.2 | 1.1 | 0.9 | 1.9 | 0.9 | 2.1 | 0.9 | 2.3 |

Source: 2008 American Community Survey Estimates, United States Census Bureau.

Note: Rate per 100,000 persons.

A 2008 population survey found 18% of males and 16% of females aged 19-24 years in Alabama do not have health insurance coverage (Table 8). Of those insured, two-thirds (66% of men and 68% of women) receive health insurance coverage through their employer. State percentages of health insurance coverage status were similar to the national average.

Table 8. Distribution of Adults (Aged 19-24 years) by Health Insurance Coverage and Sex, Alabama 2007-2008, United States 2008

| Health Insurance Coverage | Alabama | | United States | |
|---------------------------|---------|---------|---------------|---------|
| | Males | Females | Males | Females |
| Employer | 66.1% | 67.9% | 61.4% | 62.6% |
| Individual | 4.1% | 4.1% | 5.6% | 5.9% |
| Medicaid/Medicare | 7.5% | 8.4% | 6.9% | 10.2% |
| Other Public | 4.3% | 3.5% | 3.2% | 3.2% |
| Uninsured | 18.1% | 16.1% | 22.9% | 18.1% |

Source: Kaiser Family Foundation, 2008.

Note: Percentages may not sum 100% due to rounding.

Forty-nine percent of Alabama children aged 0-18 years were covered under their parent or guardian's employer health insurance (Table 9). Another 39% of children aged 0-18 years were insured via Medicaid and 9% of children in Alabama were uninsured.

Table 9. Distribution of Children (Aged 0-18 years) by Health Insurance Coverage, Alabama 2007-2008, United States 2008

| Health Insurance Coverage | Alabama | United States |
|---------------------------|---------|---------------|
| Employer | 49% | 50% |
| Individual | NSD† | 4% |
| Medicaid | 39% | 34% |
| Other Public | NSD† | 2% |
| Uninsured | 9% | 10% |

Source: Kaiser Family Foundation, 2010.

Note: Percentages may not sum 100% due to rounding. †NSD – No Statistical Data

According to the 2010 U.S. Census statistics, the most common level of education (30%) in Alabama among people aged 25 years and older is a high school diploma or its equivalent (Table 4). Only 12% of residents attain a bachelor’s degree and 25% of residents fail to graduate high school with 6% reporting less than a ninth grade education. Assessing Alabama’s four most populous counties show similar trends in Jefferson, Mobile, and Montgomery Counties although Madison County residents attain higher educational success with 24% receiving a bachelor’s degree.

II. SCOPE OF THE HIV EPIDEMIC

A. HIGHLIGHTS

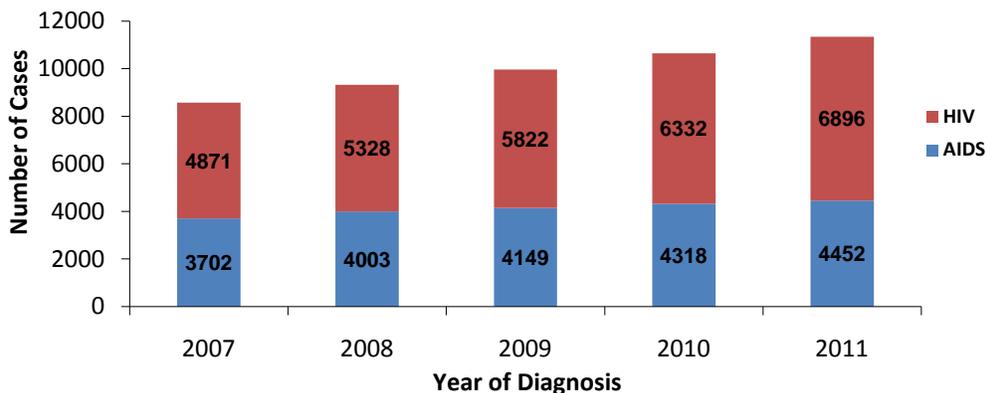
The HIV epidemic affects persons in all gender, age, race, ethnicity, and socioeconomic groups and in every county in Alabama. However, the effect has not been the same for all groups. At the beginning of the epidemic, the majority of HIV infections occurred in White men who have sex with men (MSM). Recent trends suggest a shift in the HIV epidemic toward African Americans 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. This section provides detailed information about demographics, risk characteristics, and trends of HIV infections diagnosed among Alabama residents diagnosed through 2011.

B. OVERALL HIV TRENDS

Alabama continues to experience an HIV epidemic of moderate magnitude when contrasted to the experience of other states. Through December 31, 2011, the Alabama Department of Public Health received a cumulative total of 17,839 HIV case reports. During 2011, 706 newly diagnosed HIV infections were reported in Alabama.

The proportion of persons living with HIV/AIDS (PLWHA) increased 32% from 2007 to 2011 (Figure 2). A total of 11,342 persons were known to be living with HIV infection in Alabama at the end of 2011, and 4,452 (39%) of these individuals have progressed to AIDS. An additional 2,000 to 4,000 Alabama residents are likely infected and unaware of their positive HIV status.

Figure 2. Persons Living with HIV/AIDS, Alabama 2007-2011



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

The increase in PLWHA is in part due to the introduction of effective drug treatments and therapies capable of delaying the progression of HIV. Currently 62% of prevalent PLWHA are between the ages of 25 to 44 although 57% of newly diagnosed incident cases occur in 13 to 34 year olds (Table 10). As a result of the aging PLWHA population, ADPH is becoming stressed to provide adequate medical and social services (e.g., Ryan White and Medicare) to HIV infected individuals. This is a major concern not only in Alabama, but for all states.

Table 10. Characteristics of Incident and Prevalent HIV Cases, Alabama 2011

| Characteristic | Incident Cases (N=706), Number (%) | Prevalent Cases (N=11,342), Number (%) |
|--------------------------|---------------------------------------|---|
| Gender | | |
| Male | 538 (76.2) | 8115 (71.6) |
| Female | 168 (23.8) | 3227 (28.5) |
| Race/Ethnicity | | |
| White, Not Hispanic | 178 (25.2) | 3408 (30.1) |
| Black, Not Hispanic | 485 (68.7) | 7389 (65.2) |
| Hispanic | 17 (2.4) | 244 (2.2) |
| Other/Unknown | 26 (3.7) | 301 (2.7) |
| Age Group (years)* | | |
| 0-12 | 2 (0.3) | 96 (0.9) |
| 13-24 | 200 (28.3) | 2164 (19.1) |
| 25-34 | 203 (28.8) | 3828 (33.8) |
| 35-44 | 133 (18.8) | 3191 (28.1) |
| 45-49 | 71 (10.1) | 966 (8.5) |
| ≥ 50 | 93 (13.2) | 1030 (9.1) |
| Public Health Area (PHA) | | |
| PHA 1 | 12 (1.7) | 192 (1.9) |
| PHA 2 | 66 (9.4) | 933 (9.0) |
| PHA 3 | 32 (4.5) | 411 (4.0) |
| PHA 4 | 205 (29.0) | 2946 (28.5) |
| PHA 5 | 33 (4.7) | 392 (3.8) |
| PHA 6 | 39 (5.5) | 466 (4.5) |
| PHA 7 | 28 (4.0) | 313 (3.0) |
| PHA 8 | 125 (17.7) | 1937 (18.8) |
| PHA 9 | 32 (4.5) | 457 (4.4) |
| PHA 10 | 35 (5.0) | 622 (6.0) |
| PHA 11 | 97 (13.7) | 1602 (15.5) |
| Other/Unknown | 2 (0.3) | 50 (0.5) |

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

Note: Data as of 3/31/2012. Percentages may not sum 100% due to rounding.

Seven of Alabama's 67 counties exhibited the highest rates of HIV infections in 2011 (Table 11). These seven counties also accounted for over 45% of HIV infections diagnosed in any year from 2007 to 2011, with Jefferson County averaging 26% of incident infections each year.

Table 11. HIV by Year of Diagnosis and County for Counties with the Highest Rates, Alabama 2007 – 2011

| County | 2007 | | 2008 | | 2009 | | 2010 | | 2011 | |
|------------|------------|------|------------|------|------------|------|------------|------|------------|------|
| | Number (%) | Rate |
| Chambers | 7 (0.8) | 20.5 | 7 (0.8) | 20.5 | 11 (1.5) | 32.2 | 9 (1.3) | 26.3 | 12 (1.7) | 35.1 |
| Conecuh | 4 (0.4) | 30.2 | 1 (0.1) | 7.6 | 1 (0.1) | 7.6 | 4 (0.6) | 30.2 | 4 (0.6) | 30.2 |
| Hale | 3 (0.3) | 19.0 | 4 (0.4) | 25.4 | 1 (0.1) | 6.4 | 7 (1.0) | 44.4 | 6 (0.8) | 38.1 |
| Jefferson | 202 (22.7) | 30.7 | 223 (25.0) | 33.9 | 202 (27.1) | 30.7 | 191 (27.1) | 29.0 | 207 (29.3) | 31.1 |
| Lowndes | 7 (0.8) | 62.0 | 2 (0.2) | 17.7 | 3 (0.4) | 26.6 | 6 (0.8) | 53.1 | 6 (0.8) | 53.1 |
| Mobile | 155 (17.4) | 37.5 | 116 (13.0) | 28.1 | 25 (3.4) | 6.1 | 102 (14.4) | 24.7 | 98 (13.9) | 23.5 |
| Montgomery | 116 (13.0) | 50.6 | 122 (13.7) | 53.2 | 95 (12.8) | 41.4 | 78 (11.0) | 34.0 | 88 (12.5) | 38.0 |
| Statewide | 890 (100) | 42.1 | 892 (100) | 42.2 | 745 (100) | 35.2 | 705 (100) | 33.4 | 706 (100) | 33.9 |

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

Note: Percentages may not sum 100% due to rounding. Rates per 100,000 persons residing in county.

Alabama's population can be divided into 3 geographical groupings: major urban centers (>200,000 population), minor urban centers (100,000-200,000 population), and rural areas (<100,000 population). In 2010, major urban centers represented 34% (1,635,632) of the state's total population and 61% (10,597) of cumulative HIV cases (Table 12). Jefferson County accounted for 28% of all HIV cases in Alabama. Minor urban centers comprised 24% (1,156,292) of the population and 14% (2437) of cumulative HIV cases. Rural areas represented 42% (1,987,792) of the population, accounting for 25% (4256) of cumulative HIV cases.

Table 12. Cumulative HIV Cases by Geographic Population Density, Alabama 2010

| | Cumulative HIV Cases (%) | Total Population (%) |
|----------------------|--------------------------|----------------------|
| Major Urban Centers† | | |
| Jefferson County | 4912 (28.4) | 658466 (13.8) |
| Madison County | 837 (4.8) | 334811 (7.0) |
| Mobile County | 2791 (16.2) | 412992 (8.6) |
| Montgomery County | 2057 (11.9) | 229363 (4.8) |
| Total | 10597 (61.3) | 1635632 (34.2) |
| Minor Urban Centers‡ | | |
| Baldwin County | 413 (2.4) | 182265 (3.8) |
| Calhoun County | 299 (1.7) | 118572 (2.5) |
| Etowah County | 202 (1.2) | 104430 (2.2) |
| Houston County | 393 (2.3) | 101547 (2.1) |
| Lee County | 273 (1.6) | 140247 (2.9) |
| Morgan County | 168 (1.0) | 119490 (3.1) |
| Shelby County | 185 (1.1) | 195085 (4.1) |
| Tuscaloosa County | 494 (2.9) | 194656 (4.1) |
| Total | 2179 (14.0) | 1156292 (24.2) |
| Rural Areas* | 4256 (24.6) | 1987812 (41.6) |
| Alabama Statewide | 17280 (100) | 4779746 (100) |

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

Note: Percentages may not sum 100% due to rounding. † Major urban centers represent counties with >200,000 population. ‡ Minor urban centers represent counties with between 100,000-200,000 population. * Rural areas represent counties with < 100,000 population.

HIV by Race, Ethnicity and Gender

African Americans continue to be disproportionately affected by the HIV epidemic. African American males are 6.6 times more likely to become infected with HIV than White males and African American females have 12 times the risk of White females (Table 13). Although only

26% of the state’s population is African American, this group represents 69% of incident HIV infections and 65% of prevalent infections in 2011 (Tables 1 & 10).

Table 13. Incident HIV Cases by Race, Ethnicity and Sex, Alabama 2011

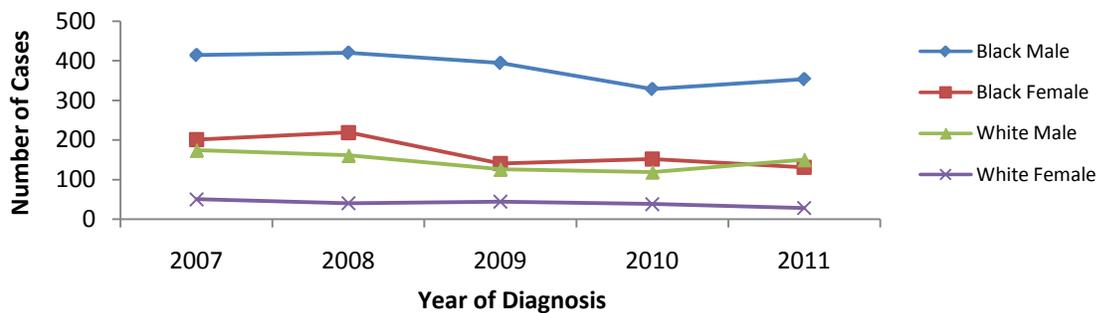
| Race/Ethnicity | Males (N=2323317) | | Females (N=2461981) | | Total | |
|--------------------------------|-------------------|------|---------------------|------|------------|------|
| | Number (%) | Rate | Number (%) | Rate | Number (%) | Rate |
| White, Not Hispanic | 150 (27.9) | 9.1 | 28 (16.7) | 1.6 | 178 (25.2) | 5.3 |
| African American, Not Hispanic | 354 (65.8) | 60.1 | 131 (78.0) | 19.4 | 485 (68.7) | 38.4 |
| Hispanic | 15 (2.8) | 43.2 | 2 (1.2) | 5.7 | 17 (2.4) | 24.3 |
| Other/Unknown | 19 (3.5) | 44.0 | 7 (4.2) | 15.5 | 26 (3.7) | 29.4 |
| Total | 538 (100) | 23.2 | 168 (100) | 6.8 | 706 (100) | 14.8 |

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

Note: Percentages may not sum 100% due to rounding. Rates per 100,000 persons in racial/ethnic group based on 2010 U.S. Census count.

Since 2004, the number of incident HIV infections has been higher in African American females than White males. However in 2011, White males surpassed African American females in incident HIV infections (Figure 3). The number of incident HIV infections diagnosed between 2007 and 2011 has remained steady among White females.

Figure 3. Incident HIV Cases by Race, Sex and Year of Diagnosis, Alabama 2007-2011

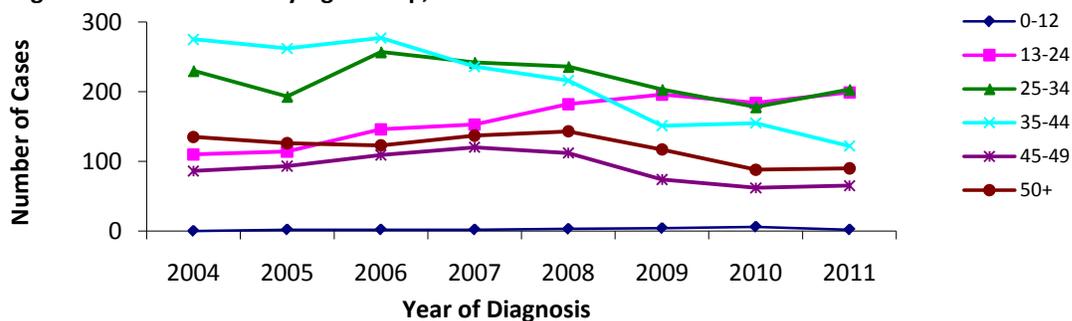


Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

HIV by Age Group

The highest incidence of newly diagnosed HIV infections shifted from persons aged 25 to 44 years in 2004 to persons aged 13 to 34 years in 2011 (Figure 4). During 2011, 13 to 34 year olds accounted for 57% of newly diagnosed cases (Table 10). While incidence among 13 to 25 year olds has increased 45%, incidence among 35 to 44 year olds has decreased.

Figure 4. Trends in HIV by Age Group, Alabama 2004-2011

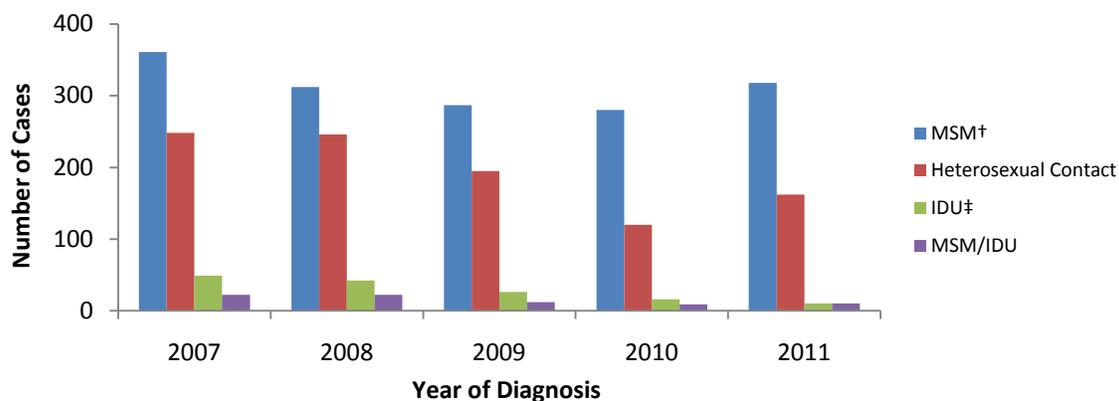


Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

HIV by Mode of Exposure

Throughout the HIV epidemic, the majority of infections have occurred among men who have sex with men (MSM). Although MSM continues to be the greatest risk factor in Alabama, recent trends suggest a shift in the epidemic toward heterosexual contact. The rate of infection has remained fairly stable over the last five years, with MSM representing the majority of incident HIV cases, followed closely by heterosexual contact, and trailed by injection drug use (IDU) and combined MSM/IDU (Figure 5). During 2011, MSM represented 45% of incident HIV infections and 40% of prevalent cases while heterosexual contact represented 26% of incident infections and 27% of prevalent cases (Table 14). The proportion of cases attributed to IDU and combined MSM/IDU has declined between 2007 and 2011 (Figure 5). In 2011, IDU accounted for 7.1% of prevalent cases, but only 1.6% of incident cases while combined MSM/IDU accounted for 3.6% of prevalent cases and 1.8% of incident cases (Table 14). The percentage of cases among persons who report heterosexual contact with a person with, or at increased risk for, HIV infection (i.e., a known IDU, MSM, or HIV infected person) has remained stable.

Figure 5. HIV Cases by Year of Diagnosis & Exposure Category, Alabama 2007-2011



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

†MSM - Men who Have Sex with Men, ‡IDU - Injection Drug Use

Table 14. Risk Factors of Incident and Prevalent HIV Infections, Alabama 2011

| Risk Factor | Incident Cases† (N=706), | Prevalent Cases‡ (N=10,320), |
|----------------------------------|--------------------------|------------------------------|
| | Number (%) | Number (%) |
| Men who have Sex with Men (MSM) | 324 (45.3) | 4159 (40.3) |
| Heterosexual contact | 170 (26.1) | 2773 (26.9) |
| Injection Drug Use (IDU) | 10 (1.6) | 737 (7.1) |
| MSM/IDU | 11 (1.8) | 374 (3.6) |
| Mother with HIV infection | 2 (0.0) | 83 (0.8) |
| Transfusion/Hemophilia | 0 (0.0) | 28 (0.3) |
| Risk not reported/not identified | 189 (25.3) | 2166 (21.0) |

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

Note: Calculated as the percentage of all cases diagnosed in 2011. Percentages may not sum 100% due to rounding. † Incident cases diagnosed in 2011. ‡ Prevalent cases living through 2011.

African American males account for 66% of incident HIV infections diagnosed in men during 2011 (Table 13). Among African Americans, MSM has emerged as the leading exposure category (42%) in 2011 (Table 15). Heterosexual contact continues to be the leading risk factor for incident HIV infection in females. In 2011, 88% of newly diagnosed female HIV infections

were attributed to heterosexual contact (Table 15). Among males, 60% of incident cases occurred in MSM and 33% reported no identified risk. Only 4% of males reported heterosexual contact as their primary risk factor in 2011.

Table 15. Risk Factors of Incident HIV Infections (N=706) by Sex and Race, Alabama 2011

| Risk Factor | Male (N=538), Number (%) | Female (N=168), Number (%) | White (N=178), Number (%) | Black (N=485), Number (%) | Other (N=43), Number (%) |
|----------------------------------|-----------------------------|-------------------------------|------------------------------|------------------------------|-----------------------------|
| Men who have Sex with Men (MSM) | 324 (60.2) | -- | 108 (60.7) | 202 (41.6) | 14 (32.5) |
| Heterosexual contact | 23 (4.3) | 147 (87.5) | 24 (13.5) | 137 (28.2) | 9 (20.9) |
| Injection Drug Use (IDU) | 2 (0.0) | 8 (4.8) | 4 (2.2) | 5 (1.0) | 1 (2.3) |
| MSM/IDU | 11 (2.0) | -- | 5 (2.8) | 5 (1.0) | 1 (2.3) |
| Mother with HIV infection | 0 (0.0) | 2 (1.2) | 0 (0.0) | 2 (0.4) | 0 (0.0) |
| Risk not reported/not identified | 178 (33.1) | 11 (6.5) | 37 (20.8) | 134 (27.6) | 18 (41.9) |

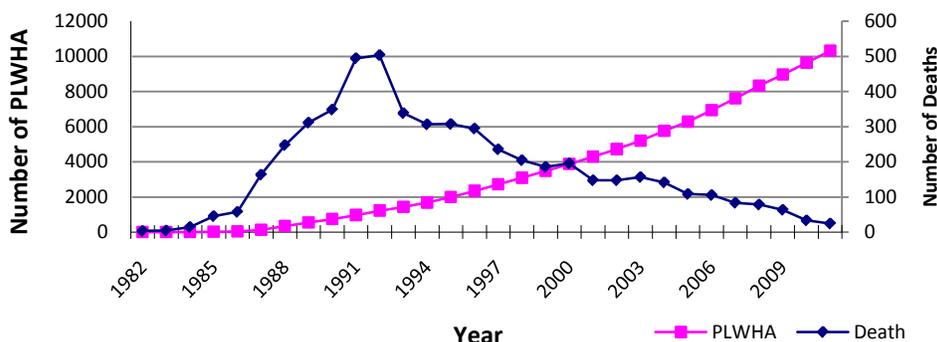
Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.

Note: Calculated as the percentage of all cases diagnosed in 2011. Percentages may not sum 100% due to rounding.

HIV/AIDS Mortality

Since the introduction and widespread utilization of highly active antiretroviral therapy (HAART) in 1995, the number of deaths among HIV infected individuals has significantly decreased. Prior to the advent of HAART, the reported number of deaths among HIV infected persons peaked at 503 in 1992 (Figure 6). Nineteen years later, only 24 deaths were reported as of June 2011 (complete mortality data not available until December 2012). Although the number of deaths among HIV infected individuals continues to decline, the number of people living with HIV/AIDS (PLWHA) is steadily increasing. The longevity of PLWHA in Alabama has a significant impact on the Alabama's resources for providing care and social services to those infected with the disease.

Figure 6. Persons Living With HIV/AIDS (PLWHA) and Deaths, Alabama 1982 - 2011



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

III. INDICATORS OF RISK FOR HIV INFECTION

A. HEALTH INDICATORS

America's Health Rankings reports Alabama ranked 46th nationally in overall health in 2011. Alabama ranked 43rd in public health efforts to manage and control sexually transmitted disease (STD) and 43rd for health care coverage. The percentage of mothers receiving prenatal care within the first trimester is 84%, ranking Alabama 28th nationally. However, Alabama ranked 10th in funding from the Centers for Disease Control and Prevention (CDC), which is

indicative of proactive implementation of preventive and educational programs targeted at improving the health of at-risk populations within the state.

The Alabama Youth Risk Behavior Survey indicates over one-half (57%) of high school students (grades 9-12) have had sexual intercourse as of 2009 (Table 16). Fifteen percent of students indicate they were never taught about HIV infection or AIDS in school.

Table 16. High School Youth Risk Behavior Surveillance Survey, Alabama 2009

| Sexual Behavior Question | Male | Female | Total |
|--|------------|------------|-------------|
| | Number (%) | Number (%) | Number (%) |
| Ever had sexual intercourse? | 577 (61.8) | 715 (51.4) | 1296 (56.6) |
| Had sexual intercourse for the first time before age 13 years? | 583 (16.2) | 719 (4.1) | 1306 (10.1) |
| Had sexual intercourse with four or more persons (during their life)? | 577 (25.7) | 716 (14.4) | 1297 (19.9) |
| Had sexual intercourse with at least one person (during the 3 months before the survey)? | 579 (40.9) | 713 (42.0) | 1296 (41.5) |
| Drank alcohol or used drugs before last sexual intercourse (in sexually active students)? | 240 (27.9) | 304 (14.7) | 547 (21.2) |
| Did not use a condom during last sexual intercourse (in sexually active students)? | 234 (37.5) | 298 (45.3) | 535 (41.5) |
| Did not use birth control pills before last sexual intercourse to prevent pregnancy (in sexually active students)? | 232 (83.5) | 303 (75.3) | 538 (79.3) |
| Were never taught in school about AIDS or HIV infection? | 635 (17.7) | 759 (12.6) | 1404 (15.4) |
| Did not use Depo-Provera before last sexual intercourse (to prevent pregnancy, in sexually active students)? | 232 (96.1) | 303 (92.8) | 538 (94.3) |
| Did not use birth control pills or Depo-Provera before last sexual intercourse (to prevent pregnancy, in sexually active students)? | 232 (79.6) | 303 (68.1) | 538 (73.6) |
| Did not use both a condom during last sexual intercourse and birth control pills or Depo-Provera before last sexual intercourse (to prevent pregnancy, in sexually active students)? | 228 (91.2) | 297 (85.7) | 528 (88.4) |

Source: Youth Risk Behavior Surveillance Survey (YRBSS), Alabama 2009.

Note: Percentages may not sum 100% due to rounding.

The Alabama School Health Profile states 68% of high schools have policies for HIV-positive students and staff addressing attendance, confidentiality, and procedures to protect against discrimination. Twenty-one percent of high schools have a gay/straight alliance or similar club.

B. SEXUALLY TRANSMITTED DISEASES

Sexually Transmitted Disease (STD) surveillance data provides a surrogate indicator of high-risk behavior. While an increase in STD occurrences does not directly indicate HIV infections are increasing, these surrogate measures may point toward an increase in unprotected sex, a known risk factor for HIV infection. Table 17 depicts STD cases by public health area and Table 18 compares the STD cases in males and females during 2010 and 2011.

Table 17. Sexually Transmitted Disease (STD) Cases by Public Health Area, Alabama 2011

| Public Health Area (PHA) | Chlamydia (N=29356), | Gonorrhea (N=9042), | Syphilis (N=748), | STD Total (N=39146), |
|--------------------------|----------------------|---------------------|-------------------|----------------------|
| | Number (%) | Number (%) | Number (%) | Number (%) |
| PHA 1 | 1232 (4.2) | 118 (1.3) | 24 (3.2) | 1374 (3.5) |
| PHA 2 | 3333 (11.4) | 877 (9.7) | 56 (7.5) | 4266 (10.9) |
| PHA 3 | 1903 (6.5) | 601 (6.6) | 38 (5.1) | 2542 (6.5) |
| PHA 4 | 5591 (19.0) | 2367 (26.2) | 238 (31.8) | 8196 (20.9) |
| PHA 5 | 1612 (5.5) | 282 (3.1) | 37 (4.9) | 1931 (4.9) |
| PHA 6 | 2032 (6.9) | 503 (5.6) | 29 (3.9) | 2564 (6.5) |
| PHA 7 | 1455 (5.0) | 350 (3.9) | 34 (4.5) | 1839 (4.7) |
| PHA 8 | 5209 (17.7) | 1765 (19.5) | 99 (13.2) | 7073 (18.1) |
| PHA 9 | 1593 (5.4) | 409 (4.5) | 73 (9.8) | 2075 (5.3) |
| PHA 10 | 2223 (7.6) | 546 (6.0) | 65 (8.7) | 2834 (7.2) |
| PHA 11 | 3173 (10.8) | 1224 (13.5) | 55 (7.4) | 4452 (11.4) |

Source: Alabama Department of Public Health, Sexually Transmitted Disease (STD) Division, updated STD Morbidity Calendar Year 2011.

Table 18. Sexually Transmitted Disease Morbidity Comparison by Sex, Alabama 2010 & 2011

| Sex | Chlamydia | | Gonorrhea | | Syphilis | |
|---------|-----------|-------|-----------|------|----------|------|
| | 2010 | 2011 | 2010 | 2011 | 2010 | 2011 |
| Female | 19360 | 21132 | 4292 | 5074 | 286 | 240 |
| Male | 6685 | 7610 | 3329 | 3803 | 497 | 507 |
| Unknown | 647 | 594 | 204 | 158 | 0 | 0 |
| Total | 26692 | 29356 | 7825 | 9042 | 783 | 747 |

Source: Alabama Department of Public Health, Sexually Transmitted Disease (STD) Division, updated STD Morbidity Calendar Year 2011.

Chlamydia

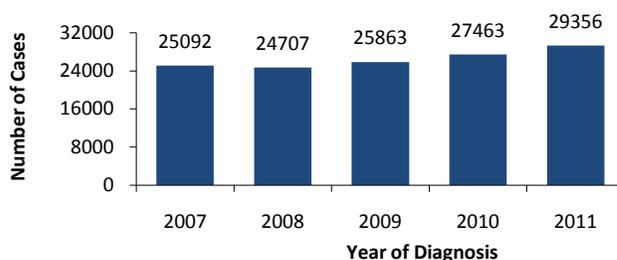
The incidence of Chlamydia is 2.8 times higher in women than men and 3.4 times higher in African Americans than Whites (Table 19). Reported cases of Chlamydia have increased each year since 2008 (Figure 7). In 2011, 29,356 cases of Chlamydia were reported in Alabama residents, an increase of 9% from 2010 (Table 18).

Table 19. Chlamydia Diagnosis† by Race, Ethnicity and Sex, Alabama 2011

| Race | Male (N=7664), Number (%) | Female (N=21242), Number (%) | Total (N=28906), Number (%) |
|---------------------|---------------------------|------------------------------|-----------------------------|
| White, not Hispanic | 1182 (15.4) | 3265 (15.4) | 4447 (15.4) |
| Black, not Hispanic | 4668 (60.9) | 10241 (48.2) | 14909 (51.8) |
| Hispanic | 48 (0.6) | 107 (0.5) | 155 (0.5) |
| Other | 32 (0.4) | 79 (0.4) | 111 (0.4) |
| Unknown | 1734 (22.6) | 7550 (35.5) | 9284 (32.1) |

Source: Alabama Department of Public Health, Sexually Transmitted Disease (STD) Division, updated STD Morbidity Calendar Year 2011.

Note: Percentages may not sum 100% due to rounding. † Chlamydia diagnosis data estimates final 2011 Chlamydia case count (N=29356).

Figure 7. Chlamydia Cases by Year of Diagnosis, Alabama 2007-2011

Source: Alabama Department of Public Health, Sexually Transmitted Disease (STD) Division, updated STD Morbidity Calendar Year 2011.

Gonorrhea

The incidence of gonorrhea is 1.3 times higher in women than men, and 8.0 times higher in African Americans than Whites (Table 20). Overall, reported cases of gonorrhea have decreased from 2007 to 2011; however, cases increased each year since 2009 (Figure 8). In 2011, 9042 cases of gonorrhea were reported in Alabama residents, an increase of 13% from 2010 (Table 18).

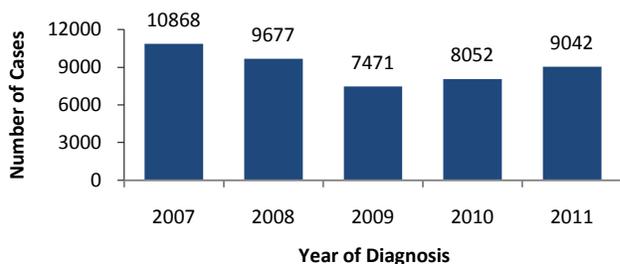
Table 20. Gonorrhea Diagnosis† by Race/Ethnicity and Sex, Alabama 2011

| Race | Male (N=3828), Number (%) | Female (N=5106), Number (%) | Total (N=8934), Number (%) |
|---------------------|---------------------------|-----------------------------|----------------------------|
| White, not Hispanic | 223 (5.8) | 500 (9.8) | 723 (8.1) |
| Black, not Hispanic | 2711 (70.8) | 3067 (60.0) | 5778 (64.7) |
| Hispanic | 9 (0.2) | 8 (0.2) | 17 (0.2) |
| Other | 13 (0.3) | 23 (0.5) | 36 (0.4) |
| Unknown | 872 (22.8) | 1508 (29.5) | 2380 (26.6) |

Source: Alabama Department of Public Health, Sexually Transmitted Disease (STD) Division, updated STD Morbidity Calendar Year 2011.

Note: Percentages may not sum 100% due to rounding. † Gonorrhea diagnosis data estimates final 2011 Gonorrhea case count (N=9042).

Figure 8. Gonorrhea Cases by Year of Diagnosis, Alabama 2007-2011



Source: Alabama Department of Public Health, Sexually Transmitted Disease (STD) Division, updated STD Morbidity Calendar Year 2011.

Syphilis

The incidence of syphilis is 2.1 times higher in men than women and 3.6 times higher in African Americans than Whites (Table 21). Overall, reported cases of syphilis have decreased from 2007 to 2011; however, a spike in cases did occur during 2008 and 2009 (Figure 9). In 2011, 747 cases of syphilis were reported in Alabama residents, a decrease of 5% from 2010 (Table 18).

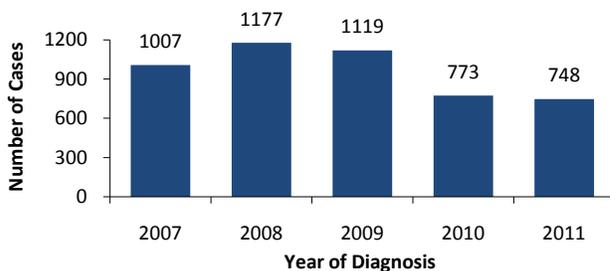
Table 21. Syphilis Diagnosis† by Race/Ethnicity and Sex, Alabama 2011

| Race | Male (N=517), Number (%) | Female (N=242), Number (%) | Total (N=759), Number (%) |
|---------------------|--------------------------|----------------------------|---------------------------|
| White, not Hispanic | 92 (17.8) | 49 (20.2) | 141 (18.6) |
| Black, not Hispanic | 352 (68.0) | 157 (64.9) | 509 (67.1) |
| Hispanic | 13 (2.5) | 6 (2.5) | 19 (2.5) |
| Other | 1 (0.2) | 1 (0.4) | 2 (0.3) |
| Unknown | 59 (11.4) | 29 (12.0) | 88 (11.6) |

Source: Alabama Department of Public Health, Sexually Transmitted Disease (STD) Division, updated STD Morbidity Calendar Year 2011.

Note: Percentages may not sum 100% due to rounding. † Syphilis diagnosis data estimates final 2011 Syphilis case count (N=748).

Figure 9. Syphilis Cases by Year of Diagnosis, Alabama 2007-2011



Source: Alabama Department of Public Health, Sexually Transmitted Disease (STD) Division, updated STD Morbidity Calendar Year 2011.

IV. PATTERNS OF UTILIZATION OF HIV SERVICES

In 1990, Congress enacted the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act to provide funding for states, territories, and eligible metropolitan areas (EMAs) to offer primary care and support services to uninsured HIV-positive individuals lacking financial resources for their care. In Alabama, HIV-positive individuals can receive care through Alabama’s AIDS Drug Assistance Program (ADAP) and the Medicare D cost assistance plan

(MEDCAP). The Alabama Department of Public Health oversees Alabama's Ryan White Part B program which funds medical and social services including Case Management and ADAP.

A. ALABAMA'S AIDS DRUG ASSISTANCE PROGRAM (ADAP)

ADAP Enrollment and Eligibility

Enrollment requirements for ADAP include an HIV diagnosis by Western Blot, a documented permanent Alabama residence, a total gross income at or below 250% of the current federal poverty level (FPL), and no third party payer sources to cover medication costs. Over 97% (1641) of active enrollees reported an annual household income less than 200% of the FPL in 2011. Males represented 71% (1209) of enrollees compared to females (487), making males 2.5 times more likely to utilize ADAP services. Over 64% (1091) of active and new enrollees were from Alabama's African American population, with Hispanics and other minorities constituting less than 5%. Recipients aged 25 to 44 years constitute 55% (928) of enrollees followed by recipients aged 45 to 64 years at 38% (639).

ADAP is highly utilized by Alabama's HIV-positive population. Enrollment caps have been instituted multiple times and a recipient waiting list exists. In 2003, enrollment was capped with slightly more than 1500 clients and remained in effect until January 2006. ADAP raised the enrollment cap to 1700 clients in December 2010. Enrollment was again capped in October 2011, with the 1700 enrollment cap in effect through the end of the year.

B. MEDICARE D COST ASSISTANCE PLAN (MEDCAP)

ADAP sponsors MEDCAP to assist enrollees eligible for Medicare, but who do not qualify for Low Income Subsidy (LIS) assistance. Co-pays and premiums associated with the MEDCAP are covered for approved enrollees. Alabama MEDCAP doubled enrollment in 2008 with 63 enrollees. Enrollment continues to increase annually with 74 recipients receiving services in 2011. Medicare Part D continues to impact Alabama's ADAP enrollment through the transitioning of ADAP clients on to Medicare Part D plans for medication services.

C. ENHANCED REFERRAL TRACKING SYSTEM (ERTS)

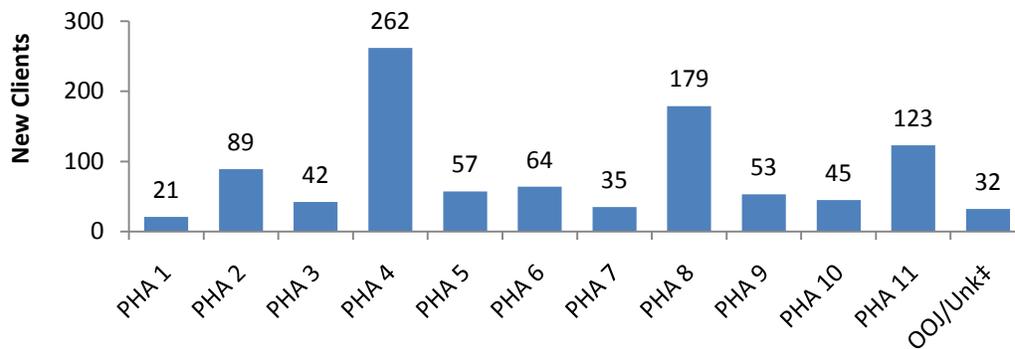
Alabama's Enhanced Referral tracking System (ERTS) monitors HIV test results to detect newly diagnosed HIV infections and has been in effect for over six years. HIV-positive test results are analyzed to create an ERTS list of previously unknown HIV-positive cases whose home address is within Alabama's jurisdiction. HIV Area Coordinators and Peer Mentors located throughout the state investigate HIV-positive individuals captured on ERTS lists to ensure they are in care. A client is documented as "in care" when at least one visit with 2 separate medical providers (a doctor, nurse, or social worker) is attended within 12 months of HIV diagnosis. The success of the ERTS program is monitored from the central office where ERTS lists are reviewed to assess how investigations were closed (e.g., coordinator-linked into care, in care).

HIV Area Coordinators are located in each of Alabama's 11 public health areas (PHAs) and investigate HIV-positive individuals to determine if they are currently in care. If not in care, HIV Area Coordinators assist HIV-positive individuals gain access to adequate medical care for HIV and AIDS treatment by guiding the referral process. Peer Mentors, funded via a federal Health

Resources and Services Administration (HRSA) grant, are HIV-positive persons contracted by the ADPH to work in collaboration with HIV care and service agencies and the HIV Coordinators to link HIV positive individuals into care. Peer Mentors review local client lists with clinic case managers to identify and contact HIV-positive patients who have missed clinic appointments. Outreach, education, and referrals are documented for each client served. Peer Mentor data is documented at the client level to facilitate tracking individual clients across programs.

ERTS provides demographic data and the geographical location of HIV-positive individuals aware of their HIV status and not in care. During 2011, 1003 newly reported ERTS cases were investigated (Figure 10).

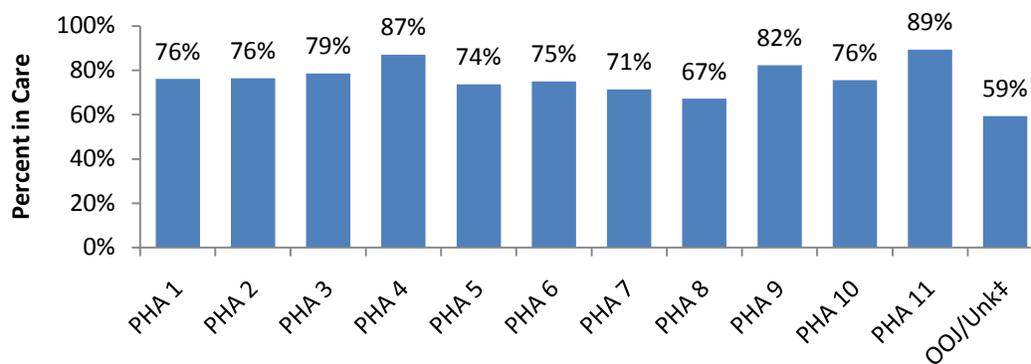
Figure 10. ERTS[†] Newly Reported Clients (N=1003) by Public Health Area, Alabama 2011



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control.
[†]ERTS - Enhanced Referral and Tracking System, [‡]OOJ/Unk - Out of Jurisdiction/Unknown

Seventy-nine percent of newly diagnosed ERTS cases (784/1003) were successfully referred and documented as in care in 2011 (Figure 11). PHA 11 had the highest percentage (89%) of ERTS clients documented in care. PHA 8 had the lowest percentage (67%) of clients in care.

Figure 11. ERTS[†] Clients (N=1003) in Care by Public Health Area, Alabama 2011



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control
 Note: Statewide, 79% (784/1003) of reported ERTS clients are in care. A client is documented as in care when at least 1 visit with 2 separate providers (doctor/nurse/social worker) is attended within 12 months of HIV diagnosis.
[†]ERTS - Enhanced Referral and Tracking System, [‡]OOJ/Unk - Out of Jurisdiction/Unknown

V. CHARACTERISTICS OF HIV POSITIVE PERSONS WHO ARE NOT IN CARE

A. MEASURING UNMET NEED

The Alabama Department of Public Health (ADPH) has been conducting HIV/AIDS case surveillance since the beginning of the HIV epidemic, with confidential, name-based reporting beginning in 1987. As of June 1, 2011 all positive HIV tests, CD4 results, and viral loads became reportable to ADPH under Alabama Public Health Law. Prior to the rule change, only HIV-positive Western Blots, CD4 cell counts <200 per μ l or <20%, and AIDS defining diseases were reportable, making an accurate estimate of unmet need within Alabama's HIV infected community difficult to obtain. To provide an estimate of unmet need, data acquired through Alabama's Enhanced Referral Tracking System (ERTS) was utilized. Based on ERTS data, and estimated 6,307 HIV-positive individuals have not accessed care in the past 12 months.

Unmet Need Calculation as Determined by HRSA

The Health Resources and Services Administration (HRSA) defines a framework for determining unmet need in its "Practical Guide to Measuring Unmet Need for HIV-Related Primary Medical Care." Unmet need is defined as no evidence of three HIV primary medical care components during a 12-month time period: (1) viral load (VL) testing, (2) CD4 count, or (3) provision of anti-retroviral therapy (ART). However, a second objective is to collect unmet service need to assist in the service planning and funding allocation decision-making process.

ADPH collaborates with Alabama's Ryan White Grantee to provide an annual HIV Epidemiologic Profile to document trends in the HIV epidemic in Alabama. ADPH utilizes the annual Epidemiologic Profile to make projections regarding funding and service needs for HIV-positive residents.

Assessment of Unmet Need

Common challenges to getting HIV-positive individuals into care include denial, fear of discrimination, lack of insurance, inadequate income, transient populations without a permanent residence, lack of transportation to services, and inability to accept responsibilities of care, medicines, and medical visits. To aid in reducing many of these challenges, ADPH established the Enhanced Referral Tracking System (ERTS) in 2005.

ERTS monitors linkages of newly diagnosed HIV-positive individuals and existing HIV cases into care. The goal of the ERTS program is to link 50% of all HIV clients referred to the program into care. Outcome data for 2011 indicate ERTS has surpassed that goal linking 78% (784) of newly reported HIV-positive clients into care. ERTS program objectives require 5% of clients initially refusing care be linked into care as a result of Coordinator Linked into Care (CLIC) activities. ERTS also surpassed this objective with 8% of clients initially refusing services linked into care.

HIV Area Coordinators are located in each of Alabama's 11 public health areas (PHAs) and investigate unreported HIV-positive individuals to determine if they are currently in care. Coordinators assist HIV-positive individuals in gaining access to care by guiding the referral process. The ERTS Program Manager audits each HIV Coordinator annually to ensure program

goals are met. Peer Mentors are HIV-positive persons contracted by the ADPH to work in collaboration with HIV Coordinators. Peer Mentors review local client lists with clinic case managers to identify and contact HIV-positive patients who have missed clinic appointments. Outreach, education, and referrals are documented for each client served.

B. ENHANCED REFERRAL TRACKING SYSTEM (ERTS)

The ERTS program focuses on early treatment of newly identified HIV-positive individuals to ensure access to HIV care and services. The program also identifies existing HIV-positive clients not in care and provides focused follow-up aimed at getting these clients into care. ERTS successfully linked 78% of clients (784/1002) into care in 2011 (Table 22). African Americans represent 65% of ERTS clients while Whites represent 32%; 77% of ERTS clients are men. A similar client distribution is observed when assessing Alabama by PHA (Figures 12 & 13). During 2011, PHA 4 had the highest number of ERTS cases investigated (262) while PHA 1 had the least (21).

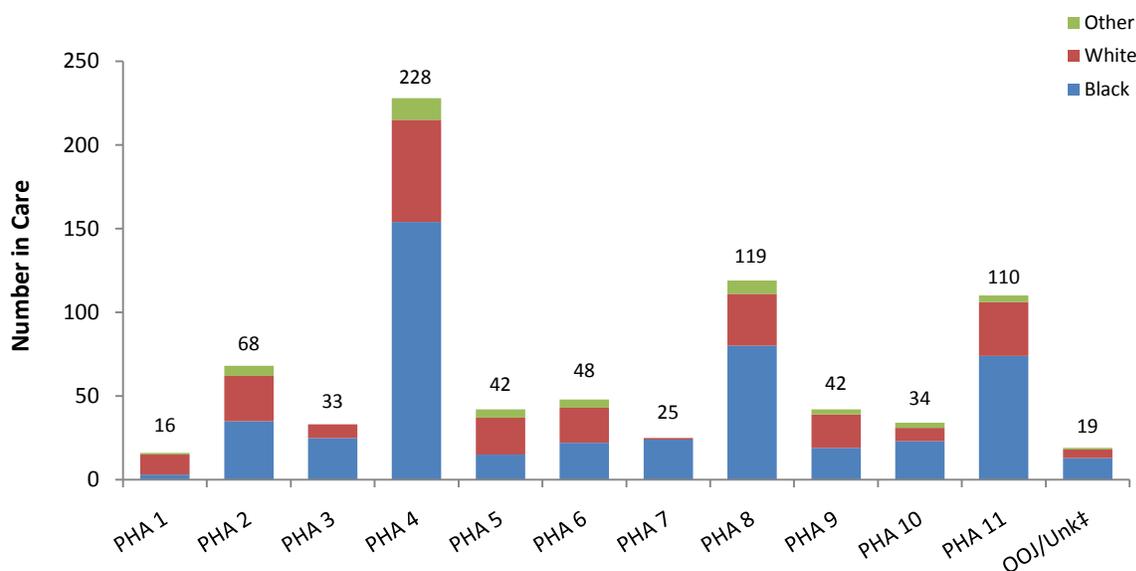
Table 22. Distribution of ERTS† Clients (N=1002) by Sex and Race, Alabama 2011

| ERTS Client Demographics | In Care (N=784), Number (%) | Total (N=1002), Number (%) |
|--------------------------|-----------------------------|----------------------------|
| Sex | | |
| Male | 597 (76.1) | 775 (77.3) |
| Female | 187 (23.9) | 227 (22.6) |
| Race | | |
| African American | 487 (62.1) | 647 (64.6) |
| White | 248 (31.6) | 291 (29.0) |
| Other/Unknown | 49 (6.3) | 64 (6.4) |

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

†ERTS - Enhanced Referral and Tracking System

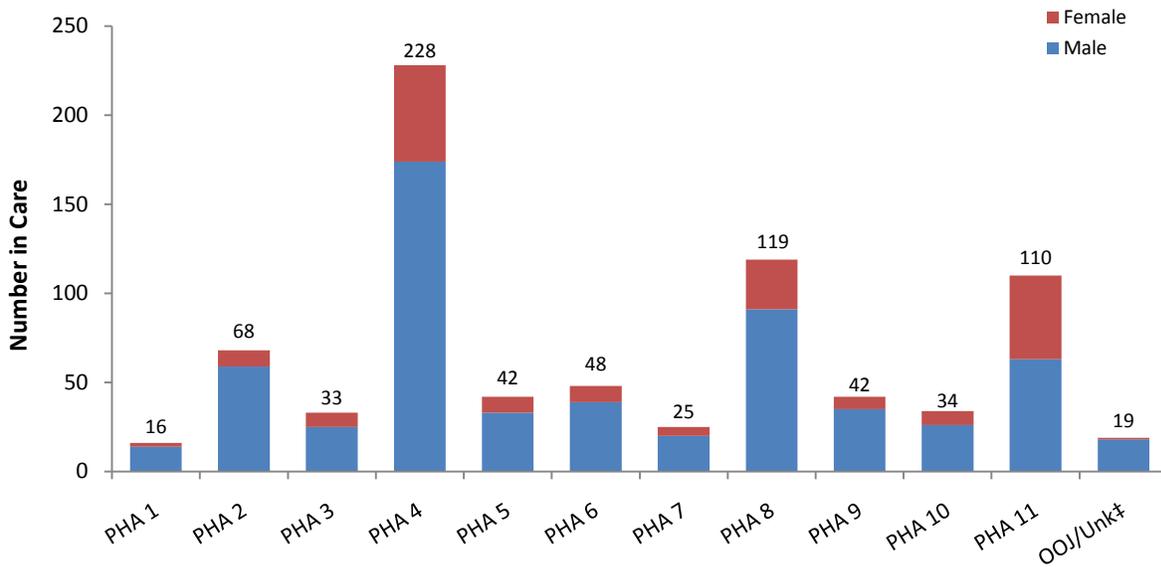
Figure 12. ERTS† Clients in Care (N=784) by Race and Public Health Area, Alabama 2011



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

†ERTS - Enhanced Referral and Tracking System, ‡OOI/Unk - Out of Jurisdiction/Unknown

Figure 13. ERTS† Clients in Care (N=784) by Sex and Public Health Area, Alabama 2011



Source: Alabama Department of Public Health, Division of HIV/AIDS Prevention and Control
 †ERTS - Enhanced Referral and Tracking System, ‡OOI/Unk - Out of Jurisdiction/Unknown

C. EXPANDED HIV TESTING

In October 2010, Alabama received funding from the Centers for Disease Control and Prevention (CDC) to implement an expanded HIV testing initiative, ADPH’s Expanded Counseling and Testing Services (CTS). The goal of this initiative is to launch HIV testing in Primary Care Centers, UAB Hospital’s emergency department (UAB ED), and select Historically Black Colleges and Universities (HBCUs). A second goal is to increase HIV testing services offered by Community-based Organizations. The Expanded CTS initiative aims to identify HIV-positive individuals and refer them for care early in the disease progress. Surveillance data guides the initiative by identifying locations where HIV testing sites would be most beneficial to populations disproportionately affected by HIV. Populations disproportionately affected by HIV include African Americans, Hispanics, men who have sex with men (MSM), and injection drug users (IDUs).

HIV Testing Experience

The ADPH Division of HIV/AIDS Prevention and Control partners with the Division of STD Control to accomplish HIV Counseling, Testing, Referral, and Partner Notification (CTRPN) services. HIV Coordinators manage ERTS services and coordinate community activities related to HIV prevention. ERTS is a prevention education, outreach, and referral service focusing on early treatment access for newly identified HIV positive individuals. Health department nurses perform HIV pre-test counseling, obtain clinical specimens, and provide results and post-test counseling to HIV-negative clients. STD Disease Intervention Specialists follow up with HIV-positive clients providing post-test counseling, making referrals for social and medical services, and perform partner notification. Disease Intervention Specialists also follow up with HIV-negative clients considered high-risk.

ADPH also provides technical assistance to HIV screening programs throughout the state. The HIV Counseling and Testing program provides training to sites applying for funded HIV testing services. Staff members participate in protocol development, process planning, and pre- and post-test counseling training. Educational materials are provided and state/federal laws and regulations are reviewed. Updated HIV information is provided during routine audits. The ADPH Bureau of Clinical Laboratories (BCL) performs all confirmatory HIV testing.

BCL performed 130,553 HIV tests in 2011 compared to 112,799 tests in 2010, reflecting an increase of 14%. This increase is primarily due to 7480 HIV tests submitted through the Expanded CTS initiative: UAB ED submitted 7132 tests, HBCU submitted 133, and Primary Care Centers submitted 215. Tests submitted through the Expanded CTS initiative account for 6% of all HIV tests performed by BCL in 2011. The majority of positive Western Blots were submitted by STD Clinics (38%), while Hospitals, Private Clinics, and Physicians submitted 32% of positive Western Blots tested at BCL and Community-based Organizations submitted 24% (Table 23).

Table 23. HIV Counseling and Testing Data by Clinic Type, Alabama 2011

| Clinic Type | Reactive (%) | Negative (%) | Total (%) | % Reactive |
|---|--------------|--------------|--------------|------------|
| Community-based Organization † | 154 (23.6) | 167 (0.1) | 321 (0.2) | 0.001 |
| Community Health Center | 34 (5.4) | 5052 (3.9) | 5086 (3.9) | 0.007 |
| Drug Treatment Center | 2 (0.3) | 1595 (1.2) | 1597 (1.2) | 0.001 |
| Family Planning Clinic | 21 (3.2) | 42597 (32.8) | 42618 (32.6) | 0.000 |
| Historically Black College University (HBCU)† | 0 (0.0) | 133 (0.1) | 133 (0.1) | 0.000 |
| Hospital/Private Clinic/Physician | 206 (31.5) | 17349 (13.4) | 17555 (13.4) | 0.012 |
| Other Alternate Test Site | 71 (10.9) | 18672 (14.4) | 18743 (14.4) | 0.004 |
| Prenatal/Maternity Clinic | 2 (0.3) | 1045 (0.8) | 1047 (0.8) | 0.002 |
| Primary Care Expanded CTS† | 0 (0.0) | 215 (0.2) | 215 (0.2) | 0.000 |
| Prison/Jail | 7 (0.1) | 2776 (2.1) | 2783 (2.1) | 0.003 |
| Sexually Transmitted Disease Clinic | 251 (38.4) | 35437 (27.3) | 35688 (27.3) | 0.007 |
| Tuberculosis Clinic | 3 (0.5) | 1075 (8.3) | 1078 (0.8) | 0.003 |
| Unknown | 56 (8.6) | 3954 (3.0) | 4010 (3.1) | 0.014 |
| Total | 653 (100) | 129900 (100) | 130553 (100) | 0.005 |

Source: Alabama Department of Public Health, HIV/AIDS Prevention and Control Division, calendar year 2011.

Note: Percentages may not sum 100% due to rounding.

† Expanded Counseling and Testing Services (CTS).

Of the 653 individuals with HIV-positive Western Blots, 70% (458/653) were African American and 24% (154/653) were White (Table 24). Of all HIV tests performed by BCL, 55% (71823/130553) were African American and 40% (51622/130553) were White.

Table 24. HIV Counseling and Testing Data by Race, Alabama 2011

| HIV Western Blot Result | White (%) | African American | Multi-Racial | Asian | Other | Unknown | Total |
|-------------------------|--------------|------------------|--------------|------------|-----------|-------------|---------------|
| Reactive | 154 (0.3) | 458 (0.6) | 0 (0.0) | 3 (0.4) | 0 (0.0) | 38 (0.7) | 653 (0.5) |
| Negative | 51468 (99.7) | 71365 (99.4) | 68 (100) | 793 (99.6) | 949 (100) | 5257 (99.3) | 129900 (99.5) |
| Total | 51622 (100) | 71823 (100) | 68 (100) | 796 (100) | 949 (100) | 5295 (100) | 130553 (100) |

Source: Alabama Department of Public Health, HIV/AIDS Prevention and Control Division, calendar year 2011.

Note: Percentages may not sum 100% due to rounding. Rates per 100,000 persons in racial/ethnic group based on 2010 U.S. Census count.

Heterosexual contact was the primary risk factor (66%) reported among individuals tested through the Expanded CTS initiative in 2011, followed by non injection drug use (28%) and MSM (4%). Among individuals testing positive for HIV through the initiative, 45% reported MSM as their primary risk factor. However, statistics demonstrate heterosexual contact is also

a significant risk factor for HIV infection, demonstrating the need for HIV prevention programs targeting heterosexuals (Figure 5). Based on information provided in the Epidemiologic Profile as well as data presented in the Alabama HIV Prevention Comprehensive Plan (AHPCP), Expanded CTS will be directed toward MSM and heterosexuals. Heterosexual men who have sex with women (MSW) and women who have sex with men (WSM) will be targeted. Special emphasis will be placed on African Americans in all populations.

CONCLUSION

The Integrated Epidemiologic Profile provides guidance for HIV prevention and control efforts by identifying target populations infected with HIV and at risk of HIV infection. Alabama's HIV-positive population is increasing, partly due to the expansion of rapid testing and opt-out routine testing and partly due to effective treatment options increasing the longevity of people living with HIV. The African American community bears the brunt of the disease, making up 65% of prevalent HIV cases and 69% of newly diagnosed HIV infections in Alabama. Recent trends suggest a shift in the epidemic from men who have sex with men toward heterosexual contact.

Despite the many challenges facing Alabama in regards to its health status and the increasing trends in new HIV infections, opportunities to improve access to care and services for Alabamians living with HIV infection exist. Expanding access to screening and prevention services may decrease new infection rates throughout Alabama. Improved access to HIV services can be sustained through collaborative partnerships with Community-based Organizations, Primary Care Clinics, and Community Health Centers as well as through state and national policy changes being implemented in preparation for the full health care reform.

HIV/AIDS Integrated Epidemiological Profile

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