

Dedication

This document is dedicated to the memory of those individuals we have lost to AIDS whose valiant efforts continue to inspire us, and to those who continue their work to bring an end to this epidemic.

Acknowledgements

- Members of the Prevention Planning Group (past and present)
- Members of the community planning partnerships (past and present)
- Members of the 2007-2009 HIV/AIDS Prevention Plan writing team (Keith Blocker, Bobby Davis, Sondra Jones Anderson, Peter Bright, Laurence Osband, Sylvia Hubbard, and Lavern Bell)
- County Health Department staff
- AIDS Service Organization and Community Based Organization staff throughout the state
- Volunteers through the state
- The thousands of Floridians who have provided input to the community planning process

PREFACE

The Florida Comprehensive Planning Network (FCPN)

The Florida Comprehensive Planning Network (FCPN) was formed January 1, 2004, and represents a transition from the previous Florida HIV/AIDS Community Planning Group. The FCPN is a statewide planning body that works in collaboration with the Department of Health (DOH) to develop a comprehensive HIV/AIDS prevention, patient care and Hepatitis plan. The membership of the FCPN consists of representatives from across the state that are selected from local health departments, local HIV/AIDS community planning groups (CPG's) and local patient care consortia. The FCPN consists of three planning entities: prevention planning group/early intervention (PPG), the patient care planning group (PCPG) and the Florida Viral Hepatitis Council. At-large members are appointed to ensure representation of special populations, such as African American Female (consumer), Religious /Faith Community (consumer or experience with program addressing the epidemic), Substance Abuse/Mental Health (consumer or specialized worker), Children's Medical Services (institutional), Behavioral Science (professional or specialist), Haitian (consumer or specialized worker), Migrant/Farm worker (consumer if possible, or professional representative), MSM (Men who have Sex with Men) of Color (consumer, predicated on epidemiology - current preference is to black rather than Hispanic), Hispanic (consumer), Hepatitis (co-infection with HIV) and Youth (consumer if possible, or representative of youth group involving youth aged 18-25).

The FCPN was known as the FCPG, until December 2003, and met four times each year. The FCPN's subsidiary planning groups meet only three times each year for more cost effective and efficient planning activities. Members of the Prevention Planning Group (PPG) developed specific guidelines to assist local community planning partnerships in the development of their local prevention plans. The guidelines were developed during PPG meetings and during workgroup meetings held between the quarterly PPG meetings. Local partnerships were required to use the guidelines to develop their plans. Each local partnership updated their priority populations during July, 2006. The local partnerships were instructed by the PPG to include the Advancing HIV Prevention (AHP) Initiative when developing their local plans.

What are the Community Planning Partnerships?

The state is divided into seventeen distinct geographical areas. However, because some areas conduct joint planning, there are a total of fourteen community-planning partnerships. Each area has a local community planning partnership or planning group (CPG). The CPG is responsible for gathering local data, conducting a local needs assessment and developing a local HIV/AIDS prevention plan. The local plan must meet the requirements set forth by the FCPN. Local planning partnerships/groups are guided by the same principles of community planning which guide the FCPN, and they actively recruit members that link various segments of the government and community. CPG's are reflective of the HIV/AIDS epidemic in their area. Additionally, each CPG nominates one of their members to serve on the FCPN. This member is not only responsible for representing the needs and concerns of the local partnership on the statewide body, but is also responsible for assuring the implementation of FCPN guidelines by the local area.

Community Planning in Florida – 2006 Restructure

In September of 2005, local planning groups learned that, effective January 1, 2006, the funding for their activities would cease. All local planning groups decided to continue their activities despite this loss of funding. During 2006, local planning groups continued to operate planning activities by submitting nominations to the Bureau of HIV/AIDS for representatives to the PPG, providing updates to the local priority populations and handling technical assistances needs. No decrease in participation in community planning at the state level has been noticed to date.

I. Epidemiologic Profile/Florida HIV/AIDS Annual Report

The epidemiologic profile outlines the HIV/AIDS epidemic in the state of Florida and includes data from a variety of sources collected throughout the state. This section was prepared by surveillance staff of the Florida Department of Health, Bureau of HIV/AIDS.

EPIDEMIOLOGICAL PROFILE
Target Area
STATE OF FLORIDA

Mid-Year Population Estimates

2004

Sex	Total Pop		Age Groups	Total Pop	
Males	8,625,126	49%	0 - 12	2,809,298	16%
Females	8,988,242	51%	13 - 19	1,607,598	9%
Total	17,613,368	100%	20 - 24	1,139,920	6%
			25 - 29	1,014,204	6%
			30 - 39	2,288,751	13%
			40 - 49	2,627,086	15%
			50 - 59	2,225,806	13%
			60+	3,900,705	22%
			Total	17,613,368	100%

Race/Ethnicity	Total Pop	
White, non-Hispanic	11,407,827	65%
Black, non-Hispanic	2,643,154	15%
Hispanic	3,152,040	18%
Other*	410,347	2%
Total	17,613,368	100%

2005

Sex	Total Pop		Age Groups	Total Pop	
Males	8,801,946	49.0%	0 - 12	2,849,971	16%
Females	9,158,491	51.0%	13 - 19	1,643,893	9%
Total	17,960,437	100.0%	20 - 24	1,185,342	7%
			25 - 29	1,020,004	6%
			30 - 39	2,271,093	13%
			40 - 49	2,691,067	15%
			50 - 59	2,318,550	13%
			60+	3,980,517	22%
			Total	17,960,437	100%

Race/Ethnicity	Total Pop	
White, non-Hispanic	11,569,485	64%
Black, non-Hispanic	2,706,257	15%
Hispanic	3,259,894	18%
Other*	424,801	2%
Total	17,960,437	100%

Note: Other includes American Indian/Alaskan Native, Asian Pacific Islander, and all other race groups

AIDS cases and rates per 100,000 population, and percent of total, by race/ethnicity, gender and age group at diagnosis and year of report. Rates are based on 2004 & 2005 Florida population estimates, by race/ethnicity, gender and age, respectively.

2004							
				%			
Gender	Cases	% Total	Rate	Age Groups	Cases	Total	Rate
Male	3,591	68.2%	41.6	0 - 12	19	0.4%	0.7
Female	1,672	31.8%	18.6	13 - 19	49	0.9%	3.0
Other/Unknown	0	0.0%	N/A	20 - 24	178	3.4%	15.6
Total	5,263	100.0%	29.9	25 - 29	384	7.3%	37.9
				30 - 39	1,651	31.4%	72.1
				40 - 49	1,857	35.3%	70.7
				50 - 59	813	15.4%	36.5
				60+	312	5.9%	8.0
				Total	5,263	100.0%	29.9
Race/Ethnicity	Cases	% Total	Rate				
White, Non-Hispanic	1,491	28.3%	13.1				
Black, Non-Hispanic	2,743	52.1%	103.8				
Hispanic	946	18.0%	30.0				
Asian/Pacific Islander	14	0.3%	N/A				
Amer. Indian/Alaskan	5	0.1%	N/A				
Other/Unknown	64	1.2%	N/A				
Total	5,263	100.0%	29.9				
2005							
				%			
Gender	Cases	% Total	Rate	Age Groups	Cases	Total	Rate
Male	3,169	68.3%	36.0	0 - 12	13	0.3%	0.5
Female	1,471	31.7%	16.1	13 - 19	59	1.3%	3.6
Other/Unknown	0	0.0%	N/A	20 - 24	181	3.9%	15.3
Total	4,640	100.0%	25.8	25 - 29	340	7.3%	33.3
				30 - 39	1,292	27.8%	56.9
				40 - 49	1,748	37.7%	65.0
				50 - 59	735	15.8%	31.7
				60+	272	5.9%	6.8
				Total	4,640	100.0%	25.8
Race/Ethnicity	Cases	% Total	Rate				
White, Non-Hispanic	1,300	28.0%	11.2				
Black, Non-Hispanic	2,404	51.8%	88.8				
Hispanic	862	18.6%	26.4				
Asian/Pacific Islander	14	0.3%	N/A				
Amer. Indian/Alaskan	6	0.1%	N/A				
Other/Unknown	54	1.2%	N/A				
Total	4,640	100.0%	25.8				

Note: Mid-year population estimates are not available for other race/ethnicity groups.

HIV (regardless of AIDS) cases and rates per 100,000 population, and percent of total, by race/ethnicity, gender and age group at diagnosis and year of report. Rates are based on 2004 & 2005 Florida population estimates, by race/ethnicity, gender and age, respectively.

2004							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	3,811	66.8%	44.2	0 - 12	43	0.8%	1.5
Female	1,890	33.2%	21.0	13 - 19	179	3.1%	6.4
Other/Unknown	0	0.0%	N/A	20 - 24	518	9.1%	18.4
Total	5,701	100.0%	32.4	25 - 29	687	12.1%	24.5
				30 - 39	1,845	32.4%	65.7
Race/Ethnicity	Cases	% Total	Rate	40 - 49	1,583	27.8%	56.3
White, Non-Hispanic	1,703	29.9%	14.9	50 - 59	626	11.0%	22.3
Black, Non-Hispanic	2,752	48.3%	104.1	60+	220	3.9%	7.8
Hispanic	1,165	20.4%	37.0	Total	5,701	100.0%	202.9
Asian/Pacific Islander	30	0.5%	N/A				
Amer. Indian/Alaskan	10	0.2%	N/A				
Other/Unknown	41	0.7%	N/A				
Total	5,701	100.0%	32.4				
2005							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	3,636	68.6%	41.3	0 - 12	47	0.9%	1.7
Female	1,663	31.4%	18.2	13 - 19	185	3.5%	6.6
Other/Unknown	0	0.0%	N/A	20 - 24	553	10.4%	19.7
Total	5,299	100.0%	29.5	25 - 29	645	12.2%	23.0
				30 - 39	1,572	29.7%	56.0
Race/Ethnicity	Cases	% Total	Rate	40 - 49	1,473	27.8%	52.4
White, Non-Hispanic	1,632	30.8%	14.1	50 - 59	598	11.3%	21.3
Black, Non-Hispanic	2,520	47.6%	93.1	60+	226	4.3%	8.0
Hispanic	1,085	20.5%	33.3	Total	5,299	100.0%	188.6
Asian/Pacific Islander	20	0.4%	N/A				
Amer. Indian/Alaskan	9	0.2%	N/A				
Other/Unknown	33	0.6%	N/A				
Total	5,299	100.0%	29.5				

Note: Mid-year population estimates are not available for other race/ethnicity groups.

Infectious syphilis cases (and rates per 100,000 population) by race/ethnicity, by gender, by age group at diagnosis and year of report, Florida

2004							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	630	86.5%	7.3	0 - 12	0	0.0%	0.0
Female	98	13.5%	1.1	13 - 19	28	3.8%	1.7
Other/Unknown	0	0.0%	N/A	20 - 24	81	11.1%	7.1
Total	728	100.0%	4.1	25 - 29	92	12.6%	9.1
Race/Ethnicity				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	309	42.4%	2.7	30 - 39	247	33.9%	10.8
Black, Non-Hispanic	241	33.1%	9.1	40 - 49	211	29.0%	8.0
Hispanic	142	19.5%	4.5	50 - 59	50	6.9%	2.2
Asian/Pacific Islander	4	0.5%	N/A	60+	19	2.6%	0.5
Amer. Indian/Alaskan	0	0.0%	N/A	Other/Unknown	0	0.0%	N/A
Other/Unknown	32	4.4%	N/A	Total	728	100.0%	4.1
Total	728	100.0%	4.1				
2005							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	101	13.8%	1.1	0 - 12	0	0.0%	0.0
Female	630	86.2%	6.9	13 - 19	29	4.0%	1.8
Other/Unknown	0	0.0%	N/A	20 - 24	104	14.2%	8.8
Total	731	100.0%	4.1	25 - 29	81	11.1%	7.9
Race/Ethnicity				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	310	42.4%	2.7	30 - 39	256	35.0%	11.3
Black, Non-Hispanic	276	37.8%	10.2	40 - 49	182	24.9%	6.8
Hispanic	117	16.0%	3.6	50 - 59	66	9.0%	2.8
Asian/Pacific Islander	4	0.5%	N/A	60+	13	1.8%	0.3
Amer. Indian/Alaskan	0	0.0%	N/A	Other/Unknown	0	0.0%	N/A
Other/Unknown	24	3.3%	N/A	Total	731	100.0%	4.1
Total	731	100.0%	4.1				
2005 data provisional.							

Note: Mid-year population estimates are not available for other race/ethnicity groups.

Tuberculosis cases (and rates per 100,000 population) by race/ethnicity, by gender, by age group at diagnosis and year of report, Florida

2004							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	711	66.2%	8.2	0 - 12	69	6.4%	2.5
Female	363	33.8%	4.0	13 - 19	41	3.8%	1.5
Other/Unknown	0	0.0%	N/A	20 - 24	66	6.1%	2.3
Total	1,074	100.0%	6.1	25 - 29	53	4.9%	1.9
				30 - 39	181	16.9%	6.4
Race/Ethnicity	Cases	% Total	Rate	40 - 49	257	23.9%	9.1
White, Non-Hispanic	255	23.7%	2.2	50 - 59	183	17.0%	6.5
Black, Non-Hispanic	443	41.2%	16.8	60+	224	20.9%	8.0
Hispanic	295	27.5%	9.4	Unknown	0	0.0%	N/A
Asian/Pacific Islander	74	6.9%	N/A	Total	1,074	100.0%	38.2
Amer. Indian/Alaskan	2	0.2%	N/A				
Unknown	5	0.5%	N/A				
Total	1,074	100.0%	6.1				

2005							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	708	64.7%	8.0	0 - 12	54	4.9%	1.9
Female	386	35.3%	4.2	13 - 19	37	3.4%	2.3
Other/Unknown	0	0.0%	N/A	20 - 24	78	7.1%	6.6
Total	1,094	100.0%	6.1	25 - 29	69	6.3%	6.8
				30 - 39	185	16.9%	8.1
Race/Ethnicity	Cases	% Total	Rate	40 - 49	253	23.1%	9.4
White, Non-Hispanic	258	23.6%	2.2	50 - 59	206	18.8%	8.9
Black, Non-Hispanic	462	42.2%	17.1	60+	212	19.4%	5.3
Hispanic	285	26.1%	8.7	Unknown	0	0.0%	N/A
Asian/Pacific Islander	84	7.7%	N/A	Total	1,094	100.0%	6.1
Amer. Indian/Alaskan	0	0.0%	N/A				
Unknown	5	0.5%	N/A				
Total	1,094	100.0%	6.1				

Note: Mid-year population estimates are not available for other race/ethnicity groups.

Hepatitis A cases (and rates per 100,000 population) by race/ethnicity, by gender, by age group at diagnosis and year of report, Florida

2004							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	152	57.4%	1.8	0 - 12	84	31.7%	3.0
Female	112	42.3%	1.2	13 - 19	33	12.5%	2.1
Other/Unknown	1	0.4%	N/A	20 - 24	22	8.3%	1.9
Total	265	100.0%	1.5	25 - 29	10	3.8%	1.0
				30 - 39	34	12.8%	1.5
Race/Ethnicity	Cases	% Total	Rate	40 - 49	29	10.9%	1.1
White, Non-Hispanic	213	80.4%	1.9	50 - 59	21	7.9%	0.9
Black, Non-Hispanic	15	5.7%	0.6	60+	32	12.1%	0.8
Hispanic	0	0.0%	0.0	Unknown	0	0.0%	N/A
Asian/Pacific Islander	11	4.2%	N/A	Total	265	100.0%	1.5
Amer. Indian/Alaskan	0	0.0%	N/A				
Other/Unknown	26	9.8%	N/A				
Total	265	100.0%	1.5				
2005							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	157	57.3%	1.8	0 - 12	78	28.5%	2.7
Female	116	42.3%	1.3	13 - 19	37	13.5%	2.3
Other/Unknown	1	0.4%	N/A	20 - 24	18	6.6%	1.5
Total	274	100.0%	1.5	25 - 29	19	6.9%	1.9
				30 - 39	32	11.7%	1.4
Race/Ethnicity	Cases	% Total	Rate	40 - 49	37	13.5%	1.4
White, Non-Hispanic	229	83.6%	2.0	50 - 59	22	8.0%	0.9
Black, Non-Hispanic	20	7.3%	0.7	60+	31	11.3%	0.8
Hispanic	0	0.0%	0.0	Unknown	0	0.0%	N/A
Asian/Pacific Islander	8	2.9%	N/A	Total	274	100.0%	1.5
Amer. Indian/Alaskan	0	0.0%	N/A				
Other/Unknown	17	6.2%	N/A				
Total	274	100.0%	1.5				
2005 data provisional.							

Note: Mid-year population estimates are not available for other race/ethnicity groups.

Hepatitis B cases (and rates per 100,000 population) by race/ethnicity, by gender, by age group at diagnosis and year of report, Florida

2004							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	325	64.7%	3.8	0 - 12	1	0.2%	0.0
Female	177	35.3%	2.0	13 - 19	1	0.2%	0.1
Other/Unknown	0	0.0%	N/A	20 - 24	44	8.8%	3.9
Total	502	100.0%	2.9	25 - 29	73	14.5%	7.2
				30 - 39	139	27.7%	6.1
Race/Ethnicity	Cases	% Total	Rate	40 - 49	140	27.9%	5.3
White, Non-Hispanic	281	56.0%	2.5	50 - 59	55	11.0%	2.5
Black, Non-Hispanic	166	33.1%	6.3	60+	49	9.8%	1.3
Hispanic	0	0.0%	0.0	Unknown	0	0.0%	N/A
Asian/Pacific Islander	6	1.2%	N/A	Total	502	100.0%	2.9
Amer. Indian/Alaskan	0	0.0%	N/A				
Other/Unknown	49	9.8%	N/A				
Total	502	100.0%	2.9				
2005							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	303	62.2%	3.4	0 - 12	1	0.2%	0.0
Female	184	37.8%	2.0	13 - 19	7	1.4%	0.4
Other/Unknown	0	0.0%	N/A	20 - 24	35	7.2%	3.0
Total	487	100.0%	2.7	25 - 29	74	15.2%	7.3
				30 - 39	172	35.3%	7.6
Race/Ethnicity	Cases	% Total	Rate	40 - 49	107	22.0%	4.0
White, Non-Hispanic	299	61.4%	2.6	50 - 59	63	12.9%	2.7
Black, Non-Hispanic	148	30.4%	5.5	60+	28	5.7%	0.7
Hispanic	0	0.0%	0.0	Unknown	0	0.0%	N/A
Asian/Pacific Islander	5	1.0%	N/A	Total	487	100.0%	2.7
Amer. Indian/Alaskan	0	0.0%	N/A				
Other/Unknown	35	7.2%	N/A				
Total	487	100.0%	2.7				

2005 data
provisional.

Note: Mid-year population estimates are not available for other race/ethnicity groups.

Chronic Hepatitis C cases (and rates per 100,000 population) by race/ethnicity, by gender, by age group at diagnosis and year of report, Florida

2004							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	14,763	61.5%	171.2	0 - 12	157	0.7%	5.6
Female	9,161	38.2%	101.9	13 - 19	210	0.9%	13.1
Other/Unknown	63	0.3%	N/A	20 - 24	464	1.9%	40.7
Total	23,987	100.0%	136.2	25 - 29	648	2.7%	63.9
				30 - 39	2,787	11.6%	121.8
Race/Ethnicity	Cases	% Total	Rate	40 - 49	9,375	39.1%	356.9
White, Non-Hispanic	9,164	38.2%	80.3	50 - 59	7,206	30.0%	323.7
Black, Non-Hispanic	2,441	10.2%	92.4	60+	3,140	13.1%	80.5
Hispanic	0	0.0%	0.0	Unknown	0	0.0%	N/A
Asian/Pacific Islander	80	0.3%	N/A	Total	23,987	100.0%	136.2
Amer. Indian/Alaskan	0	0.0%	N/A				
Other/Unknown	12,302	51.3%	N/A				
Total	23,987	100.0%	136.2				

2005							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	12,553	61.5%	142.6	0 - 12	97	0.5%	3.4
Female	7,805	38.3%	85.2	13 - 19	160	0.8%	9.7
Other/Unknown	39	0.2%	N/A	20 - 24	413	2.0%	34.8
Total	20,397	100.0%	113.6	25 - 29	596	2.9%	58.4
				30 - 39	2,190	10.7%	96.4
Race/Ethnicity	Cases	% Total	Rate	40 - 49	7,222	35.4%	268.4
White, Non-Hispanic	7,328	35.9%	63.3	50 - 59	6,868	33.7%	296.2
Black, Non-Hispanic	2,023	9.9%	74.8	60+	2,851	14.0%	71.6
Hispanic	0	0.0%	0.0	Unknown	0	0.0%	N/A
Asian/Pacific Islander	73	0.4%	N/A	Total	20,397	100.0%	113.6
Amer. Indian/Alaskan	0	0.0%	N/A				
Other/Unknown	10,973	53.8%	N/A				
Total	20,397	100.0%	113.6				

2005 data provisional.

Note: Mid-year population estimates are not available for other race/ethnicity groups.

HIV COUNSELING AND TESTING DATA FLORIDA

Includes Total Number of Tests Performed at the State Laboratories From all Testing Sites

2004 Exposure Category	Number of Tests	Number Positive	Percent Positive	Gender	Number of Tests	Number Positive	Percent Positive
Male Sex With Male/IDU	831	101	12.2	Male	108,301	3,688	3.4
Male Sex With Male	15,007	1,420	9.5	Female	178,775	1,980	1.1
Injecting Drug User	11,166	427	3.8	Unknown	1,640	54	3.3
Sex Partner at Risk	12,964	1,080	8.3	Total	288,716	5,722	2.0
Child of Woman with HIV/AIDS	53	7	13.2	Race/ Ethnicity	Number of Tests	Number Positive	Percent Positive
STD Diagnosis	24,827	564	2.3	White	112,277	1,466	1.3
Sex for Drugs or Money	5,692	173	3.0	Black	101,703	3,021	3.0
Hemophilia/Blood Recipient	3,602	58	1.6	Hispanic	63,261	1,009	1.6
Victim of Sexual Assault	10,777	109	1.0	Asian	2,920	20	0.7
Health Care Exposure	1,924	15	0.8	Am.			
Heterosexual	152,015	1,088	0.7	Native	577	15	2.6
No Acknowledged Risk	44,263	529	1.2	Other	1,395	31	2.2
Unknown	5,595	151	2.7	Unknown	6,583	160	2.4
Total	288,716	5,722	2.0	Total	288,716	5,722	2.0

2005 Exposure Category	Number of Tests	Number Positive	Percent Positive	Gender	Number of Tests	Number Positive	Percent Positive
Male Sex With Male/IDU	909	92	10.1	Male	107,907	3,318	3.1
Male Sex With Male	17,385	1,565	9.0	Female	177,517	1,872	1.1
Injecting Drug User	10,803	310	2.9	Unknown	834	40	4.8
Sex Partner at Risk	13,032	957	7.3	Total	286,258	5,230	1.8
Child of Woman with HIV/AIDS	188	7	3.7	Race/ Ethnicity	Number of Tests	Number Positive	Percent Positive
STD Diagnosis	13,764	323	2.3	White	103,448	1,189	1.1
Sex for Drugs or Money	6,217	175	2.8	Black	102,102	2,872	2.8
Hemophilia/Blood Recipient	3,396	50	0.4	Hispanic	72,356	987	1.4
Victim of Sexual Assault	11,218	79	N/A	Asian	2,281	12	0.5
Health Care Exposure	0	0	0.0	Am.			
Heterosexual	194,803	1,349	0.7	Native	533	6	1.1
No Acknowledged Risk	14,075	321	2.3	Other	1,139	10	0.9
Unknown	468	2	0.4	Unknown	4,399	154	3.5
Total	286,258	5,230	1.8	Total	286,258	5,230	1.8

This Page Intentionally Blank

Section 2 -- Table III Co-Morbidities / Other Factors / Surrogate Markers

Documented Co-morbidity cases in 2005	Prevalence within the HIV/AIDS population in your area	Data Source	Date of Data
AIDS Cases diagnosed through 2005 with Tuberculosis diagnosed in 2005	115	HARS	Data through 2005 (data as of 03/06)
Infectious Syphilis reported in 2005 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	143	STDMIS	Data through 2005 (data as of 03/06)
Gonorrhea reported in 2005 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	318	STDMIS	Data through 2005 (data as of 03/06)
Chlamydia reported in 2005 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	221	STDMIS	Data through 2005 (data as of 03/06)
Hepatitis (defined as any HIV/AIDS case noted with a history of acute and/or chronic Hepatitis and documented in HARS)	6,592	HARS (local use variable)	Data through 2005 (data as of 03/06)
Substance Abuse (defined as any HIV/AIDS case noted with a history of substance abuse, eg. alcohol, methamphetamine, cocaine, inhalants, etc, and documented in HARS)	9,606	HARS (local use variable)	Data through 2005 (data as of 03/06)
Chronic Mental Illness (defined as any HIV/AIDS case noted with a history of mental illness and documented in HARS)	1,495	HARS (local use variable)	Data through 2005 (data as of 03/06)

Other Factors / Surrogate Markers Documented in 2005	Prevalence within the HIV/AIDS population in your area	Data Source	Date of Data
HIV-infected Offenders who returned to County	1,427	Dept. of Corrections Offender-based Information System	CY 2005, data as of 05/06
MSM (estimated seroprevalance of males with HIV/AIDS who have an MSM or MSM/IDU risk)	43,460	(Determined by PLWHA data)	Data through 2005 (data as of 03/06)
IDU (estimated seroprevalance of persons with HIV/AIDS who have and IDU or MSM/IDU risk)	14,691	(Determined by PLWHA data)	Data through 2005 (data as of 03/06)
Other Local Surrogate Markers:			

This page intentionally left blank

HIV/AIDS Annual Report, 2005

In 2004, Florida ranked second among states in the number of reported acquired immune deficiency syndrome (AIDS) cases. As in the previous year, New York reported the largest number of cases (7,641) and California ranked third, reporting 4,679 cases in 2004 (Table 1).

Florida ranked second among the states that report human immunodeficiency virus (HIV) cases in 2004. New York, which started reporting HIV in December of 2000, reported 6,033 cases (18%), followed by Florida, then Texas with 4,143 cases (12%). Georgia ranked fourth with 2,154 cases (6%) for the same time period (Table 1).

Table 1. HIV (not AIDS) and AIDS cases, top ten reporting states, 2004. (2005 data not available)

Reporting State**	Number of AIDS Cases	% US AIDS Cases	Number of HIV Cases***	% US HIV Cases
New York	7,641	17%	6,033	18%
Florida	5,822	13%	5,107	15%
California	4,679	10%	N/A	N/A
Texas	3,298	7%	4,143	12%
New Jersey	1,848	4%	1,704	5%
Illinois	1,679	4%	N/A	N/A
Georgia	1,640	4%	2,154	6%
Pennsylvania	1,629	4%	1,330	4%
Maryland	1,451	3%	N/A	N/A
North Carolina	1,137	3%	1,099	3%
Remainder of US*	13,913	31%	11,993	36%
Total Cases	44,737	100%	33,563	100%

Source: CDC HIV/AIDS Surveillance Report, Vol. 16.

*Date HIV reporting initiated for Florida, July 1997; New Jersey, Jan. 1992; New York, Dec. 2000; North Carolina, Feb. 1990; Pennsylvania, Oct 2002; Texas, Jan 1999; Georgia, 2003.

**Remainder of States where HIV is reportable as of 12/02: Alabama, Alaska, Arizona, Arkansas, Colorado, Idaho, Indiana, Iowa, Kansas, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, South Dakota, Utah, W. Virginia, Wisconsin and Wyoming.

Connecticut has confidential HIV infection reporting for pediatric cases only.

Washington reports symptomatic infection and name-to-code-based system.

California, District of Columbia, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Rhode Island and Vermont

report HIV on a code-based system. Delaware, Maine, Montana, and Oregon report on a name-to-code-based system. New Hampshire has other type of reporting.

Data only from those states where HIV is reportable.
Includes only persons reported with HIV infection who have not developed AIDS.

Among metropolitan statistical areas in the United States, Dallas ranked eighth (920) in the number of AIDS cases reported in December 2004 (Table 2) behind New York City, Miami, Washington D.C., Chicago, Philadelphia and Houston. During this same time period, Miami had the highest AIDS case rate in the nation with 53.8 per 100,000 population, followed by New York City (41.9).

Table 2. AIDS cases, top ten reporting MSA's in the United States, December 2004 (2005 data not available).

Metropolitan Statistical Area	Number of Cases	Percent of US Cases
New York City, NY	7,837	17.6%
Miami, FL	2,882	6.5%
Washington, DC	1,797	4.0%
Chicago, IL	1,497	3.4%
Philadelphia, PA	1,312	2.9%
Houston, TX	1,239	2.8%
Atlanta, GA	1,010	2.3%
Dallas, TX	920	2.1%
Baltimore, MD	866	1.9%
Remainder of US MSAs	25,204	56.6%
Total Cases	44,564	100%

Source: CDC HIV/AIDS Surveillance Report, Vol. 16.

In 2005, Florida reported a higher percentage of heterosexual AIDS cases (30%) than the United States (13%)(Table 3). However, the state reported a lower percentage of male sex with male (MSM) and injection drug user (IDU) than the United States. MSM/IDU cases accounted for (3%) of total reported cases in Florida and (7%) in the United States. A higher proportion of cases with no identified risk (NIR) were reported in Florida (25%) than in the United States as a whole (10%). Florida reported a slightly higher percentage of AIDS cases among blacks (53%) compared with the United States (39%). Florida also reported a higher percentage of cases among women (31%) compared with the United States (19%).

Similar to reported AIDS cases in 2005, Florida reported a higher percentage of HIV heterosexual cases (25%) compared to reported cases in the United States (20%) (Table 4). Florida reported a lower percentage of IDU than the United States. MSM/IDU cases accounted for (2%) of total reported cases in Florida and (4%) in the United States. Florida reported a slightly higher percentage of cases with NIR compared with the U.S., 30% versus 28%. The state reported the same percentage of HIV cases among blacks (48%) compared with the United States (48%). Florida also reported a slightly higher percentage of cases among women (31%) compared with the United States (30%).

Table 3. AIDS cases, U.S. 2004 and Florida, 2005.

	United States*		Florida	
	# Cases	% of Total	# Cases	% of Total
No. Adult/Adolescent Cases	908,905	99%	4,856	99%
No. Pediatric Cases (<13 years)	9,381	1%	13	1%
Total Cases	918,286	100%	4,869	100%
Exposure Category (Adults)				
Male to Male Contact	402,722	44%	1,596	33%
Injection Drug User (IDU)	219,053	24%	467	10%
Male to Male Contact/IDU	60,038	7%	152	3%
Transfusion/Hemophiliac	14,701	2%	9	0%
Heterosexual Contact	117,887	13%	1,442	30%
None of the Above	94,504	10%	1,193	25%
Race/Ethnicity (All Cases**)				
White (Non-Hispanic)	366,281	40%	1,330	27%
Black (Non-Hispanic)	361,189	39%	2,581	53%
Hispanic	169,361	18%	883	18%
Other/Unknown	12,072	1%	75	2%
Sex (Adults Only)				
Male	737,300	81%	3,370	69%
Female	171,603	19%	1,486	31%

2005 US data not available

*Source: CDC, HIV/AIDS Surveillance Report, Vol. 16; Florida HARS

**US race totals do not include Pediatric cases (n=9,381)

Table 4. HIV cases, U.S. 2004 and Florida, 2005.

	United States HIV		Florida HIV		Florida HIV	
	(not AIDS)*		(not AIDS)*		(regardless of AIDS status)**	
	# Cases	% of Total	# Cases	% of Total	# Cases	% of Total
No. Adult/Adolescent Cases	224,597	98%	4,625	99%	5,575	99%
No. Pediatric Cases (<13 years)	4,814	2%	45	1%	46	1%
Total Cases	229,411	100%	4,670	100%	5,621	100%
Exposure Category (Adults)						
Male to Male Contact	76,003	34%	1,740	38%	2,059	37%
Injection Drug User (IDU)	31,709	14%	251	5%	351	6%
Male to Male Contact/IDU	8,298	4%	86	2%	119	2%
Transfusion/Hemophiliac	1,550	1%	0	0%	3	0%
Heterosexual Contact	44,208	20%	1,149	25%	1,429	26%
None of the Above	62,829	28%	1,399	30%	1,613	29%
Race/Ethnicity (All Cases)						
White (Non-Hispanic)	76,703	33%	1,451	31%	1,694	30%
Black (Non-Hispanic)	109,991	48%	2,242	48%	2,761	49%
Hispanic	33,640	15%	931	20%	1,103	20%
Other/Unknown	2,374	1%	46	1%	63	1%
Sex (Adults Only)						
Male	157,047	70%	3,205	69%	4,526	81%
Female	67,543	30%	1,420	31%	2,087	37%

2005 US data not available.

Source: CDC HIV/AIDS Surveillance Report, Vol. 16.

**Date HIV reporting initiated for Florida, July 1997; New Jersey, Jan. 1992; New York, Dec. 2000; North Carolina, Feb. 1990; Pennsylvania, Oct 2002; Texas, Jan 1999.

Remainder of States where HIV is reportable as of 12/02: Alabama, Alaska, Arizona, Arkansas, Colorado, Idaho, Indiana, Iowa, Kansas, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, South Dakota, Utah, W. Virginia, Wisconsin and Wyoming.

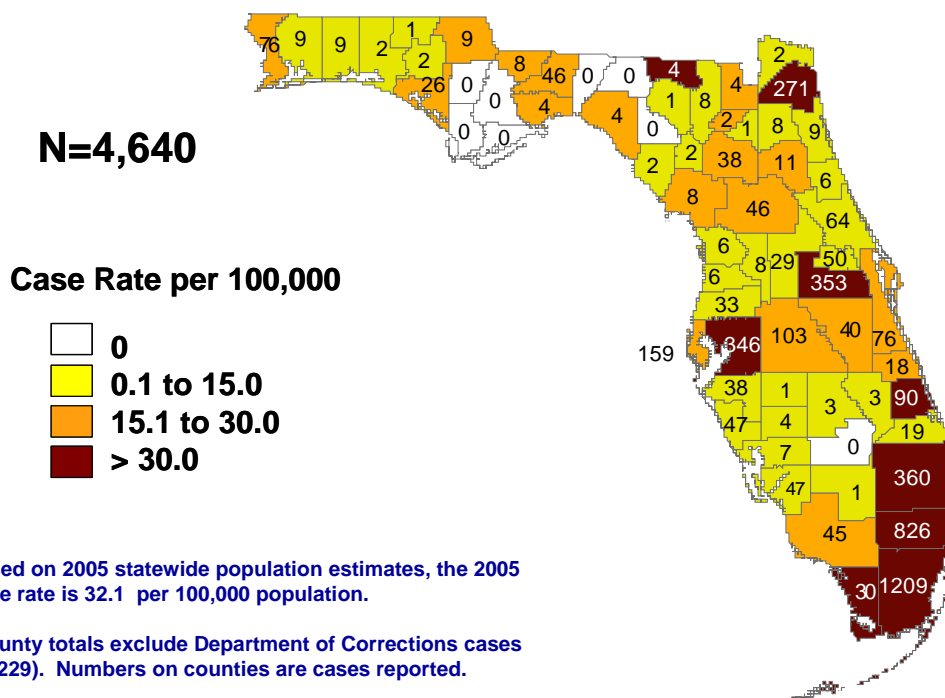
Connecticut has confidential HIV infection reporting for pediatric cases only.

Washington reports symptomatic infection and name-to-code-based system. California, District of Columbia, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Rhode Island and Vermont report HIV on a code-based system. Delaware, Maine, Montana, and Oregon report on a name-to-code-based system. New Hampshire has other type of reporting.

Florida is composed of 67 counties, which are located within 15 areas. In 2005, at least one AIDS case was reported in all but eight counties (Figure 1). Although the AIDS epidemic is widespread throughout Florida, the majority of cases were reported from the seven most populous counties: Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, and Pinellas. These seven counties reported a combined total of 3,524 cases, or 72% of Florida's total reported cases in 2005 (Table 5). The greatest numbers of AIDS cases were reported from three counties located in the southeastern part of the state, Broward, Miami-Dade, and Palm Beach. These three counties reported a combined total of 2,395 cases in 2005, or 49% of the statewide total.

Analysis of county-specific AIDS case rates per 100,000 population for 2005 indicate that Miami-Dade County ranked the highest with a rate of 49.9, followed by Broward (46.5), St. Lucie (40.3), Monroe (37.1), Orange (33.8) and Duval (31.7) Counties (Table 5).

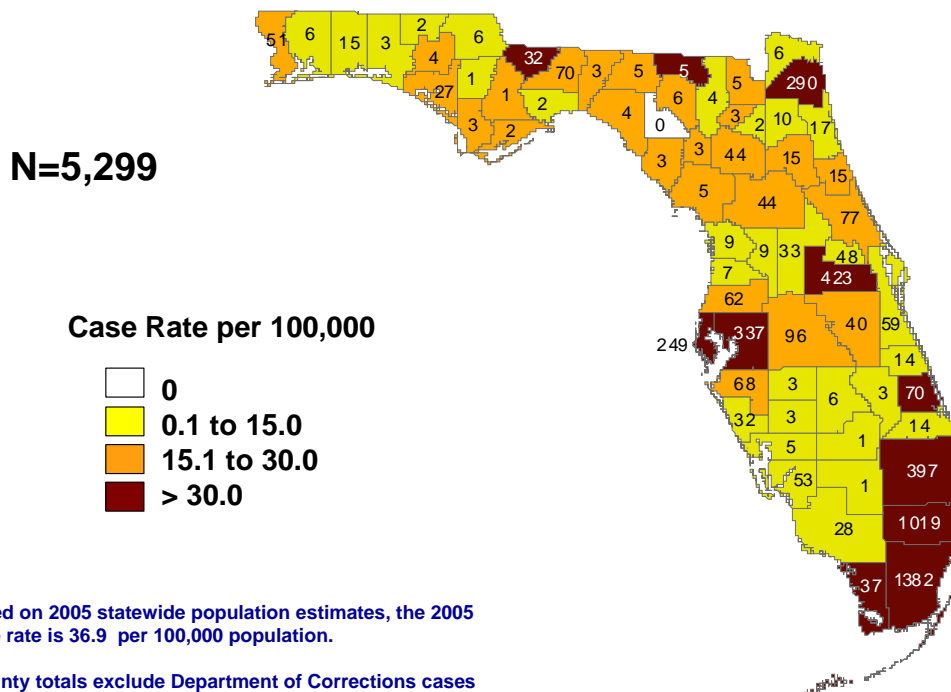
Figure 1. AIDS cases and rates per 100,000 population, by county of residence, Florida, 2005 (excluding Department of Corrections).



The majority of HIV cases were also reported from the same seven counties. These seven counties reported a combined total of 4,097 cases, or 73% of Florida's total reported cases in 2005 (Table 5). The greatest numbers of HIV cases were reported from Miami-Dade, Broward, and Orange Counties. These three counties reported a combined total of 2,824 cases in 2005, or 50% of the statewide total.

Analysis of county-specific data for 2005 indicate that Miami-Dade County ranked the highest with 25% of the HIV cases, followed by Broward (18%), Palm Beach (7%), Orange (7%) and Hillsborough (6%) (Table 5).

Figure 2. HIV cases , by county of residence, Florida, 2005 (excluding Department of Corrections).



Based on 2005 statewide population estimates, the 2005 state rate is 36.9 per 100,000 population.

*County totals exclude Department of Corrections cases (N=322). This map does not reflect HIV incidence. Numbers on counties are cases reported.

Table 5. HIV cases and AIDS cases and rates per 100,000 population, by county of residence, Florida, 2005.

Area	County	Population	HIV			AIDS		
			Cases	% Total	Rate/100,000	Cases	% Total	Rate/100,000
3	ALACHUA	239,711	44	0.8%	18.4	38	0.8%	15.9
4	BAKER	24,083	5	0.1%	20.8	4	0.1%	16.6
2	BAY	159,403	27	0.5%	16.9	26	0.5%	16.3
3	BRADFORD	27,887	2	0.0%	7.2	1	0.0%	3.6
7	BREVARD	527,680	59	1.0%	11.2	76	1.6%	14.4
10	BROWARD	1,774,842	1,019	18.1%	57.4	826	17.0%	46.5
2	CALHOUN	13,840	1	0.0%	7.2	0	0.0%	0.0
8	CHARLOTTE	159,732	5	0.1%	3.1	7	0.1%	4.4
13	CITRUS	131,534	9	0.2%	6.8	6	0.1%	4.6
4	CLAY	165,877	10	0.2%	6.0	8	0.2%	4.8
8	COLLIER	319,565	28	0.5%	8.8	45	0.9%	14.1
3	COLUMBIA	63,293	4	0.1%	6.3	8	0.2%	12.6
8	DE SOTO	35,417	3	0.1%	8.5	4	0.1%	11.3
3	DIXIE	15,697	3	0.1%	19.1	2	0.0%	12.7
4	DUVAL	854,145	290	5.2%	34.0	271	5.6%	31.7
1	ESCAMBIA	310,043	51	0.9%	16.4	76	1.6%	24.5
12	FLAGLER	68,345	15	0.3%	21.9	6	0.1%	8.8
2	FRANKLIN	10,763	2	0.0%	18.6	0	0.0%	0.0
2	GADSDEN	47,174	32	0.6%	67.8	8	0.2%	17.0
3	GILCHRIST	16,616	3	0.1%	18.1	2	0.0%	12.0
8	GLADES	11,146	1	0.0%	9.0	0	0.0%	0.0
2	GULF	16,041	3	0.1%	18.7	0	0.0%	0.0
3	HAMILTON	14,116	5	0.1%	35.4	4	0.1%	28.3
14	HARDEE	28,077	3	0.1%	10.7	1	0.0%	3.6
8	HENDRY	39,586	1	0.0%	2.5	1	0.0%	2.5
13	HERNANDO	147,563	7	0.1%	4.7	6	0.1%	4.1
14	HIGHLANDS	93,997	6	0.1%	6.4	3	0.1%	3.2
6	HILLSBOROUGH	1,128,668	337	6.0%	29.9	346	7.1%	30.7
2	HOLMES	19,234	2	0.0%	10.4	1	0.0%	5.2
15	INDIAN RIVER	127,154	14	0.2%	11.0	18	0.4%	14.2
2	JACKSON	50,224	6	0.1%	11.9	9	0.2%	17.9
2	JEFFERSON	14,039	3	0.1%	21.4	0	0.0%	0.0
3	LAFAYETTE	7,731	0	0.0%	0.0	0	0.0%	0.0
13	LAKE	258,665	33	0.6%	12.8	29	0.6%	11.2
8	LEE	527,431	53	0.9%	10.0	47	1.0%	8.9

data as of 12/31/05

Table 5 (cont'd). HIV cases and AIDS cases and rates per 100,000 population, by county of residence, Florida, 2005.

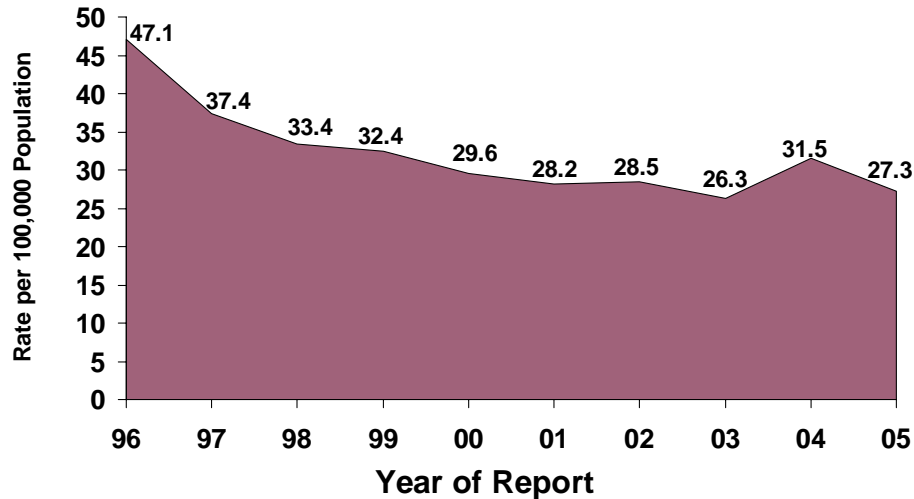
County	Population	HIV			AIDS		
		Cases	% Total	Rate/100,000	Cases	% Total	Rate/100,000
LEON	264,387	70	1.2%	26.5	46	0.9%	17.4
LEVY	38,611	5	0.1%	12.9	8	0.2%	20.7
LIBERTY	7,422	1	0.0%	13.5	0	0.0%	0.0
MADISON	19,430	5	0.1%	25.7	0	0.0%	0.0
MANATEE	301,497	68	1.2%	22.6	38	0.8%	12.6
MARION	298,390	44	0.8%	14.7	46	0.9%	15.4
MARTIN	140,898	14	0.2%	9.9	19	0.4%	13.5
MIAMI-DADE	2,422,503	1,382	24.6%	57.0	1,209	24.8%	49.9
MONROE	80,837	37	0.7%	45.8	30	0.6%	37.1
NASSAU	66,923	6	0.1%	9.0	2	0.0%	3.0
OKALOOSA	188,282	15	0.3%	8.0	9	0.2%	4.8
OKEECHOBEE	38,206	3	0.1%	7.9	3	0.1%	7.9
ORANGE	1,043,846	423	7.5%	40.5	353	7.2%	33.8
OSCEOLA	231,417	40	0.7%	17.3	40	0.8%	17.3
PALM BEACH	1,274,615	397	7.1%	31.1	360	7.4%	28.2
PASCO	394,057	62	1.1%	15.7	33	0.7%	8.4
PINELLAS	954,841	249	4.4%	26.1	159	3.3%	16.7
POLK	532,100	96	1.7%	18.0	103	2.1%	19.4
PUTNAM	73,134	15	0.3%	20.5	11	0.2%	15.0
SANTA ROSA	137,247	6	0.1%	4.4	9	0.2%	6.6
SARASOTA	362,612	32	0.6%	8.8	47	1.0%	13.0
SEMINOLE	415,004	48	0.9%	11.6	50	1.0%	12.0
ST JOHNS	151,136	17	0.3%	11.2	9	0.2%	6.0
ST LUCIE	223,572	70	1.2%	31.3	90	1.8%	40.3
SUMTER	68,605	9	0.2%	13.1	8	0.2%	11.7
SUWANNEE	39,002	6	0.1%	15.4	1	0.0%	2.6
TAYLOR	21,363	4	0.1%	18.7	4	0.1%	18.7
UNION	14,893	3	0.1%	20.1	2	0.0%	13.4
VOLUSIA	489,445	77	1.4%	15.7	64	1.3%	13.1
WAKULLA	26,900	2	0.0%	7.4	4	0.1%	14.9
WALTON	50,924	3	0.1%	5.9	2	0.0%	3.9
WASHINGTON	22,719	4	0.1%	17.6	2	0.0%	8.8
DOC/FCI	N/A	322	5.7%	N/A	229	4.7%	N/A
STATE TOTAL	17,844,137	5,621	100.0%	31.5	4,869	100.0%	27.3

*Dept. of Corrections/Federal Correctional Institute data as of 12/31/05

In 1993, CDC expanded the surveillance case definition of AIDS to incorporate a broader range of AIDS-indicating diseases and conditions. This significant change resulted in an initial increase in the annual number of reported cases during 1993, followed by annual decreases both nationally and statewide since then. AIDS

case rates per 100,000 population followed a similar pattern (Figure 3) (1993 data not shown).

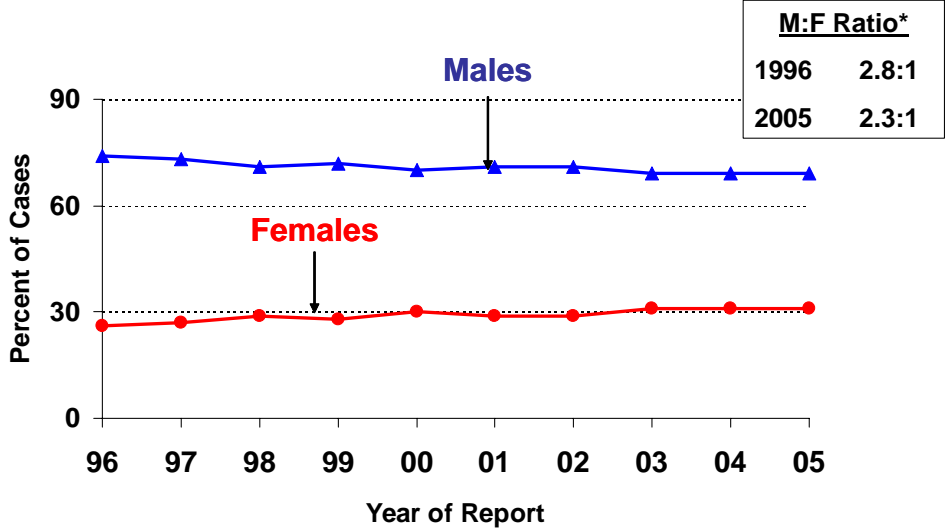
Figure 3. AIDS case rates per 100,000 population, by year of report, Florida, 1996-2005.*



*Population rates calculated from annual population estimates.
Comment: The advent of HAART was associated with decreases in AIDS cases in the late 1990's. Generally, AIDS cases remained fairly stable in the early 2000's, with an increase in 2004 due to increased CD4 testing statewide. Increasingly, a diagnosis of AIDS reflects late diagnosis of HIV and limited access to treatment.

In 1996, 26% of the AIDS cases reported in Florida were female (Figure 4). Over the past ten years, the proportion of AIDS cases among women has increased steadily. This has resulted in a decline of the male-to-female ratio, from 2.8:1 in 1996 to 2.3:1 in 2005. In 2005, the case rate per 100,000 population was 46.9 among adult males and 19.5 among adult females, indicating that AIDS cases in this period were still more likely to be reported among males than females in Florida.

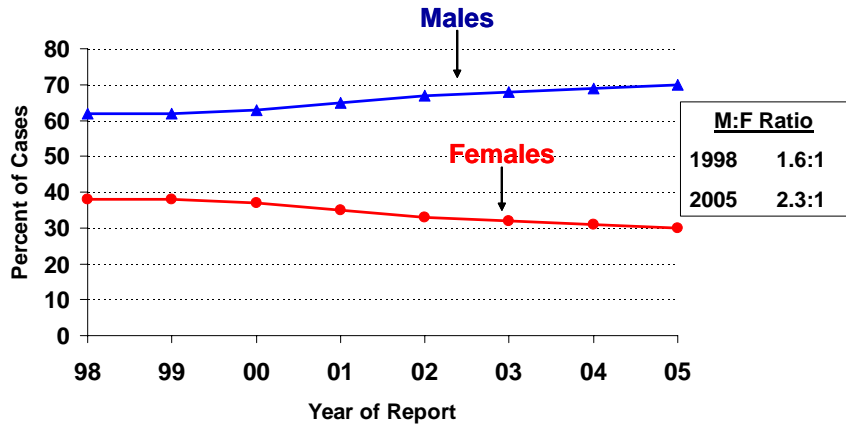
Figure 4. Percent of adult AIDS cases by sex and year of report, Florida, 1996 – 2005.



Comment: AIDS cases tend to represent HIV transmission that occurred many years ago. The relative increases in female cases reflect the changing face of the AIDS epidemic over time.
 *The male-to-female ratio is the number or percent of cases among males divided by the number or percent of female cases.

In 1998, 38% of the HIV cases reported in Florida were female (Figure 5). Except for a slight decrease to 37% in 2000, the proportion of HIV cases among women has decreased steadily over the past five years. The result is an increase of the male-to-female ratio, from 1.6:1 in 1998 to 2.3:1 in 2005. This increase in the male-to-female ratio differs from the ratio for AIDS cases during the same time period.

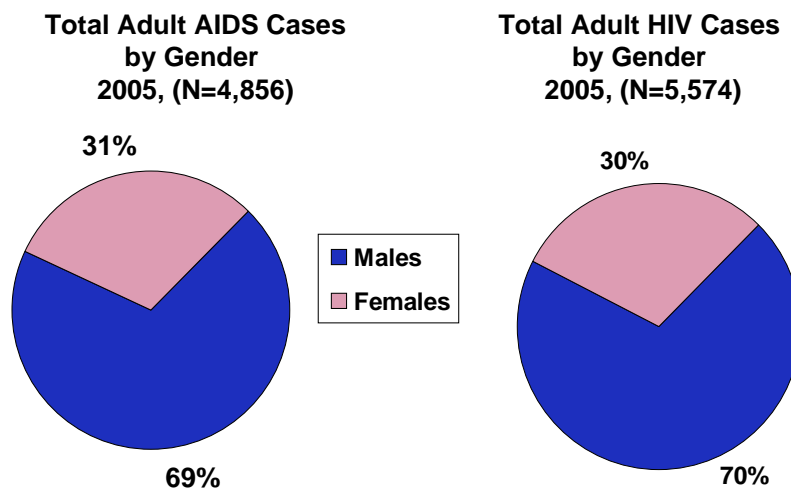
Figure 5. Percent of adult HIV cases by sex and year of report Florida, 1998–2005.



Comment: The trend for HIV cases by sex is the opposite of that for AIDS cases. Recent trends in HIV transmission are best described by the HIV case data. The relative increases in male HIV cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM), which may influence future AIDS trends. There is additional evidence to support this MSM hypothesis, which we will now examine more closely.

In 2005, a total of 3,370 adult males and 1,486 adult females were reported with AIDS, representing 69% and 31% of cases, respectively (Figure 6). Also in 2005, a total of 3,904 adult males and 1,670 adult females were reported with HIV infection, representing 70% and 30% of cases, respectively. The male-to-female ratio of adult AIDS cases was 2.3:1, compared to a corresponding ratio of 2.3:1 for adult HIV cases.

Figure 6. Percent of adult AIDS cases by sex, Florida, compared with percent of adult HIV cases by sex, Florida, 2004.

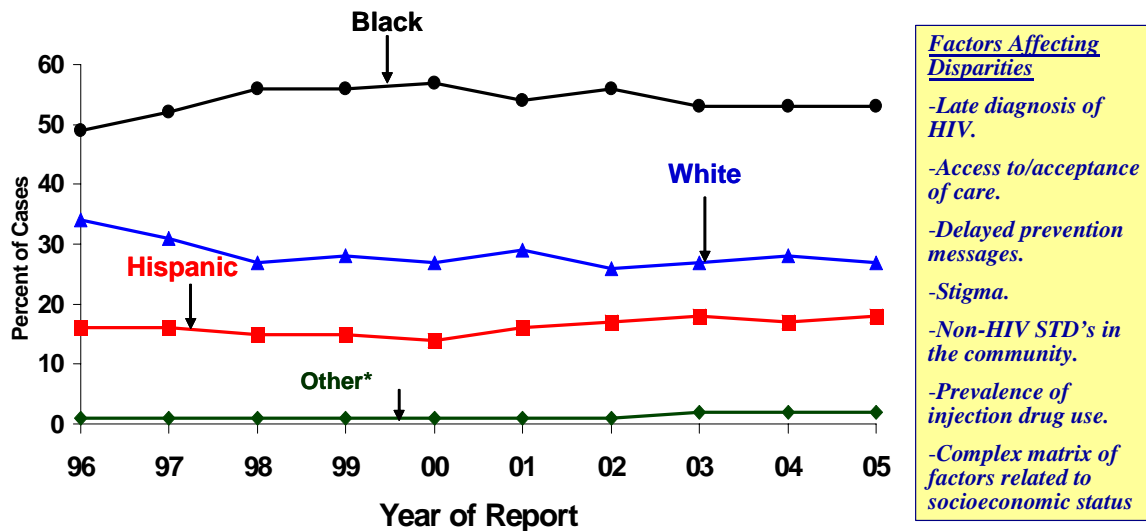


Comment: Florida's Adult Population is: 49% Male and 51% Female, therefore male cases are disproportionately impacted.

HIV case reporting, implemented in July 1997, tends to indicate newer infections than are reflected by AIDS case data, although we do not know the proportion of diagnosed HIV cases that were recently acquired. HIV case reports augment AIDS case data and provide good information by age, sex and race/ethnicity on persons who have been tested confidentially. Overall, however, HIV infection data represent the minimum of HIV prevalence in Florida, which is estimated at approximately 125,000 persons living with HIV infection.

Thirty-four percent of the adult AIDS cases reported in Florida in 1996 were white, compared with 49% black (Figure 7). By 2005, the percentage of AIDS cases among whites decreased to 27%, while the percentage of AIDS cases among blacks climbed to 53%. The percentage of AIDS cases among Hispanics has increased to 18%.

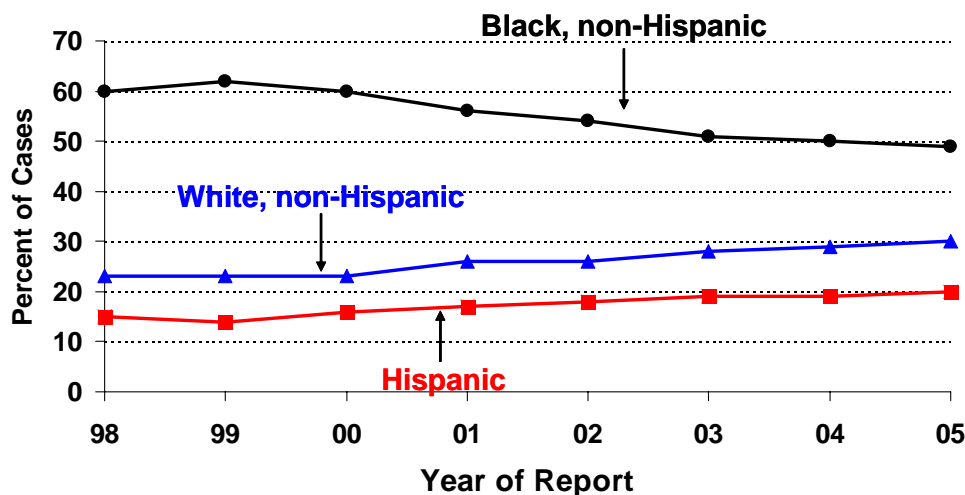
Figure 7. Percent of adult AIDS cases by race/ethnicity and year of report, Florida, 1996–2005.



Comment: In 2005, blacks accounted for 53% of reported AIDS cases, but only 15% of the population. Hispanic cases increased from 16% in 1996 to 18% in 2005. Disparities are even more evident among women: Annually, more than 70% of female AIDS cases have been reported among black women since 1988. HIV case reporting, implemented in mid-1997, has shown a very similar distribution of cases by race/ethnicity and sex.
 *Other includes American Indian/Alaska Native, Asian/Pacific Islander, and Multi-racial.

Twenty-three percent of the adult HIV cases reported in Florida in 1998 were white, compared with 60% black (Figure 8). By 2005, the percentage of HIV cases increased for whites (30%) and decreased among blacks to 49%. The percentage of HIV cases among Hispanics has realized a slight steady increase since 2000.

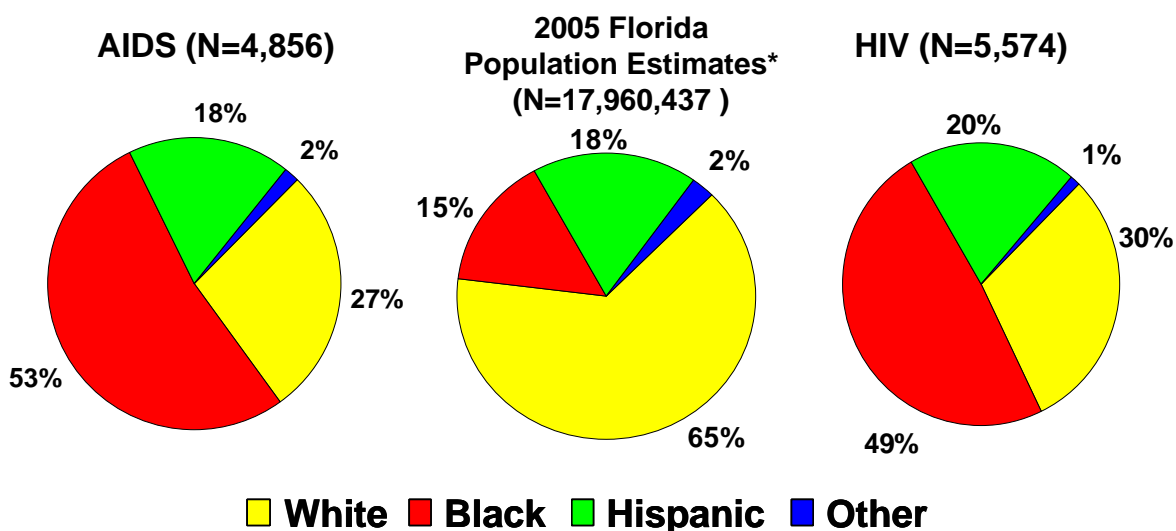
Figure 8. Percent of adult HIV cases by race/ethnicity and year of report, Florida, 1998–2005.



Comment: In absolute numbers, from 1999-2005, HIV cases among blacks decreased by 32%, while increasing by 13% among whites. The decreases among blacks may correspond to some extent with recent targeted prevention, while the increases among whites may be associated with recent increases in HIV transmission among white MSM.

Blacks comprise only 15% of the adult population, but represent 53% of the AIDS cases and 49% of the HIV cases reported in 2005 (Figure 9). Hispanics comprise 18% of Florida’s adult population, and account for 18% of the AIDS cases and 20% of the HIV cases.

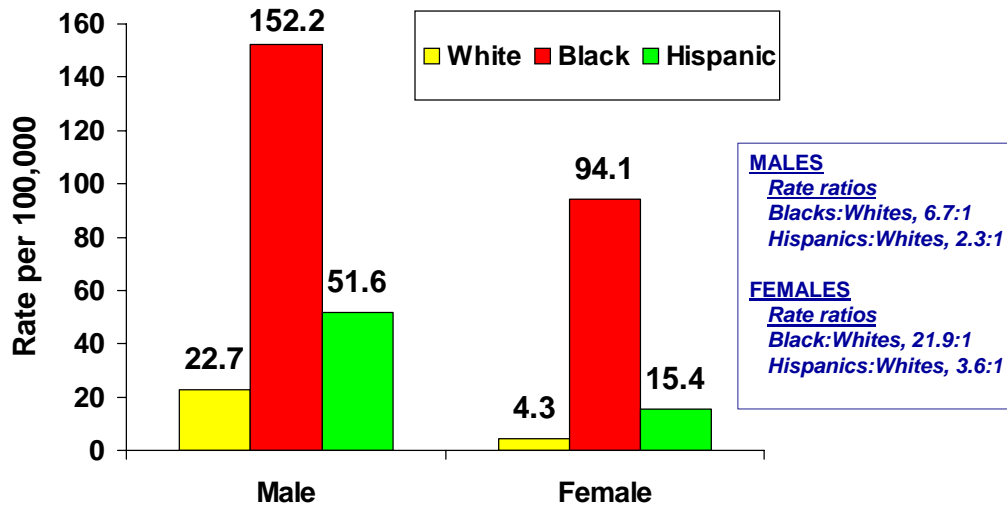
Figure 9. Percent of adult AIDS cases by race/ethnicity, Florida, compared with percent of adult HIV cases by race/ethnicity, Florida, 2005.



Comment: In 2005, blacks are over-represented among the AIDS and HIV cases, accounting for 53% of adult AIDS cases and 49% of adult HIV cases, but only 15% of the adult population. Hispanics represent 18% of the adult population and account for 18% of the adult AIDS cases and 20% of the adult HIV cases. A group is disproportionately impacted to the extent that the percentage of cases exceeds the percentage of population.

Black men and, to an even greater extent, black women are over-represented in the AIDS epidemic in terms of rates per 100,000 population (Figure 10). To a lesser extent, Hispanic males and females are also over-represented, when compared to the percentage of Hispanic population in Florida.

Figure 10. Adult AIDS cases and case rates per 100,000 population by sex and race/ethnicity, Florida, 2005.

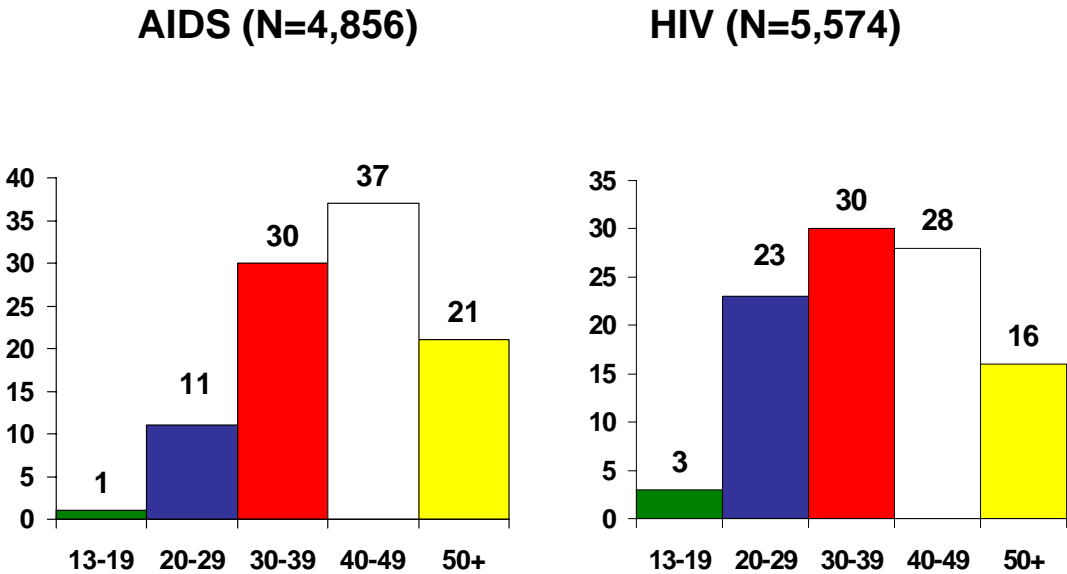


Comment: Among black males, the AIDS case rate for 2005 is 7 times higher than among white males. Among black females, the AIDS case rate is 22 times higher than among white females. Hispanic male rates are 2 times higher and Hispanic female rates are 4 times higher than the rates among their white counterparts.
 *2005 Florida Population Estimates, DOH, Office of Planning, Evaluation and Data Analysis for ages 13+.

As in previous years, the greatest proportion of AIDS cases reported in 2005 was among persons 40-49 years old (37%) (Figure 11). The 30-39 age group was second, with 30% of the reported AIDS cases. The 20-29 age group accounted for 11% of these cases, and the 50-and-older age group accounted for 21%. Persons reported with AIDS in the 40-49 age group account for 37% of the cases but only 16% of the total population. However, because AIDS-defining conditions appear late in the course of HIV disease, AIDS cases represent individuals who may have been infected an average of ten years earlier.

As with AIDS cases, a greater proportion of HIV cases in 2005 were reported among those aged 30-39 (30%), those aged 20-29 (23%) and those aged 40-49 (28%). There was a lower proportion among those aged 13-19 (3%) and a higher proportion among those aged 20-29 years, but a lower proportion for those aged 50 and older (16%), all of which is consistent with earlier detection of HIV cases.

Figure 11. Age distribution of Florida’s adult AIDS cases compared with the age distribution of Florida’s adult HIV cases , 2005.



Comment: HIV cases tend to be younger than AIDS cases. HIV cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic.

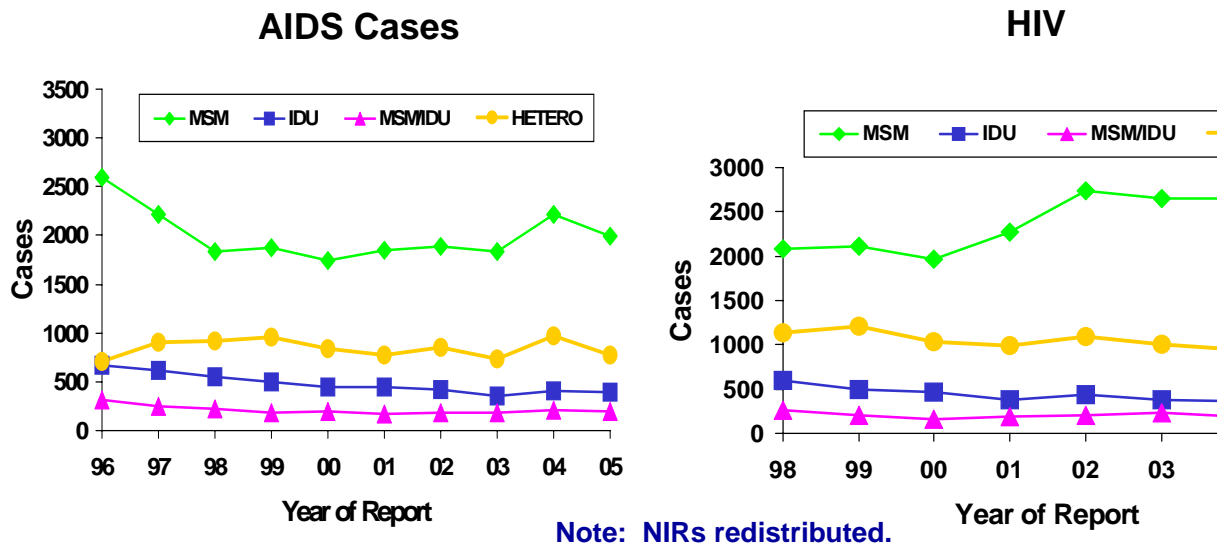
HIV/AIDS BY MODE OF EXPOSURE

The dynamics of the HIV epidemic are different in each population; so multiple data sets must be used to compile a representative epidemiologic profile for HIV prevention, planning, and targeting of resources and outreach. The following data represent HIV and AIDS cases by mode of exposure where cases reported with no identified risks (NIRs) have been redistributed into “known” risk categories, based on the history of reclassifying NIRs.

Males

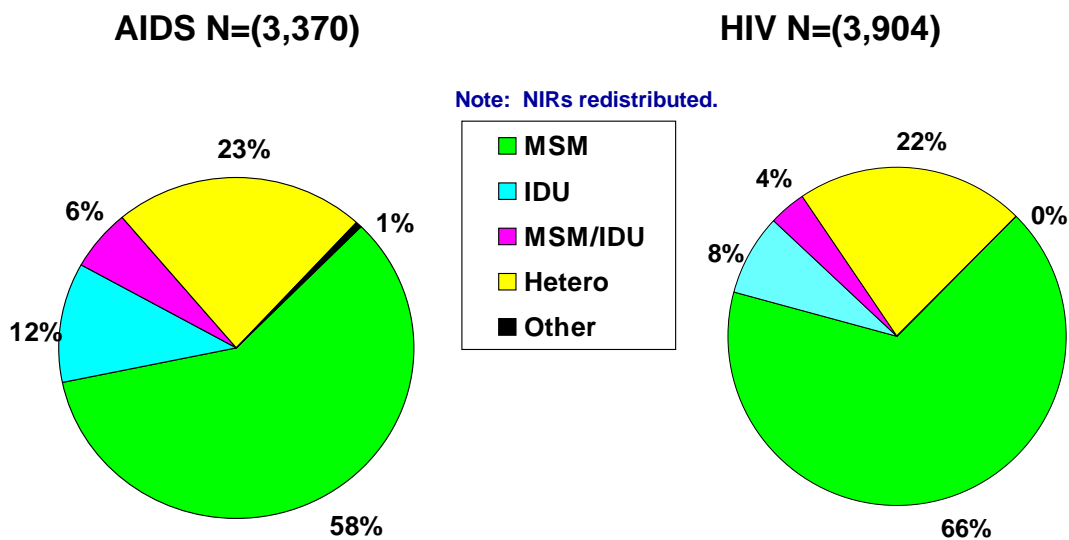
Compared with other modes of exposures for male AIDS cases, male sex with male (MSM) represents the highest risk among males (Figure 12). Decreases among AIDS cases in this risk were observed from 1995 through 1998, where there was a leveling, and then a significant jump in 2004 (as was observed among all risk groups for that year). Like AIDS cases, male sex with males (MSM) continue to represent the highest risk group among male HIV cases, with a sharp increases from 2000 to 2002, and then a leveling off through 2005.

Figure 12. Adult male AIDS cases (1996-2005) and HIV (1998-2005) by mode of exposure by year of report, Florida.



Among the male AIDS and HIV cases reported for 2005, MSM was the highest risk (58% and 66% respectively) followed by cases with a heterosexual risk (23% for AIDS and 22% for HIV) (Figure 15). Cases with an IDU risk are more common among AIDS cases (12%) than HIV cases (8%) as this has been a waning risk for HIV infection in Florida over the past 10 years.

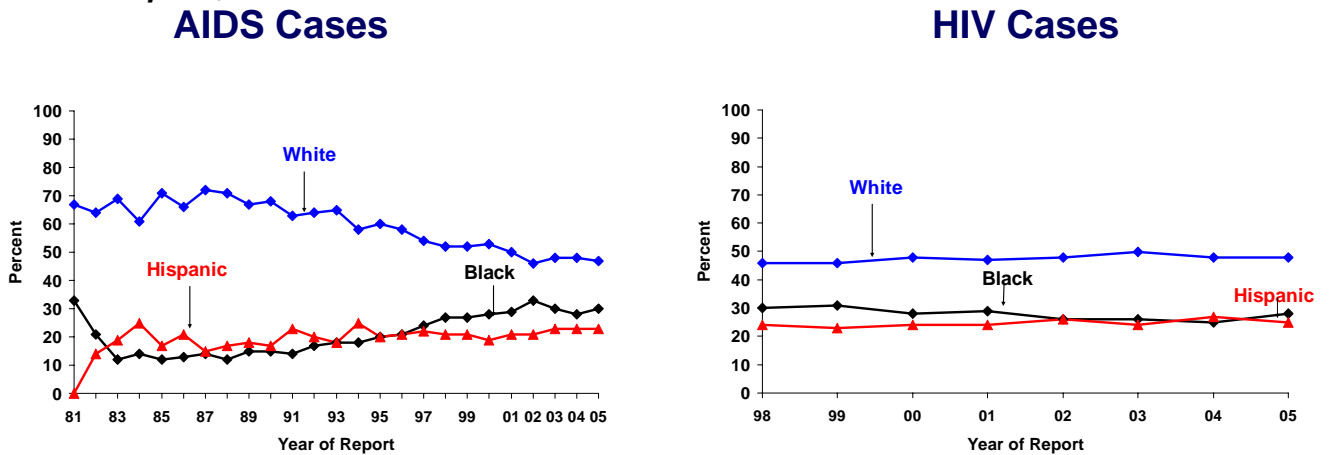
Figure 15. Adult male AIDS and HIV cases by mode of exposure, Florida, 2005.



Comment: The recent increase among MSM is indicated by the higher percent of MSM among HIV cases compared to AIDS

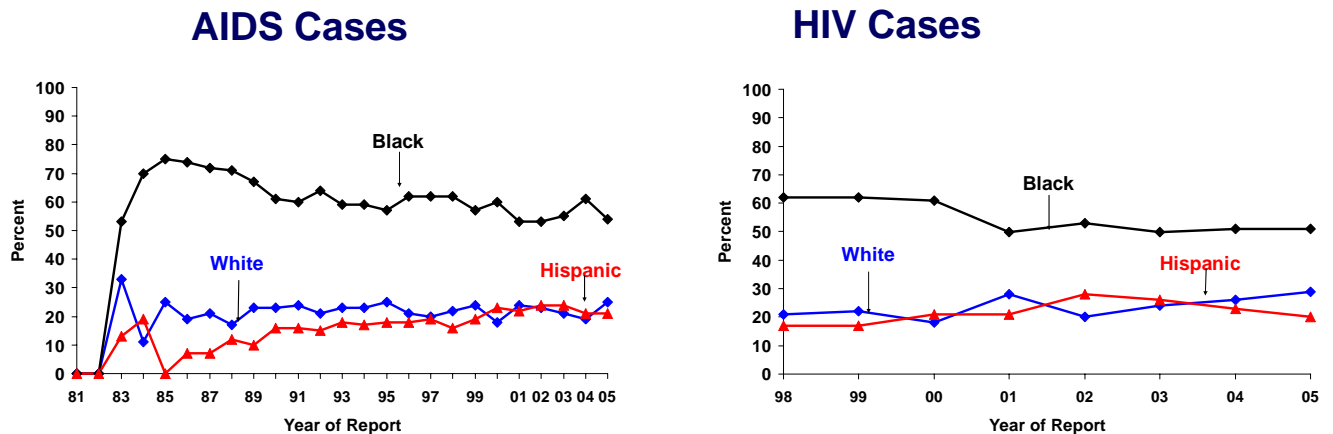
From 1981-2002, the annually proportion of MSM cases reflect a slight, but ongoing decline among whites, then leveling through 2005 (Figure 17). As with AIDS cases, the greatest proportion of MSM HIV cases reported from 1998 to 2005 are white. Since 1991, there is a continuous increase in the percent of AIDS cases among black MSM, until 2002, where a decrease began. The proportion of black and Hispanic MSM HIV cases have remained fairly stable over time with minor fluctuations.

Figure 17. Percent distribution of adult AIDS (1981-2005) and HIV (1998-2005) cases among men who have sex with men, by race/ethnicity and year of report, Florida



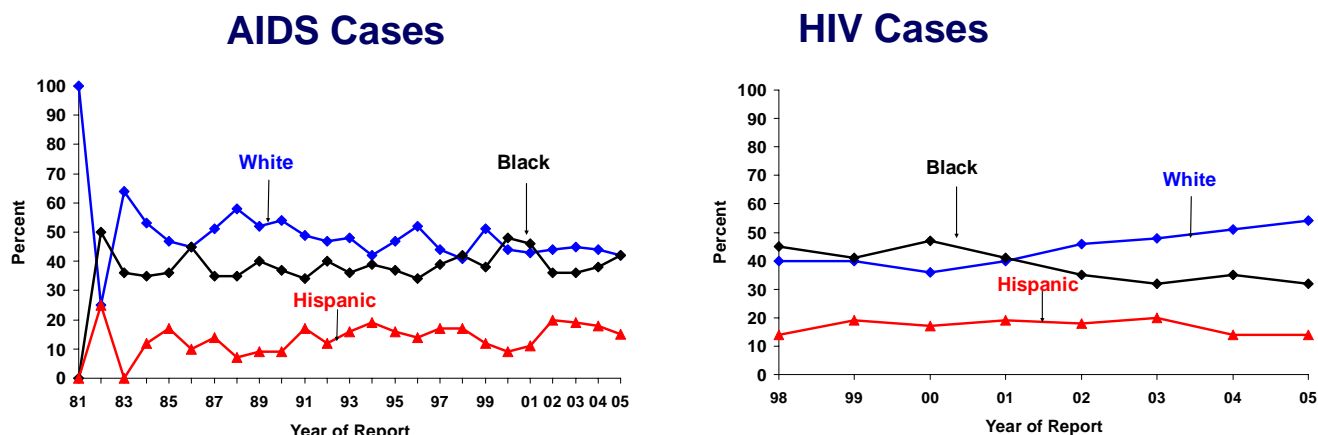
Blacks have represented the highest proportion of male IDU AIDS cases since 1983 and of male HIV cases since 1998 (Figure 19). In the past 3 years, there were noticeable fluctuations among the proportion of male IDU AIDS cases by race. Among male HIV IDU cases, there has been a slight leveling off in the proportion among blacks in the past several years, whereas an increase was noted among whites and a decrease among Hispanics.

Figure 19. Percent distribution of adult male AIDS (1981-2005) and HIV (1998-2005) cases among injection drug users, by race/ethnicity and year of report, Florida.



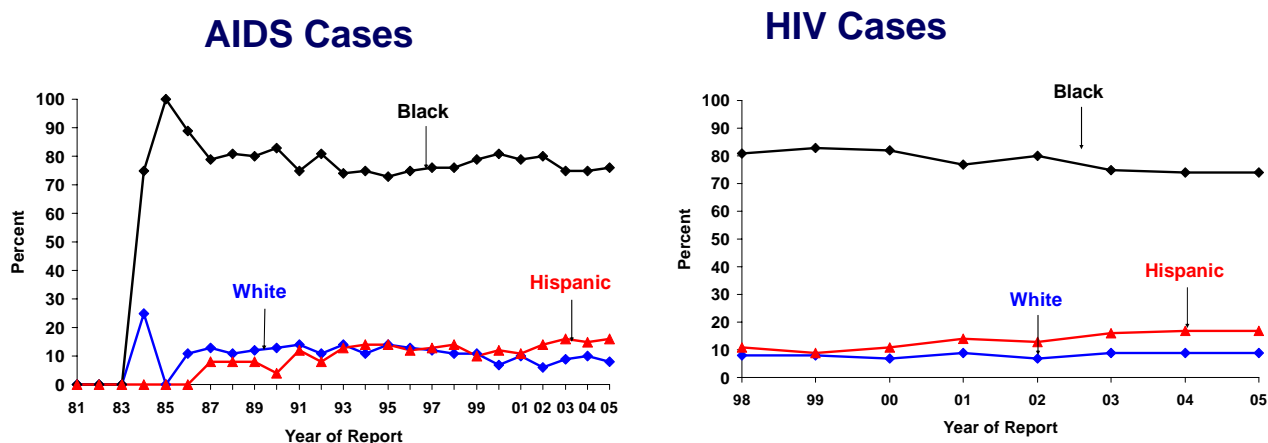
There were gradual year-to-year fluctuations in the percent distribution of MSM/IDU AIDS cases by race ethnicity, during 1981-2005 (Figure 24.) The percentage of white and Hispanic MSM/IDU AIDS cases slightly increased from 2000 to 2002, and then decreased through 2005, whereas among blacks, the percentage decreased from 2000 to 2002 and then increased through 2005. Among MSM/IDU HIV cases, the proportion of black and white cases switched in 2001, with the highest proportion being among whites in 2005.

Figure 24. Percent distribution of adult AIDS (1981-2005) and HIV (1998-2005) cases among men who have sex with men and used injection drugs, by race/ethnicity and year of report, Florida.



Among male heterosexual AIDS and HIV cases, figures show relative stability over time among the three major racial/ethnic groups, with blacks consistently comprising a much higher share of cases, compared with whites and Hispanics (Figure 26). In the past few of years, the proportion of cases among blacks has decreased, whereas the proportion among whites and Hispanics has increased.

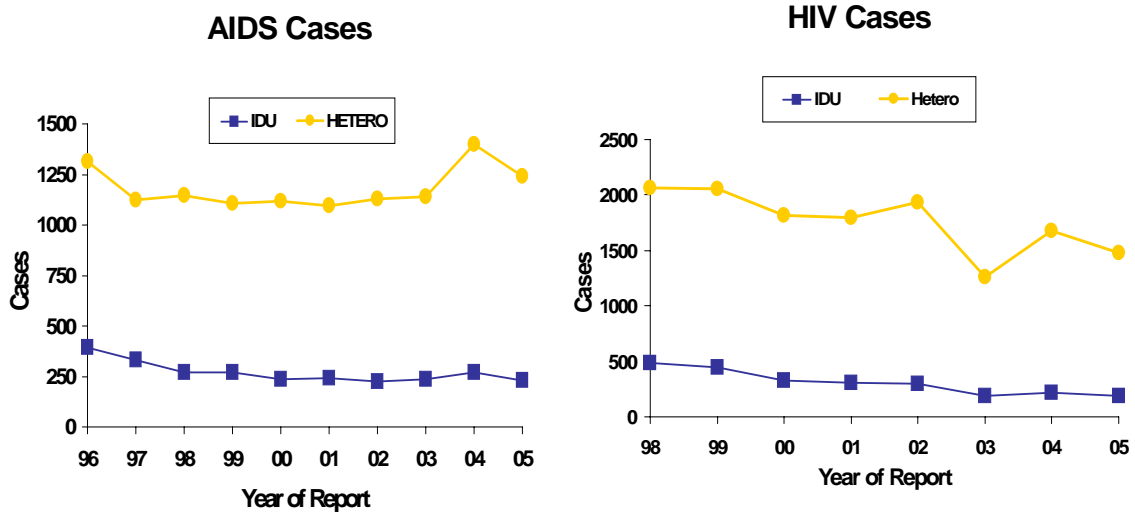
Figure 26. Percent distribution of adult male AIDS (1981-2005) and HIV (1998-2005) cases with heterosexual contact, by race/ethnicity and year of report, Florida.



Females

Among females, heterosexual risk has been the main mode of exposure among both AIDS and HIV cases for the past several years (Figure 14).

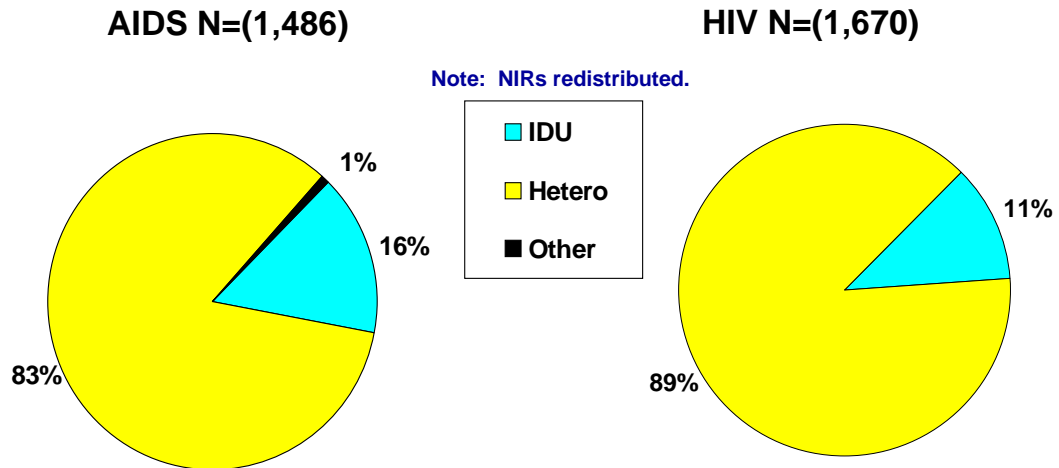
Figure 14. Adult female AIDS cases (1996-2005) and HIV cases (1998-2005) by mode of exposure by year of report, Florida



Note: NIRs redistributed

Amc Comment: The heterosexual risk continues to be the dominant mode of exposure among females. the highest risk followed by IDU (Figure 16).

Figure 16. Adult female AIDS and HIV cases by mode of exposure, Florida, 2005.

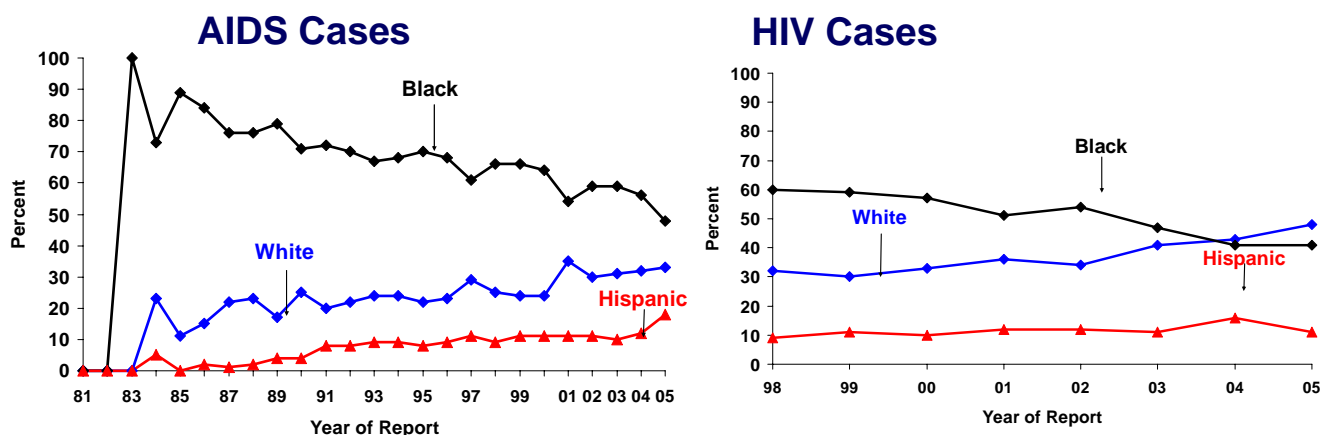


Note: NIRs redistributed.

Comment: The ongoing increase among heterosexual risk compared with IDU is indicated by the higher percent of heterosexuals among HIV cases compared to AIDS cases, as HIV cases tend to represent a more recent picture of the epidemic.

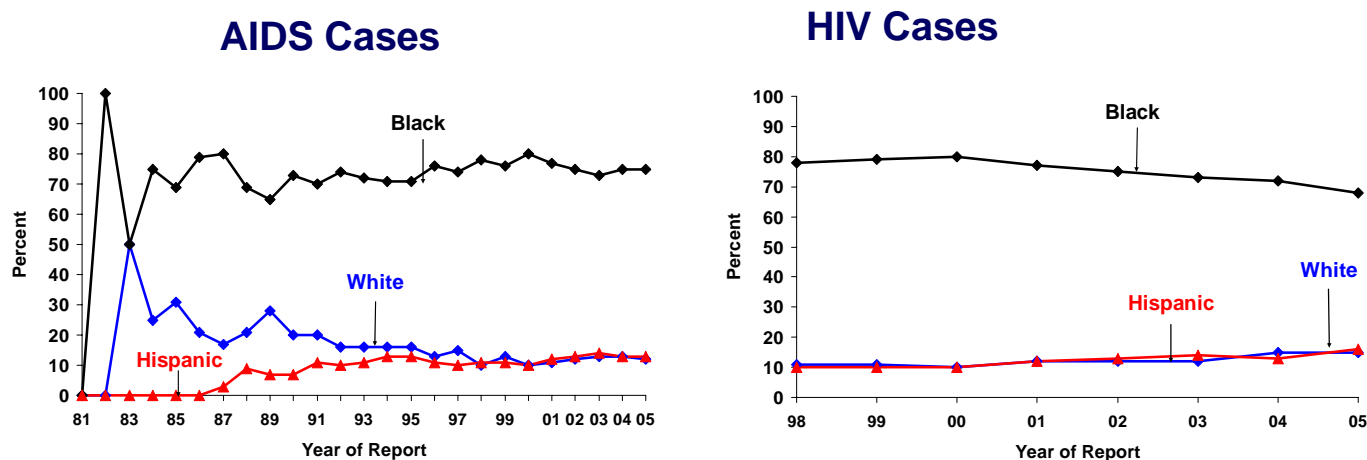
As with males, blacks have represented the highest proportion of female IDU HIV cases since 1983 and of female male HIV cases since 1998 (Figure 20). Since 1989, there was a noticeable decrease among the proportion of black female IDU AIDS cases conversely an increase was noted among both white and Hispanic IDU AIDS cases. (Note this is the opposite trend observed among male IDU AIDS cases). Among female HIV IDU cases, there as an increase in the proportion of cases among whites since 2002 and a decrease among the proportion of blacks and Hispanics.

Figure 20. Percent distribution of adult female AIDS (1981-2005) and HIV (1998-2005) cases among injection drug users, by race/ethnicity and year of report, Florida.



Among female heterosexual AIDS and HIV cases, blacks consistently comprise a much higher share compared with whites and Hispanics (Figure 27). Among the AIDS cases, figures show relative stability with minor fluctuations among the three major racial/ethnic groups since 1995. Among the HIV cases, an ongoing proportional decrease is observed among blacks, whereas a slight ongoing increase is observed among whites and Hispanics through 2005.

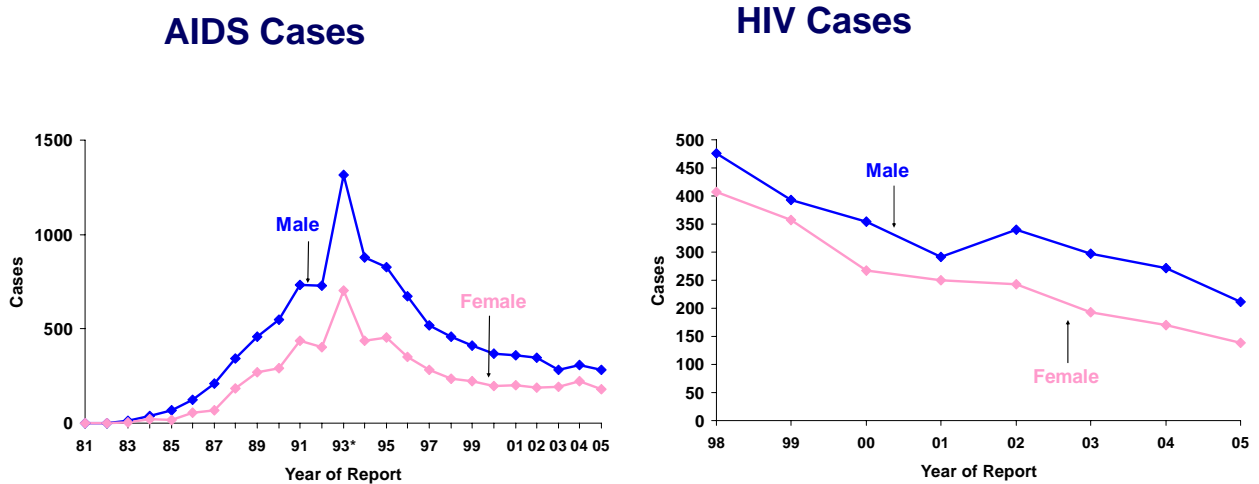
Figure 27. Percent distribution of adult female AIDS (1981-2005) and HIV (1998-2005) cases with heterosexual contact, by race/ethnicity and year of report, Florida.



HIV Transmission Among Injection Drug Users

Males represent the greater number of both AIDS and HIV IDU cases (Figure 18). Both males and females showed an obvious decline in reported AIDS cases among IDUs since 1993. Declines are also observed among the number of reported male and female HIV IDU cases since 1998.

Figure 18. Reported AIDS (1981-2005) and HIV (1998-2005) cases among injection drug users by sex and year of report, Florida.

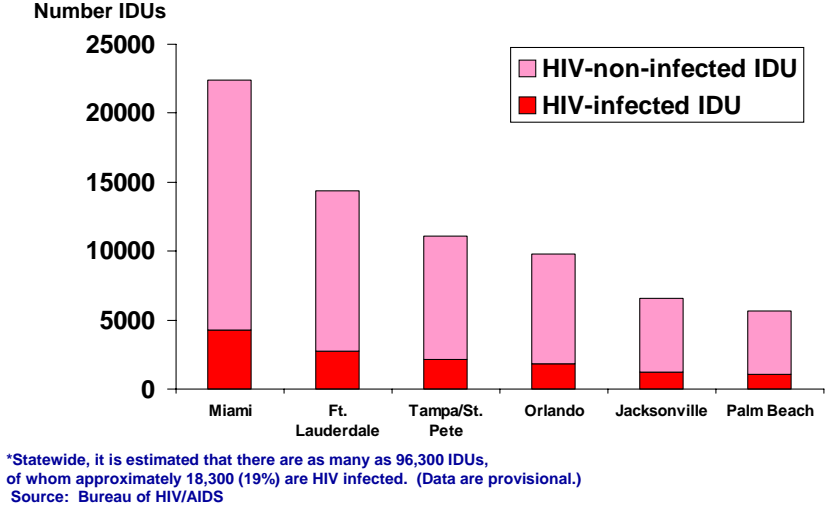


The Bureau of HIV/AIDS estimates that there are as many as 96,300 IDUs in the state. Approximately 19% of these IDUs are estimated to be HIV infected, and 81%, or 78,000 are presently uninfected but at high risk of becoming HIV infected (Figure 23).

For more information, please refer to the IDU slide presentation for 2004, posted to our website

(http://www.doh.state.fl.us/disease_ctrl/aids/trends/slides/IDU_2004.ppt)

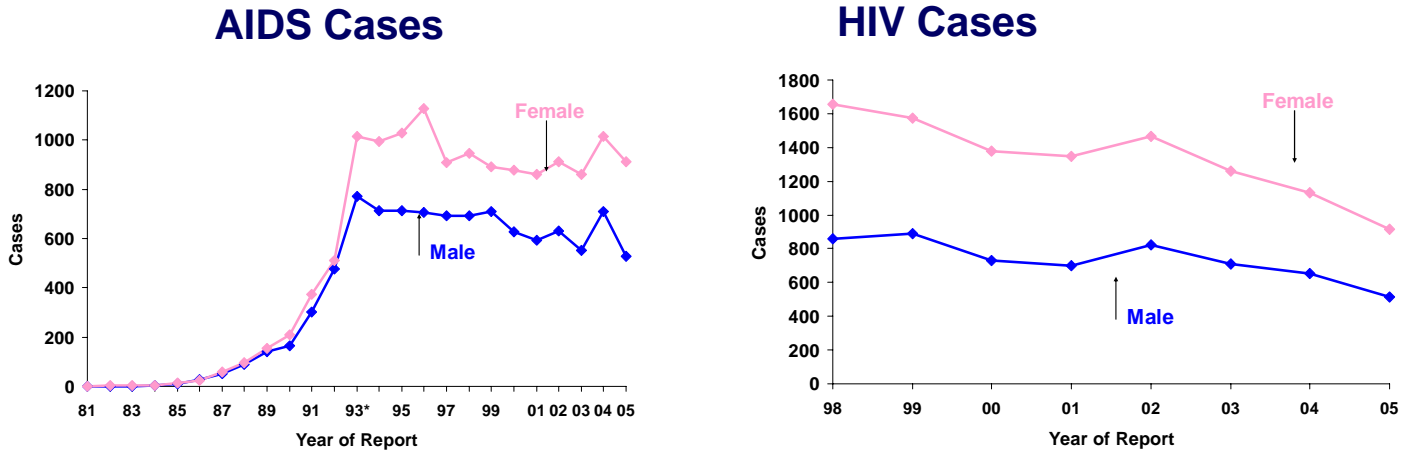
Figure 23. Estimated Number of Injection Drug Users (IDUs) According to HIV-Infection Status, Title I Eligible Metropolitan Areas, Florida.



Persons At Risk For HIV Infection Through Known Heterosexual Contact

Females represent the greater number of both AIDS and HIV heterosexually acquired cases (Figure 25). The annual number of AIDS cases among persons with heterosexual contact increased sharply from 1985 through the mid 1990’s for both males and females. Since 1998, there has been a steady decline among both male and female heterosexual AIDS cases through 2003 with a slight increase observed in 2005. Gradual declines are also observed among the number of reported male and female HIV heterosexual cases since 1998.

Figure 25. Reported AIDS (1981-2005) and HIV (1998-2005) cases with a heterosexual risk by sex and year of report, Florida.



Persons At Risk For HIV Infection via Blood Receipt Due To Transfusion or Hemophilia

Less than 1% of all AIDS and HIV cases reported in 2005 were among persons with a blood related risk (data not shown). Early in the epidemic, HIV transmission occurred among persons with hemophilia or among those who received blood or blood products. However, since screening of the blood supply began in 1985, HIV transmissions of this type are very rare. As a result, the percentage of AIDS cases among persons whose risk exposure category was either hemophilia or blood transfusion declined from 5% in the 1980's to less than 1% of the total cases in the 1990's.

Extensive efforts are made by surveillance staff to investigate all transfusion-associated cases occurring after March 1985 (when HIV testing began at all blood banks). Field surveillance staff work with the local blood banks to determine if any donors have since been identified as being HIV-infected. If all donors are contacted and found to be HIV-negative, the transfusion risk is deleted from the HIV/AIDS reporting system (HARS).

Other Risk Factors for HIV

Drug use can play a variety of roles in HIV transmission. The sharing of injection drugs or IDU equipment can directly lead to HIV transmission. In addition, non-injection drugs, including alcohol, can have a disinhibiting effect on individuals that can impair judgment, leading to greater risk taking in sexual behavior. Recent research has suggested that adolescents, who are still in the process of developing their capacities for mature judgment, may be especially prone to riskier behaviors while under the influence of drugs. Dependence on drugs such as heroin, cocaine, crack, and methamphetamine can lead to poverty, homelessness, and other socioeconomic consequences. These consequences may in turn perpetuate the cycle of addiction and lead individuals to increased risk-related behaviors. (Source: NASTAD HIV Prevention Fact Sheet, "People with Multiple Diagnoses at Risk for HIV", www.nastad.org). Drug users are at great risk of heterosexual transmission due to their involvement in high-risk practices, including unprotected sexual intercourse, multiple partners, trading sex for drugs/money, and having sex with an injection drug user. The advent of crack cocaine has exacerbated this drugs/sex relationship with HIV (AIDS and Behavior, Vol. 2, No. 2, 1998).

Documentation of Other Risks

Since April 2000, field surveillance staff have collected additional risk factors for both HIV and AIDS cases. These risks are documented in a local use field in HARS for previously reported cases as well as for newly reported cases. The codes used to document these risk factors in HARS are listed below (Figure 31). Although the collection of other risks does not make it possible to *reclassify* a case at this time, it does provide further insight as to what other risk factors may possibly indicate a true risk for a given sex/race group. HIV/AIDS surveillance staff are encouraged to pay special attention to any documentation of IDU risks among females and to indicate a "NO" to IDU (if documented) risk when reporting the HIV/AIDS case.

Figure 31. Other risk factors collected on HIV/AIDS cases.

If a case has one or more of the following risk factors, it can be documented as:

- A. A history of drug and/or alcohol **abuse**.
- B. A history of **sex with a prostitute** (commercial sex workers or persons who exchange sex for money or drugs).
- C. A history of **prostitution** (commercial sex workers or persons who exchange sex for money or drugs).
- D. A history of one or more **sexually transmitted diseases**.
- E. A History of **Hepatitis** (note: HAV, HBV or HCV in comment section to the right.)
- F. Multiple Heterosexual partners
- G. Possible HIV+ heterosexual partner (thinks partner is positive) (Area 5)
- H. Possible MSM (Area 5)
- J. History of time in Jail or DOC
- M. Mental Health Case (Area 10)
- V. Victim of Sexual Assault

A total of 24,439 male and 13,111 female HIV/AIDS cases have been updated with "other risks" through 2005. This represents nearly 1/4 of all of the reported HIV/AIDS cases. An analysis was conducted by sex and race/ethnicity of cases with a "known risk" who also indicated an "other risk". The results indicated a high probability that certain race/sex groups would be more likely to have a "known" risk if a given "other risk" was indicated in their record.

Key findings suggest that:

1. White or Hispanic men with a history of having a risk for prostitution, an STD, Hepatitis or multiple sex partners were more likely to have an MSM risk.
2. Black men with a history of having a risk for prostitution were more likely to have an MSM risk. However, black men with a history of multiple sex partners were more likely to have a heterosexual risk.
3. White or Hispanic women with a history of alcohol/drug abuse or prostitution were more likely to be IDU, whereas black women with these risks were more likely to have a heterosexual risk.
4. White, black and Hispanic women with a history of STD's or multiple sex partners were more likely to have a heterosexual risk.
5. Black women with any "other risk" were more likely to have a heterosexual risk.

Pediatric HIV/AIDS Cases

Florida ranks second, behind New York, in the number of pediatric AIDS cases reported in 2004 (Table 7). Florida also ranks second in cumulative cases, followed by New Jersey and California. (2005 data not yet available).

Table 7. Reported Pediatric AIDS cases by State.

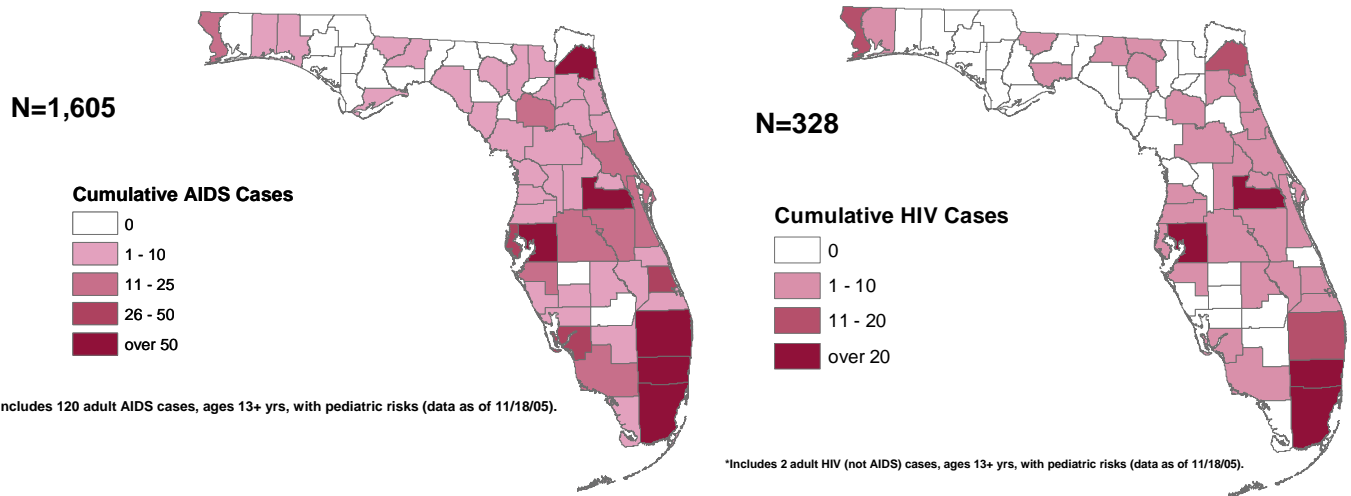
Reporting State	January - December 2004		Cumulative through 12/2004	
	# of Cases	% of Total	# of Cases	% of Total
New York	32	26%	2,356	26%
Florida	22	18%	1,504	17%
New Jersey	6	5%	765	9%
California	12	10%	648	7%
Texas	1	1%	390	4%
Pennsylvania	7	6%	352	4%
Maryland	5	4%	314	4%
Illinois	3	2%	281	3%
Georgia	5	4%	222	2%
Massachusetts	0	0%	210	2%
Connecticut	1	1%	179	2%
Virginia	1	1%	175	2%
District of Columbia	2	2%	180	2%
Remainder of U.S.	25	20%	1,388	15%
Total Cases	122	100%	8,964	100%

*Source: Annual data from CDC slides, Cumulative Data from CDC, HIV/AIDS Surveillance Report, Vol. 16.

Florida reported 1,605 pediatric (<13 years) AIDS cases through 2004, with the majority (64%) of these cases reported from Miami-Dade (N=534), Broward (N=272) and Palm Beach (N=229) counties (Figure 32).

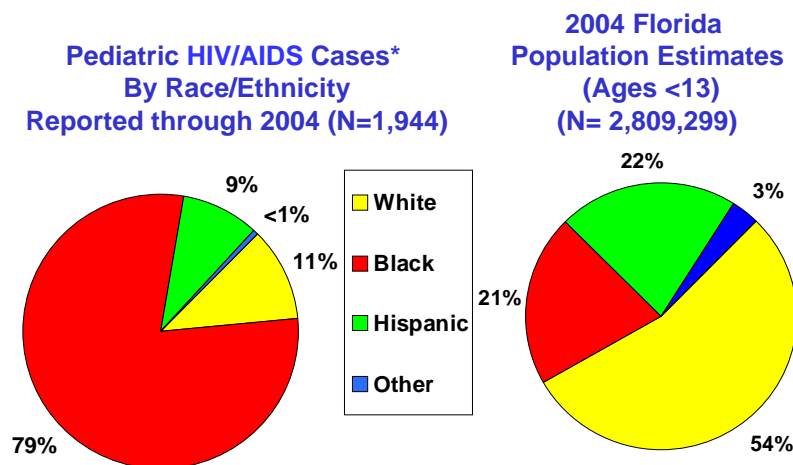
Florida has reported a total of 328 pediatric (infected under 13 years) HIV cases from July 1997 through 2004 (Figure 17). The majority (59%) of these cases were reported from Miami-Dade (N=120), Broward (N=47) and Orange (N=27) counties (Figure 32). Other counties with a high number of reported HIV pediatric cases included: Hillsborough (N=21), Duval (N=16), Escambia (N=15) and Palm Beach (N=14).

Figure 32. Cumulative reported pediatric AIDS and HIV cases by county, Florida, reported through 2004.



were white, 79% were black and 9% were Hispanic. When compared with the general population of persons less than 13 years of age, blacks are disproportionately affected by HIV/AIDS. Although only 21% of children in Florida are black, 80% of children reported with HIV/AIDS through 2004 were black (Figure33).

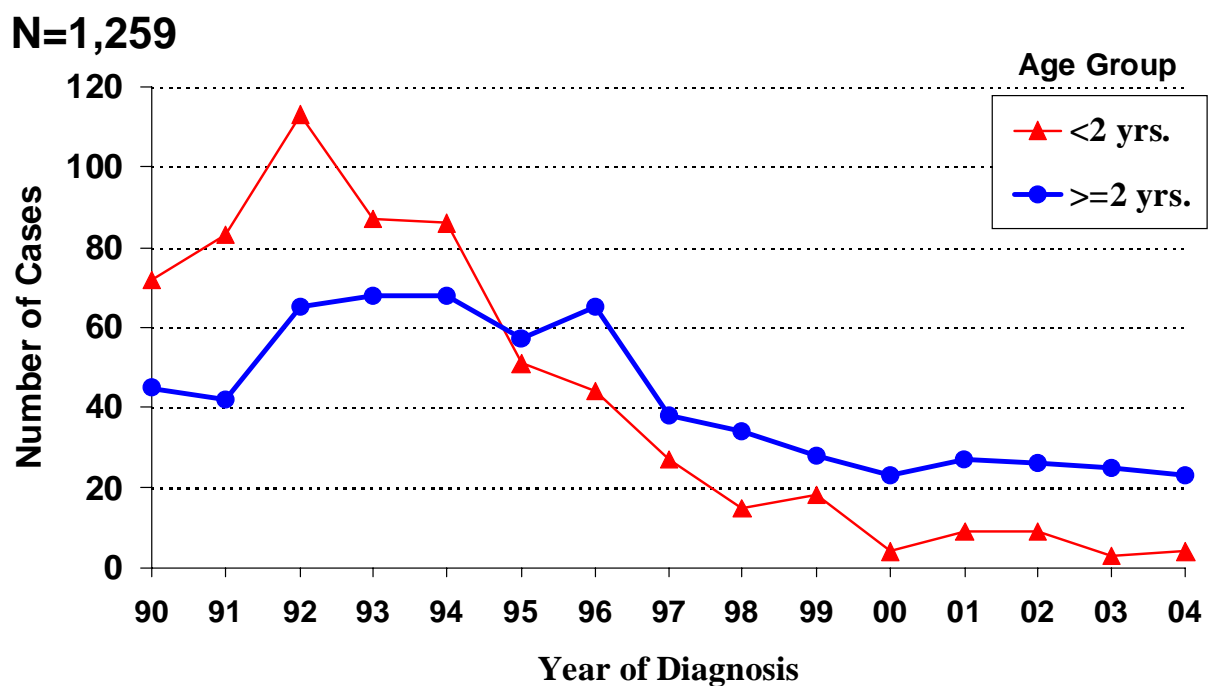
Figure 33. Percent of Pediatric HIV/AIDS cases and percent of population, Florida.



*Include cases in persons aged >12 yrs. at HIV or AIDS diagnosis with a ped risk aged <=12.
2004 data are provisional. 2004 Population Estimates, DOH, Office of Planning, Evaluation and Data Analysis

The incidence of AIDS in children under age two reached a high of 113 cases in 1992; this decreased to only four cases for children under the age of two in 2004 (Figure 34). HIV testing of pregnant women, combined with the introduction of zidovudine (ZDV) to prevent perinatal HIV transmission, has resulted in a 94% reduction in perinatal HIV/AIDS cases in infants born in Florida since 1992. Consequently, it is important for all pregnant women to know their HIV status. This is substantiated by the fact that 95% of the 1,944 pediatric HIV/AIDS cases reported in Florida through 2004 were perinatally acquired. Florida law requires health care providers who attend a pregnant woman to test her for HIV at the initial prenatal care visit and again at 28 – 32 weeks gestation, unless she refuses. Pregnancy Risk Assessment Monitoring System data (PRAMS) indicate that in 2004, 89.6% of pregnant women received an HIV test during pregnancy. Pediatric AIDS cases reported at age two and older have also sharply declined since 1994. The maternal use of antiretroviral treatment to prevent perinatal transmission of HIV, as well as the use of prophylactic medicines in HIV-infected pediatric cases to prevent AIDS opportunistic infections may have contributed to these decreases.

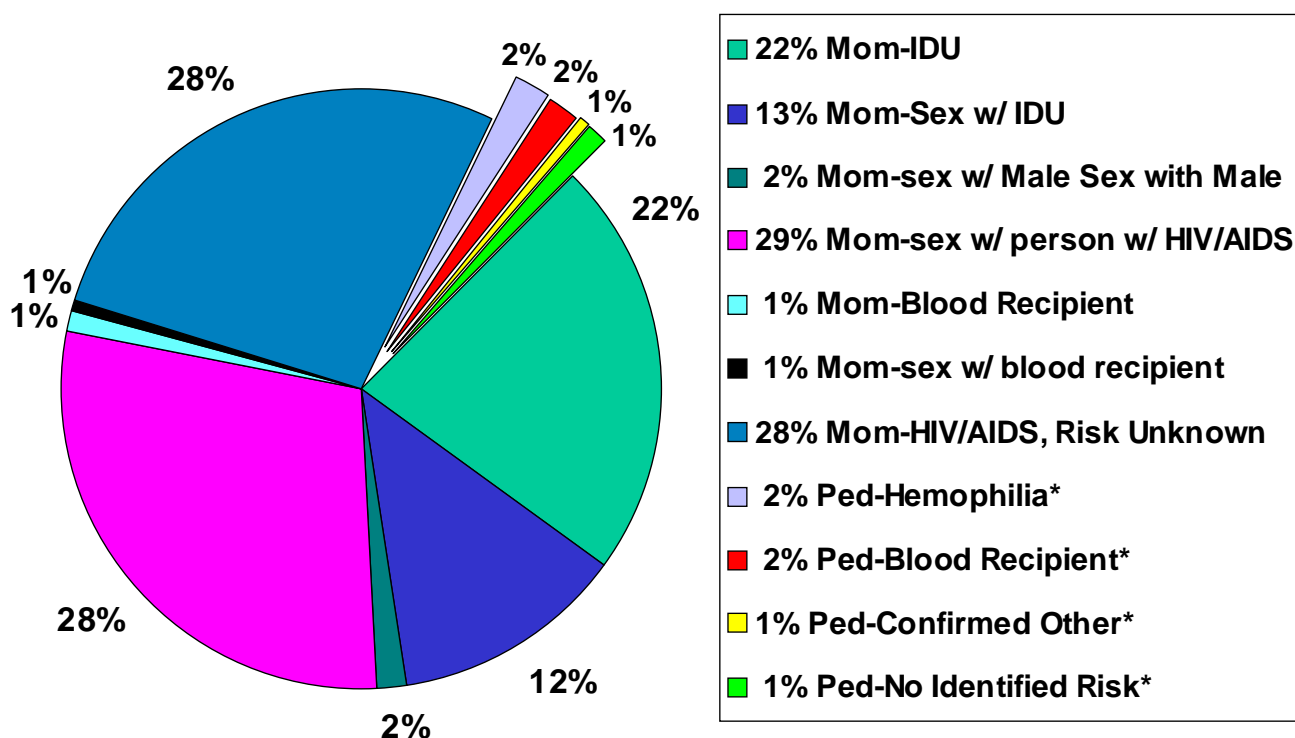
Figure 34. Pediatric AIDS cases by age group and year of diagnosis, Florida, 1990-2004



These data represent a 85% decline in pediatric AIDS cases diagnosed from 1992 (N=178) to 2004 (N=27).
 *Include cases in persons aged >12 yrs. at AIDS diagnosis with a ped risk aged ≤12, (N=123).
 **Due to reporting lags 2004 data are provisional. Data as of 11/18/05

Ninety-five percent of the 1,944 pediatric HIV/AIDS cases reported through 2004 were perinatally acquired (Figure 35). Five percent were related to other confirmed risks, which include hemophilia, transfusion or pediatric sexual abuse cases. The remaining 1% is pending investigation to determine mode of transmission.

Figure 35. Cumulative Pediatric HIV and AIDS Cases By “Expanded” Exposure Category, Florida, Reported through 2004 (N=1,944).



***Note: 5.2% (exploded pieces) are NOT perinatal transmission cases**

Distribution of the mother’s exposure category has changed over time for children who were infected perinatally. In the early 1980’s, many of these women were exposed to HIV through injection drug use or heterosexual contact (Figure 7). From 1989-1992, the risk of injection use decreased as the risk of heterosexual contact continued to increase. A review of data on women who were initially reported with no identified risk and later reclassified, suggests that greater than 80% of women with no identified risk were exposed through heterosexual contact. For more information, please refer to the Pediatric Epidemiologic Profile, 2004, posted on our web site (http://www.doh.state.fl.us/disease_ctrl/aids/trends/epiprof/epiprofpeds2004.pdf) On our web site under trends and statistics, you will also find a pediatric slide set for 2004 under slides and a fact sheet under fact sheets.

HIV/AIDS Among Adolescents and Young Adults (Age 13-24)

(Note: HIV data is represented as regardless of AIDS status unless stated otherwise.)

In the three-year period of 2003-2005, there were 663 AIDS cases among those ages 13-24 years. For HIV, those ages 13-24 years accounted for 2,332 cases. The greatest impact of HIV/AIDS on persons age 13-24 is among minorities. Blacks accounted for 71% of the AIDS cases and 64% of HIV cases reported 2003-2005 (Table 8).

From 2003-2005 the distribution by sex for persons ages 13-24 differs from that of other age groups. Young women accounted for nearly one-half of the HIV cases. Among the 314 male AIDS and 1,302 male HIV cases in this age group, 69% of males with AIDS and 76% of males with HIV had a male sex with male (MSM) risk. Eighteen percent of males with AIDS and 15% with HIV had a heterosexual risk and 4% of both AIDS and HIV had an injecting drug use (IDU) risk. Among 349 female AIDS and 1,030 HIV cases in this age group, 81% of females with AIDS and 95% with HIV were associated with heterosexual contact and 9% of AIDS and 4% of HIV had an IDU risk.

Table 8. AIDS and HIV cases among adolescents and young adults age 13-24, by sex, race/ethnicity and mode of exposure category, Florida, 2003-2005.

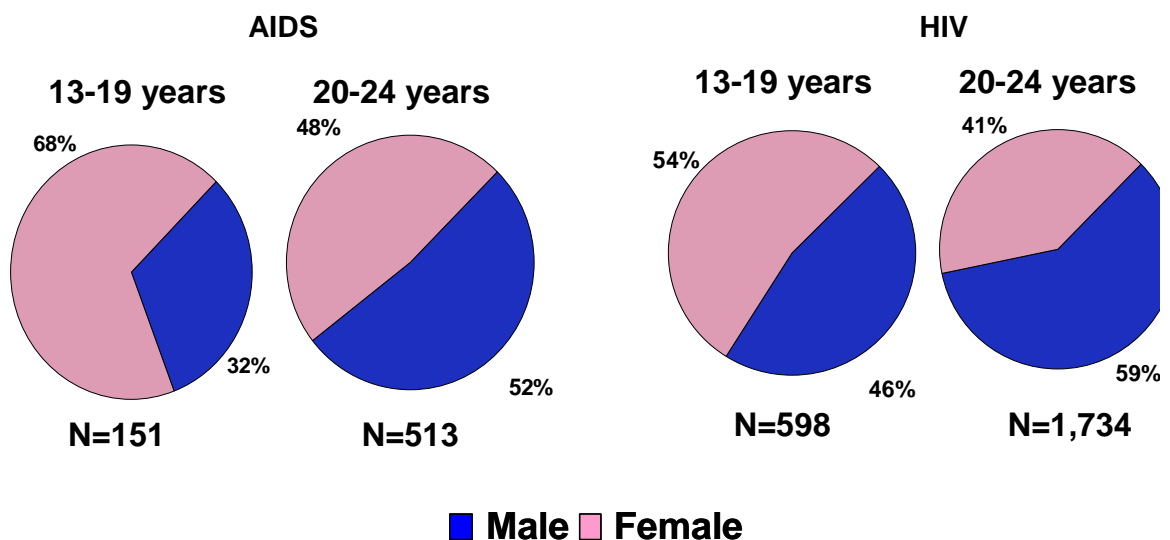
	AIDS						HIV					
	Men		Women		Total		Men		Women		Total	
Race/ethnicity	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
White	53	17%	39	11%	92	14%	326	25%	145	14%	454	19%
Black	195	62%	278	80%	473	71%	681	52%	766	74%	1484	64%
Hispanic	60	19%	25	7%	85	13%	271	21%	113	11%	391	17%
Other	6	2%	8	2%	14	2%	24	2%	6	1%	30	1%
Age Group of Dx												
13-19	48	15%	103	30%	151	23%	278	21%	320	31%	598	26%
20-24	266	85%	247	71%	513	77%	1,024	79%	710	69%	1734	74%
Exposure Category												
MSM	218	69%	0	0%	218	33%	989	76%	0	0%	989	42%
IDU	11	4%	30	9%	41	6%	56	4%	46	4%	102	4%
MSM/IDU	9	3%	0	0%	9	1%	63	5%	0	0%	63	3%
Heterosexual Contact	57	18%	282	81%	339	51%	193	15%	978	95%	1171	50%
Other	19	6%	37	11%	56	8%	1	0%	6	1%	7	0%
Total	314		349		663		1,302		1,030		2,332	

Adjustments have been made to redistribute NIR cases.

In Florida, the male-to-female ratio of persons diagnosed with AIDS varies by age group at diagnosis. Among all adult AIDS cases (age 13 and over) in 2005, 27% were female. Of the AIDS cases reported from 2003-2005, females represented 68% of the AIDS among adolescents ages 13-19, and 48% among young adults ages 20-24 (Figure 36).

Similar to AIDS cases reported during 2003-2005, females made up the greatest percentage (54%) of HIV cases reported among 13-19 year olds (Figure 37). During this same time period, females represented (41%) of HIV cases among the 20-24 year olds reported in Florida.

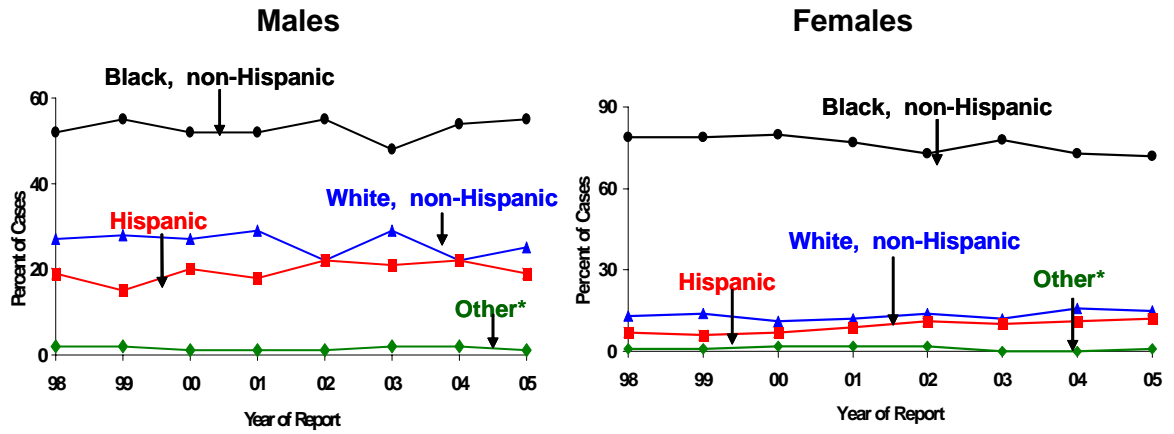
Figure 36. AIDS and HIV cases in adolescents and young adults, by sex and age at diagnosis, Florida, 2003-2005.



HIV data includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually exclusive.

males and females ages 13-24 (Figure 38). The percent of black males with HIV in this age group remained about the same from 1998 (52%) to 2005 (55%). while the proportion of whites decreased and the Hispanics increased. The proportion of young black females with HIV decreased from 1998 to 2005, while increases were observed among both whites and Hispanics. The disproportionate impact of HIV/AIDS on blacks is more evident among adolescents than it is among young adults (data not shown). Of the adolescent and young adult AIDS cases reported during 2003-2005, the percentage of cases among blacks was highest in the 13-19 year olds (77%). The percentage of whites and Hispanics increased with each age group. The statewide AIDS case data suggest that adolescents and young adults – in particular, minority heterosexual youth – warrant special attention concerning targeted HIV prevention efforts.

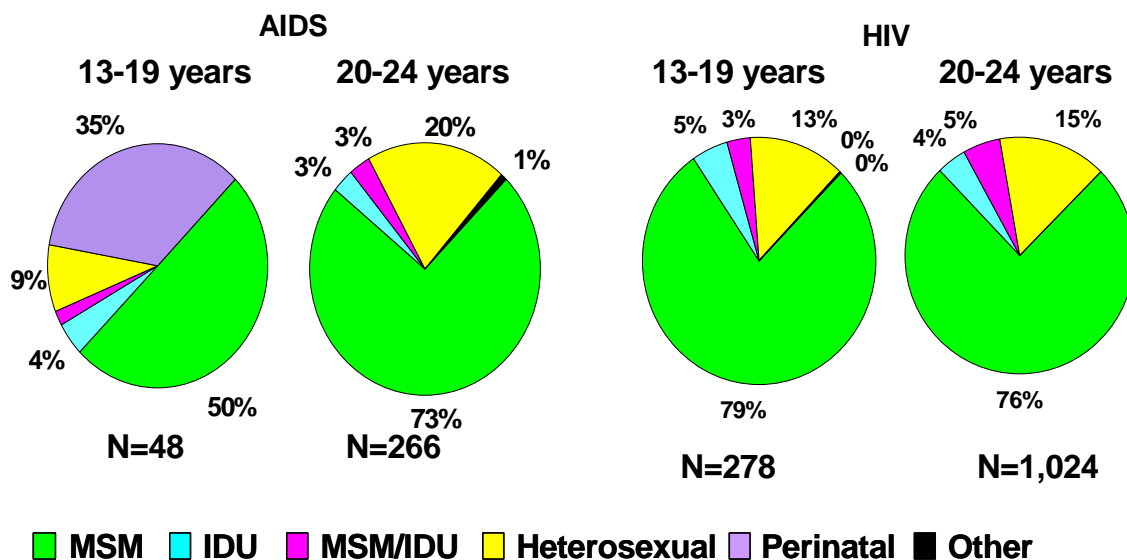
Figure 38. Percent distribution of Adult HIV cases, ages 13-24, by race/ethnicity, year of report and sex, Florida, 1998-2005.



*Other includes Asian/Pacific Islander, Native American/Alaska Native, and Other races.

HIV transmission among MSM was higher among adolescents (79%) compared to (50%) for AIDS cases reported 2003-2005 (Figure 40). Similarly, the proportion of male AIDS cases reported with a heterosexual risk was lower among adolescents (9%) compared to young adults (20%). However, a significant proportion (35%) of AIDS cases in the 13-19 age group was reported with a perinatal risk. There is also little difference between the two age groups for HIV cases for MSM, heterosexual and IDU modes of exposure.

Figure 40. Male AIDS and HIV cases among adolescents and young adults, by mode of exposure and age at diagnosis, Florida, 2003-2005.

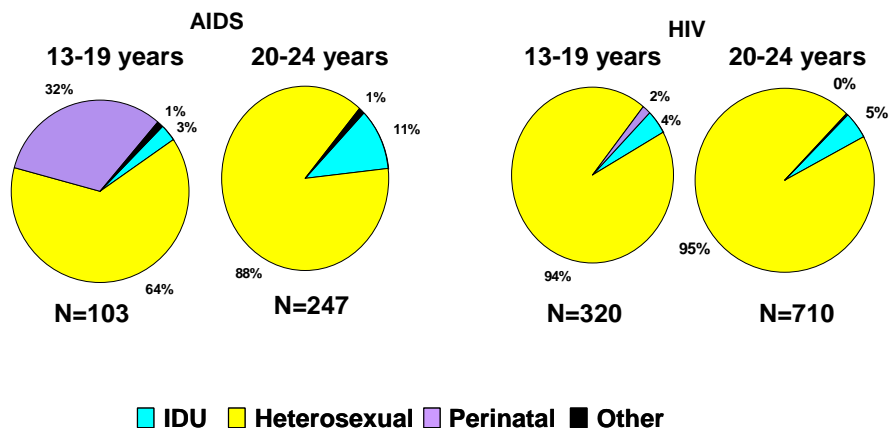


HIV data includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually exclusive.

Note: NIRs redistributed.

Heterosexual transmission is reported as a risk for over 60% of AIDS cases reported in adolescents and young women (Figure 41). As with AIDS cases, the vast majority of adolescent and young adult women reported with HIV infection, identified heterosexual transmission as a risk. Perinatal transmission accounted for 32% of the AIDS cases and 2% of the HIV cases among 13-19 year-old females.

Figure 41. Female AIDS and HIV cases among adolescents and young adults, by mode of exposure and age at diagnosis, Florida, 2003-2005.



HIV data includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually exclusive.

Note: NIRs redistributed.

Among the total cases of HIV and AIDS (age 13-24) reported through 2005, and presumed living, 72% are black and 78% are women (Table 9). Among men, 75% of the cases are between the ages of 20-24. The primary modes of exposure for men were MSM (58%) followed by Pediatric risk (24%). Among females, 71% of the cases are between the ages of 20-24. Heterosexual contact was the main mode of transmission (71%) while the Pediatric risk was 25%.

Table 9. Presumed alive adolescent HIV/AIDS cases, Florida, through 2005.

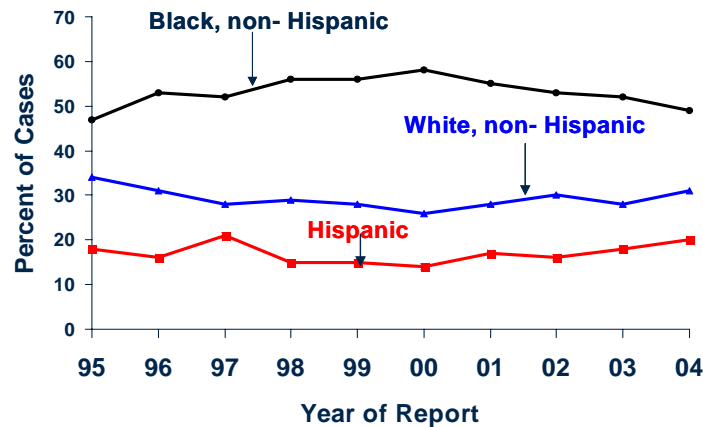
	AIDS/HIV					
	Men		Women		Total	
Race/Ethnicity	No.	Percent	No.	Percent	No.	Percent
White	228	17%	182	12%	410	14%
Black	869	64%	1,233	78%	2,102	72%
Hispanic	238	18%	147	9%	385	13%
Other	15	1%	18	1%	33	1%
Current Age Group						
13-19	339	25%	462	29%	801	27%
20-24	1,011	75%	1,118	71%	2,129	73%
Exposure Category						
MSM	777	58%	0	0%	777	27%
IDU	33	2%	54	3%	87	3%
MSM/IDU	35	3%	0	0%	35	1%
Heterosexual Contact	166	12%	1126	71%	1,292	44%
Pediatric Risk	329	24%	391	25%	720	25%
Other confirmed Risk	11	1%	9	1%	19	1%
Total	1,350		1,580		2,930	
Adjustments have been made to redistribute NIR cases.						

Persons Aged 50 and over

Distribution of AIDS and HIV cases among persons age 50+ by race/ethnicity and gender

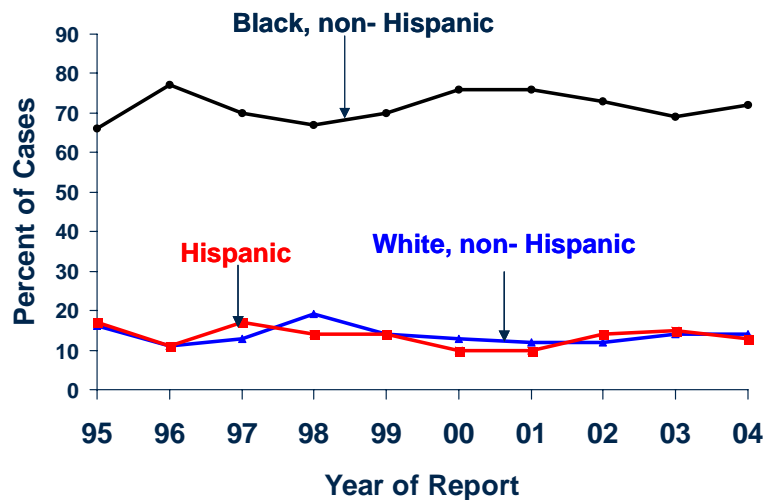
The proportion of black male AIDS cases ages 50 and older increased slightly from 47% in 1995 to 49% in 2004, while cases among whites decreased from 34% to 31%. The percentage of cases among Hispanics has remained fairly stable throughout the years with the exception of a noticeable increase in 1997 and 2004 (Figure 43).

Figure 43. Percent distribution of adult male AIDS cases among persons aged 50+, by race/ethnicity and year of report, Florida, 1995-2004.



Black females ages 50 and older have shown an increase during the time period 1995-2004, from 66% to 72%. White decreased from 16% to 14%. Hispanic females decreased slightly from 17% to 13% (Figure 44).

Figure 44. Percent distribution of adult female AIDS cases among persons aged 50+, by race/ethnicity and year of report, Florida, 1995-2004.



Distribution of AIDS and HIV cases among persons age 50+ by age of diagnosis

Table 10 shows a generally increasing trend of the proportion of cases AIDS cases among persons age 50+ from the early 1990s through 2004, from 12.2% to 20.0%, but decrease slightly to 18% in 2003. This trend reveals an aging of the epidemic over time. This would be consistent with the observation that HAART, which was introduced in 1996, has tended to forestall the development of AIDS in the HIV-infected population. The data also underscores the need for persons age 50+ to be targeted through outreach programs for prevention of further transmission of HIV. Special targeting of those aged 30-49 may be indicated as many of those over 50 may have been infected in this age group.

Table 10. Annual percent of total of reported AIDS cases, by age group, Florida, 1993-2004.

Year	Age 13-39		Age 40-49		Age 50+		Total	
	Cases	% Total	Cases	% Total	Cases	% Total	Cases	% Total
93*	6,518	64.0%	2,421	23.8%	1,244	12.2%	10,183	100%
94	5,124	62.5%	2,016	24.6%	1,060	12.9%	8,200	100%
95	4,842	61.6%	1,962	25.0%	1,055	13.4%	7,859	100%
96	4,236	59.9%	1,878	26.5%	956	13.5%	7,070	100%
97	3,377	58.1%	1,617	27.8%	819	14.1%	5,813	100%
98	2,896	54.2%	1,596	29.9%	847	15.8%	5,339	100%
99	2,862	54.0%	1,620	30.6%	819	15.4%	5,301	100%
00	2,580	52.4%	1,530	31.1%	816	16.6%	4,926	100%
01	2,507	50.2%	1,666	33.4%	821	16.4%	4,994	100%
02	2,398	47.8%	1,651	33.0%	969	19.3%	5,018	100%
03	2,221	46.0%	1,729	36.0%	880	18.0%	4,830	100%
04	2,532	44.0%	2,071	36.0%	1,194	20.0%	5,797	100%

*The AIDS surveillance case definition was expanded for adults/adolescents in 1993.

Of the 30,866 adult AIDS cases reported in Florida from 1999-2004, 5,499 (18%) were aged 50 years or older. AIDS and HIV cases were similar by race for males and by race for females (Table 11). Among male HIV and AIDS cases, more than half were black, and more than one-third were white. Among females, nearly three-fourths of the HIV and AIDS cases were black and only one-eighth was white. A little more than three-fourths of both the HIV and AIDS cases among both men and women were aged 50-59. The remaining one-fourth was aged 60 and older.

Prevalence of HIV/AIDS among persons age 50+

(Adjustments have been made to redistribute NIR cases.)

Of the 18,812 presumed living cases of HIV and AIDS among persons age 50+ reported through 2004, (Table 12) 75% are male, 73% are between the ages of 50-59, and 53% are black. The percent of cases by race and sex differ greatly. Almost one-half of the males age 50 and older were black and more than one-third were white. Among females aged 50 older, nearly three-fourth were black and almost one-eighth were white.

With the NIRs redistributed, 48% of the male cases were reported as MSM, followed by heterosexual contact (29%), and IDU (18%). More than 80% of the female cases were reported with heterosexual contact and 11% were IDU.

Table 12. Presumed alive HIV/AIDS cases among persons age 50+, Florida, through 2004*.

	HIV/AIDS					
	Men		Women		Total	
Race/Ethnicity	No.	Percent	No.	Percent	No.	Percent
White	4,778	35%	688	15%	5,466	30%
Black	6,468	47%	3,155	70%	9,623	53%
Hispanic	2,450	18%	621	14%	3,071	17%
Other	116	1%	42	1%	158	1%
Age Group						
50-59	10,042	73%	3,309	73%	13,351	73%
60-69	2,958	21%	918	20%	3,876	21%
70+	812	6%	279	6%	1,091	6%
Exposure Category						
MSM	6697	48%	0	0%	6,697	37%
IDU	2432	18%	822	18%	3,254	18%
MSM/IDU	638	5%	0	0%	638	3%
Heterosexual Contact	3982	29%	3636	81%	7,617	42%
Other Confirmed Risk	64	0%	48	1%	112	1%
Total	13,812		4,506		18,318	
Adjustments have been made to redistribute NIR cases.						

For additional information, please refer to the seniors slide presentation for 2004, posted on our website (http://www.doh.state.fl.us/disease_ctrl/aids/trends/slides/seniors_2004.ppt)

Impact of HIV-related deaths

As of December 31, 2005, a total of 101,013 AIDS cases were known to have been diagnosed in Florida through 2005. Some cases are lost to follow-up, so vital status is unknown. Of these cumulative cases, 53,994 (54%) were known to have died (Table 13).

Table 13. AIDS cases and deaths by year of diagnosis, Florida, 1980-2005.

Year of Diagnosis	Cases	Number Dead	Percent Dead
Before 1980	1	1	100.0%
1980	9	9	100.0%
1981	26	25	96.2%
1982	97	82	84.5%
1983	245	226	92.2%
1984	470	434	92.3%
1985	953	879	92.2%
1986	1,427	1,332	93.3%
1987	2,388	2,217	92.8%
1988	3,200	2,942	91.9%
1989	4,005	3,631	90.7%
1990	4,596	4,044	88.0%
1991	5,736	4,996	87.1%
1992	7,587	6,241	82.3%
1993	7,561	5,641	74.6%
1994	7,395	4,861	65.7%
1995	7,060	3,730	52.8%
1996	6,473	2,752	42.5%
1997	5,424	2,125	39.2%
1998	4,963	1,747	35.2%
1999	4,663	1,419	30.4%
2000	4,619	1,323	28.6%
2001	4,563	989	21.7%
2002	4,352	857	19.7%
2003	4,597	732	15.9%
2004	5,161	558	10.8%
2005	3,442	201	5.8%
Total	101,013	53,994	53.5%

Data as of 12/31/05

NOTE: Due to reporting delays, data are incomplete for more recent years.

Deaths are assigned to the year in which the case was diagnosed, regardless of the year in which the death occurred.

HIV/AIDS deaths decreased markedly from 1996-1998, associated with the advent of HAART in 1996. Deaths in 2004 were 60% lower than in the peak year, 1995. A leveling of the trend since 1998 may reflect factors such as viral resistance, late diagnosis of HIV, adherence problems, and lack of access to or acceptance of care (Figure 45). Racial/ethnic disparities are evident in the death rate data.

From 1995 to 1996, the first time in the HIV epidemic, there was a dramatic 29% decrease in resident HIV deaths (as determined from death certificates coded ICD-9 042-044) (Figure 18). From 1996 to 1997, a 39% decrease represented an accelerated decline. From 1997 to 1998 there was an 18% decrease. Changes in the annual number of deaths were observed among all race/ethnic/sex groups between the years of 2000 and 2004 (Table 14).

Since 1998, the number of reported HIV resident deaths has remained fairly stable with minor fluctuations each year. In 1999, there was a 7% increase in the number of resident HIV deaths. This partially reflects a broadening of the way HIV-related deaths are defined due to the changeover from ICD-9 to ICD-10 mortality coding rules, effective, 1/1/99. This change resulted in an estimated 14% greater number of HIV-related deaths in 1999 and in 2000 than would otherwise have been recorded. In 2003 there was a 2% increase. Factors that may contribute to the increase include lack of access to and acceptance of effective treatments, adherence to medication regimens, viral resistance, late diagnosis of HIV infection, and new patterns of secondary disease.

As previously mentioned, it is believed that new medications and treatment options, which began to be widely available in 1996, played a major role in the dramatic overall drop in resident HIV deaths. A second factor is thought to be HIV prevention measures that were adopted in the mid- to late-1980s, particularly among white and Hispanic MSM.

Figure 45. Resident HIV deaths, by year of death, Florida, 1993–2004.

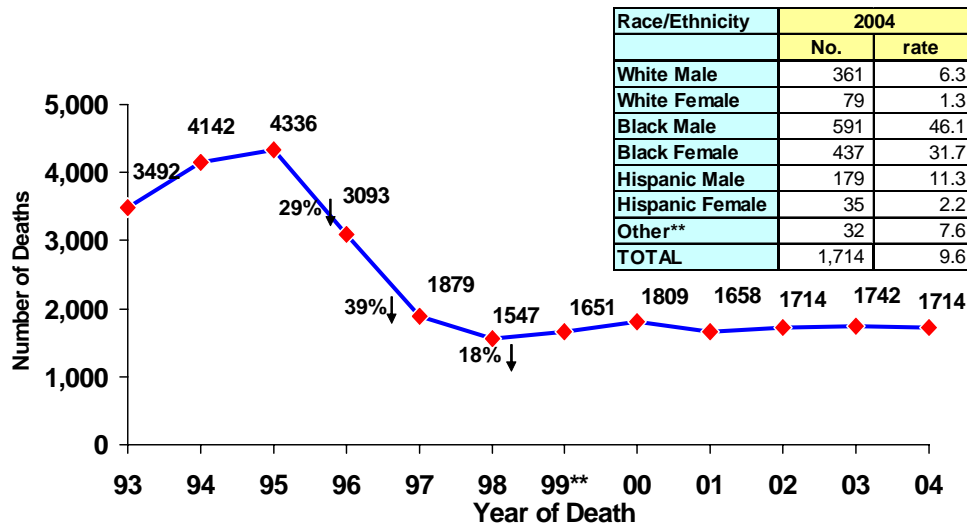


Table 14. Number of resident HIV deaths and rate per 100,000 population, by year of death, sex and race/ethnicity, Florida, 2000–2004.

Race/Ethnicity and Sex	2000		2001		2002		2003		2004	
	No.	% of total	No.	% of total	No.	% of total	No.	% of total	No.	% of total
White Male	477	26%	405	24%	366	21%	384	22%	361	21%
White Female	92	5%	75	5%	75	4%	71	4%	79	5%
Black Male	617	34%	596	36%	654	38%	619	36%	591	34%
Black Female	427	24%	408	25%	438	26%	419	24%	437	25%
Hispanic Male	157	9%	138	8%	113	7%	181	10%	179	10%
Hispanic Female	36	2%	31	2%	40	2%	26	1%	35	2%
Other**	3	0%	5	0%	28	2%	42	2%	32	2%
TOTAL	1,809	100%	1,658	100%	1,714	100%	1,742	100%	1,714	100%

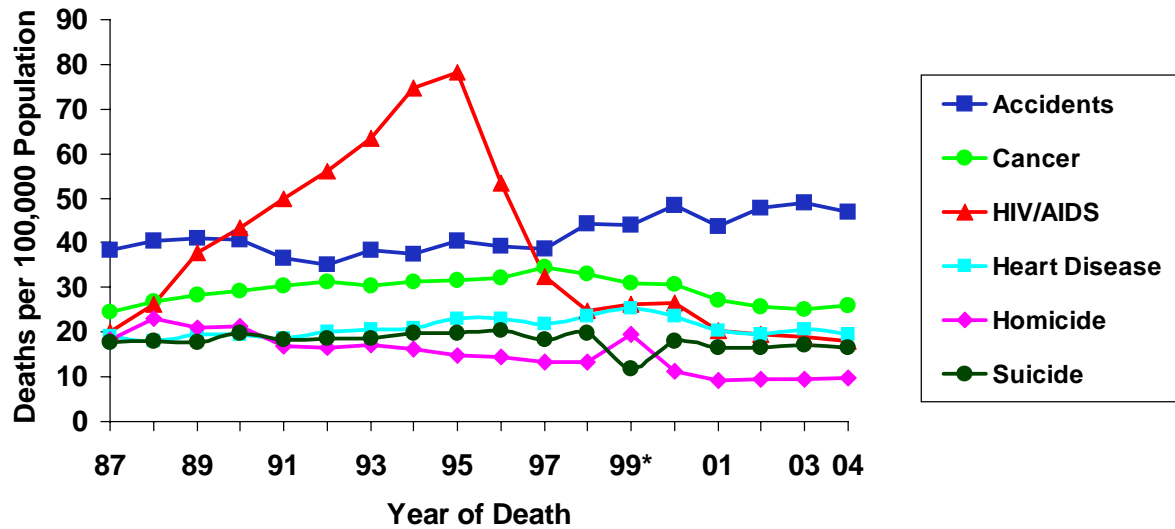
*2000, 2001 & 2002 rates based on 2000 Census Population, 2003 & 2004 rates based on same year Florida population estimates.

**Other includes persons of other/unknown race and non-Hispanic origin or sex.

Florida Department of Health, Office of Vital Statistics and Bureau of HIV/AIDS

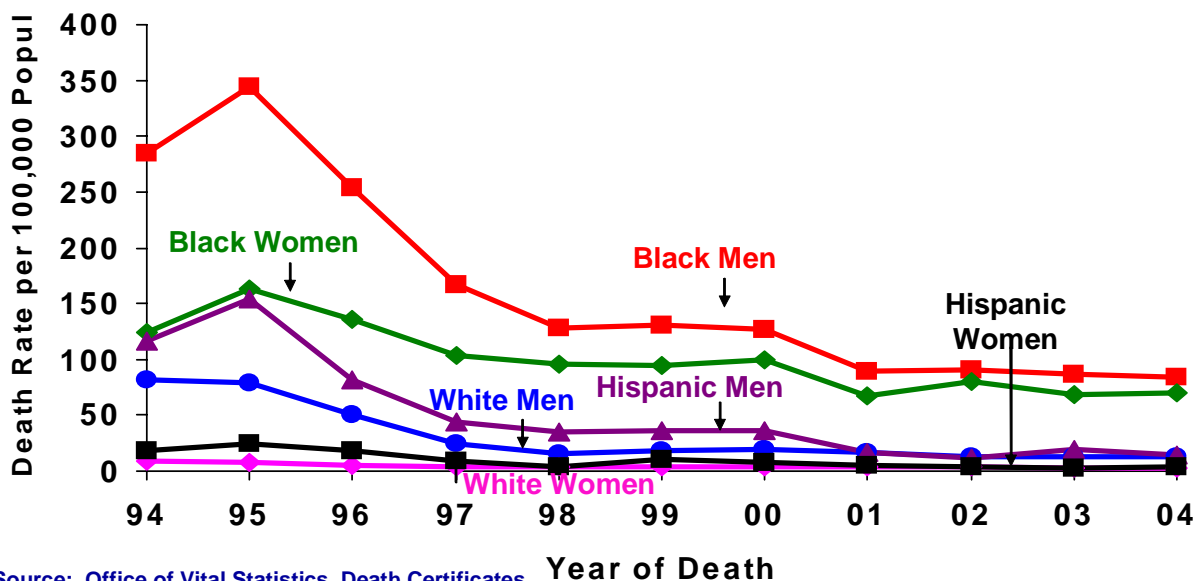
From 1990 to 1995, HIV was the leading cause of death among all Floridians aged 25-44 years (Figure 46). In 1997, HIV became the third leading cause of death in this age group, behind unintentional injuries and cancer, and remained so until 2001 when it dropped to the fourth leading cause of death. However, HIV still remained the leading cause of death among black males and black females in this age group in 2004. Death rates per 100,000 population, by race/ethnicity and sex, over the past nine years are shown in (Figure 47).

Figure 46. Death rates per 100,000 population, from leading causes of death in persons aged 25-44 years, by year of death, Florida, 1987–2004.



Source: Office of Vital Statistics, Death Certificates
 1987-1999 rates based on 1990 Census population; 2000-present rates based on 2000 Census
 *A change in coding of HIV/AIDS deaths from ICD-9 to ICD-10, effective in 1999, has resulted in an estimated increase of approximately 14% in the annual number of HIV/AIDS deaths.

Figure 47. Resident HIV death rates per 100,000 population, in persons aged 25-44 years, by sex and race/ethnicity, Florida, 1994–2004



Source: Office of Vital Statistics, Death Certificates
 1987-1999 rates based on 1990 Census population; 2000-present rates based on 2000 Census
 *A change in coding of HIV/AIDS deaths from ICD-9 to ICD-10, effective in 1999, has resulted in an estimated increase of approximately 14% in the annual number of HIV/AIDS deaths.



Prevalence Of HIV/AIDS

In accordance with CDC’s initiative for prevention for positives, our prevalence section has been expanded here to provide a more complete picture of the current epidemic in Florida. Assessment of the extent of the HIV epidemic is an important step in community planning for HIV prevention and HIV/AIDS patient care. HIV prevalence—the estimated number of persons living with HIV infection—includes those living with a diagnosis of HIV or AIDS and those who may be infected but who are unaware of their serostatus.

Approximately 1,039,000–1,185,000 persons are living with HIV infection in the United States (2004). Florida has consistently reported 10–12% of the national AIDS morbidity and currently accounts for 11% of all persons living with AIDS in the U.S (See Table 15 for the demographic and mode of exposure comparison). The Department of Health now estimates that approximately 125,000 persons, or roughly 11.7% of the national total, are currently living with HIV infection in Florida through 2005. Table 16 shows PLWHAs for Florida, by demographic and mode of exposure groups with a footnote about estimating HIV prevalence.

Table 15. Persons living with AIDS (PLWAs), U.S. and Florida, through 2005.

Subgroup	U.S. N=362,260	Florida N=42,070
Male	78%	72%
Female	22%	28%
White	37%	33%
Black	42%	48%
Hispanic	20%	18%
Other	1%	1%
MSM	45%	43%
IDU	27%	14%
MSM/IDU	6%	4%
Heterosexual	20%	37%
Other	3%	2%

*Source: U.S. Data: CDC, HIV/AIDS Surv. Report, 2004;9(No. _);

Florida Data: HARS, alive and reported through 2005, as of 04/05/06.

Note: NIRs redistributed. M:F ratio: U.S., 3.5:1. Fla., 2.5:1.

Table 16. Reported people living with HIV/AIDS by race/ethnicity, exposure category and sex, and age, Florida, as of 12/31/2005.

THESE DATA ARE ESTIMATES OF PLWHAs, ADJUSTED FOR UNREPORTED & UNDIAGNOSED CASES
HIV Seroprevalence Estimates, Florida, 2005

Race/Ethnicity	Males	% of Males	Females	% of Females	Total	% of Total
White, Non-Hispanic	30,960	36%	6,170	16%	37,130	30%
Black, Non-Hispanic	36,428	42%	27,618	71%	64,046	51%
Hispanic	17,573	20%	4,718	12%	22,291	18%
Other	1,015	1%	519	1%	1,534	1%
Total	85,975	100%	39,025	100%	125,001	100%

Mode of Exposure	Males	% of Males	Females	% of Females	Total	% of Total
Male Sex With Male (MSM)	51,455	60%	N/A	N/A	51,455	41%
Injecting Drug User (IDU)	9,634	11%	6,230	16%	15,864	13%
MSM/IDU	4,854	6%	N/A	N/A	4,854	4%
Heterosexual Contact	18,992	22%	31,632	81%	50,624	40%
Other	244	0%	167	0%	410	0%
Pediatric	797	1%	996	3%	1,793	1%
Total	85,975	100%	39,025	100%	125,000	100%

	Age at Diagnosis		Current Age Group	
	Total	% of Total	Total	% of Total
0-12	1,775	1%	725	1%
13-19	3,538	3%	1,263	1%
20-24	10,275	8%	3,313	3%
25-29	17,113	14%	7,188	6%
30-39	47,700	38%	30,325	24%
40-49	31,013	25%	49,538	40%
50-59	10,263	8%	23,963	19%
60+	3,325	3%	8,688	7%
Total	125,000	100.00%	125,000	100.00%

*Cases with no identified risk (NIRs) have been re-distributed.

The smaller the number of cases in a given subgroup, the greater the uncertainty about the estimated HIV prevalence. Subgroups with fewer than 50 cases would produce extremely unreliable estimates.

Note: Due to rounding, some totals may not completely match

Local Partnership Level

Partnership- or area-specific HIV-prevalence point-estimates (Table 17) may be regarded as being more provisional in nature than the statewide estimates. Estimates based on smaller numbers of reported living HIV/AIDS cases would have broader plausible ranges associated with them. In addition, completeness and timeliness of HIV/AIDS reporting may vary by area; to the extent that reportable cases are missed, the share of the state's total HIV prevalence in a given area may be underestimated. Out-of-state residents who receive in-state, HIV-related services may not be captured by the HIV/AIDS Reporting System (HARS), though they could contribute to the community's burden of HIV prevalence. Inter-area movement and migration out of state by HIV-infected persons could also be factors whose precise impact on local HIV prevalence and services may be difficult to assess.

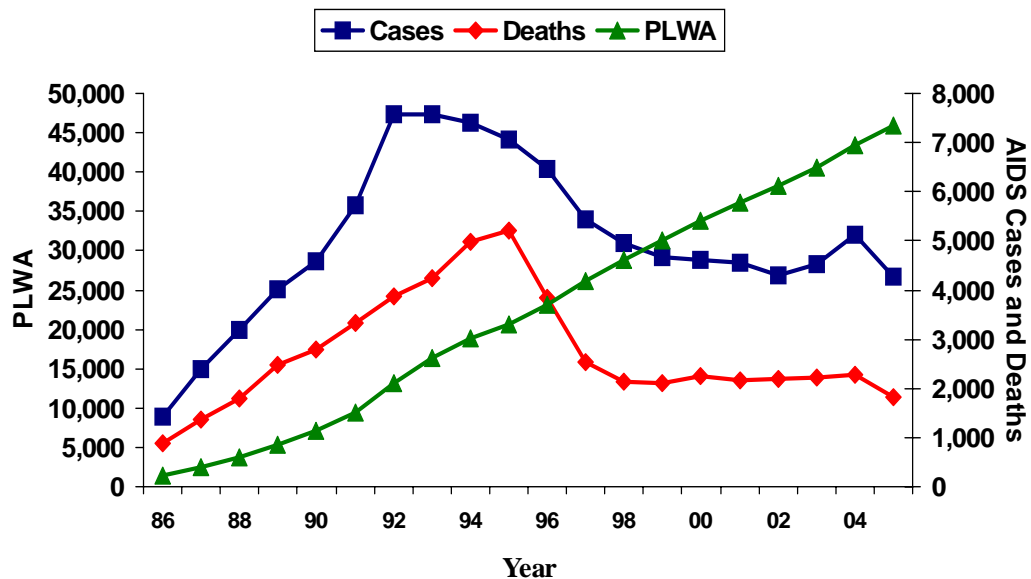
Table 17. Provisional HIV prevalence estimates by partnership area, Florida, 2005.

Partnership	NUMBER & PERCENT OF HIV/AIDS CASES		ESTIMATED HIV PREVALENCE
	TOTAL	PERCENT	
1	1,210	1.5%	1,921
2a	403	0.5%	640
2b	922	1.2%	1,464
3	1,152	1.5%	1,829
4	4,538	5.8%	7,204
5	3,321	4.2%	5,272
6	5,465	6.9%	8,676
7	7,453	9.5%	11,832
8	2,896	3.7%	4,597
9	6,867	8.7%	10,901
10	12,877	16.4%	20,442
11a	21,616	27.5%	34,315
11b	655	0.8%	1,040
12	1,121	1.4%	1,780
13	947	1.2%	1,503
14	1,427	1.8%	2,265
15	1,831	2.3%	2,907
Areas 1-15	74,701	94.9%	118,587
DOC	4,040	5.1%	6,413
STATE	78,741	100.0%	125,000

AIDS Incidence, Mortality and Prevalence

Since the epidemic began, the number of new cases reported each year has exceeded the number of deaths (Figure 48). The expansion of the AIDS case definition in 1993 created a large increase in the number of reported AIDS cases. Declines in reported AIDS cases and deaths are primarily due to the success of antiretroviral therapies introduced in 1996 that delay disease progression and prolong life. This graph tells 3 stories. PLWAs are also called “AIDS prevalence”, and are equal to cumulative (total) AIDS cases less cumulative (total) AIDS deaths, at any given point in time. Whenever AIDS cases exceed AIDS deaths, AIDS prevalence increases. Through 2005, there were a total of 45,869 reported PLWAs in Florida. In general, similar trends in AIDS cases, deaths and prevalence have been observed throughout the U.S. Data as of 03/06.

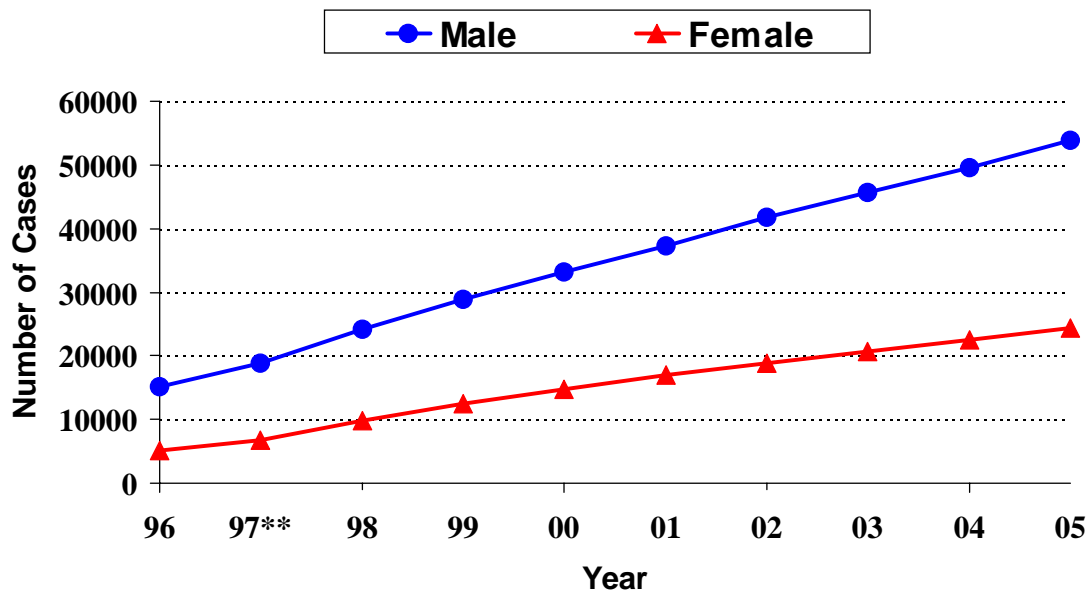
Figure 48. AIDS cases, AIDS case deaths and AIDS case prevalence, by year, 1986–2005, Florida.



*AIDS cases by year of diagnosis. AIDS case deaths by year of death. AIDS case deaths are individuals reported in HARS with AIDS whose status is now dead. They may or may not have died of AIDS-related illness.
 **The AIDS surveillance case definition was expanded for adults/adolescents in 1993.
 Data as of 04/05/06.

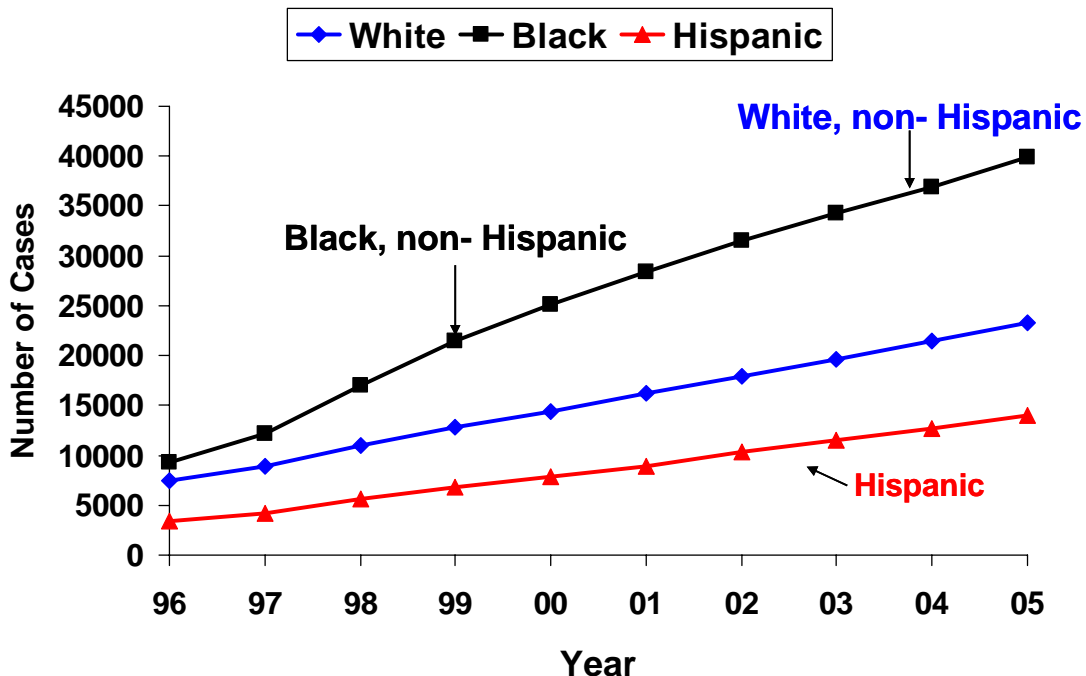
The number of living persons reported with HIV/AIDS (prevalence) has continually increased. The number of HIV/AIDS cases presumed to be alive at the end of 2005 was nearly 80,000. Although increases are seen among both men and women, women account for an increasing proportion of persons living with AIDS. In 2005, women accounted for 31% of person living with AIDS, compared with 25% in 1996 (Figure 49).

Figure 49. Prevalence of Adult HIV/AIDS cases by sex, by year of diagnosis, 1996–2004, Florida.



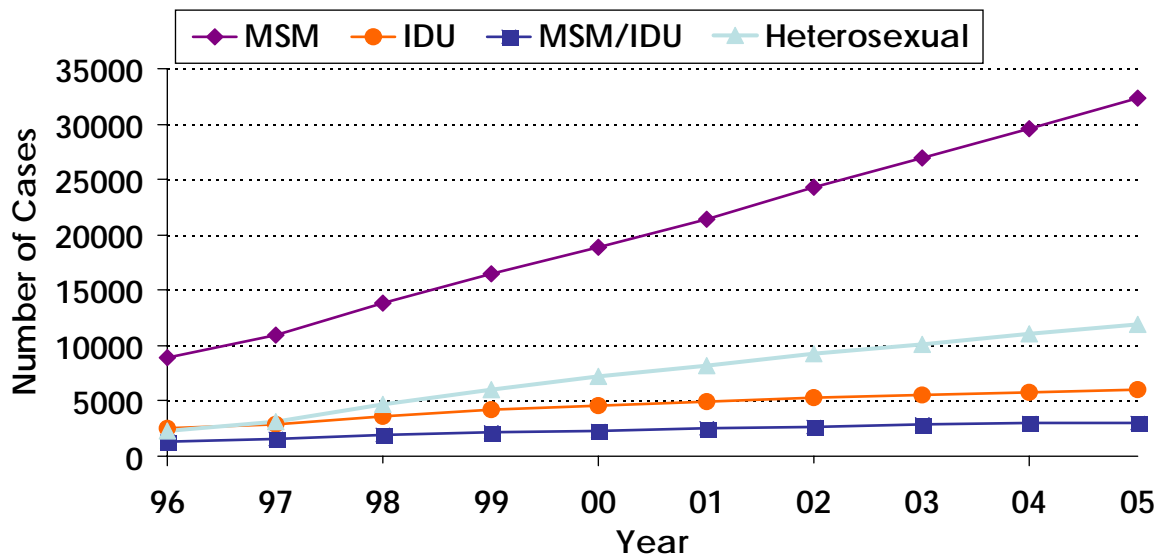
The proportional distribution by race/ethnicity among persons living with HIV/AIDS has changed since 1996 (Figure 50). In 1996, 37% of persons living with AIDS were white and 46% were black, compared with 30% white and 52% black in 2005.

Figure 50. Prevalence of HIV/AIDS cases by race/ethnicity, by year of diagnosis, 1996–2005, Florida.



PLWHA's represent those in need of care and secondary prevention initiatives to prevent further transmission. The increase in number of PLWHA's is due to a combination of factors: survival time is increasing, those recently reported are more likely to be alive, and the annual number of persons reported with HIV or AIDS exceeds the number of deaths. Among males, MSM is the predominant mode of exposure (Figure 51) and are increasing the fastest. Among females, heterosexual cases are increasing the fastest (Figure 52).

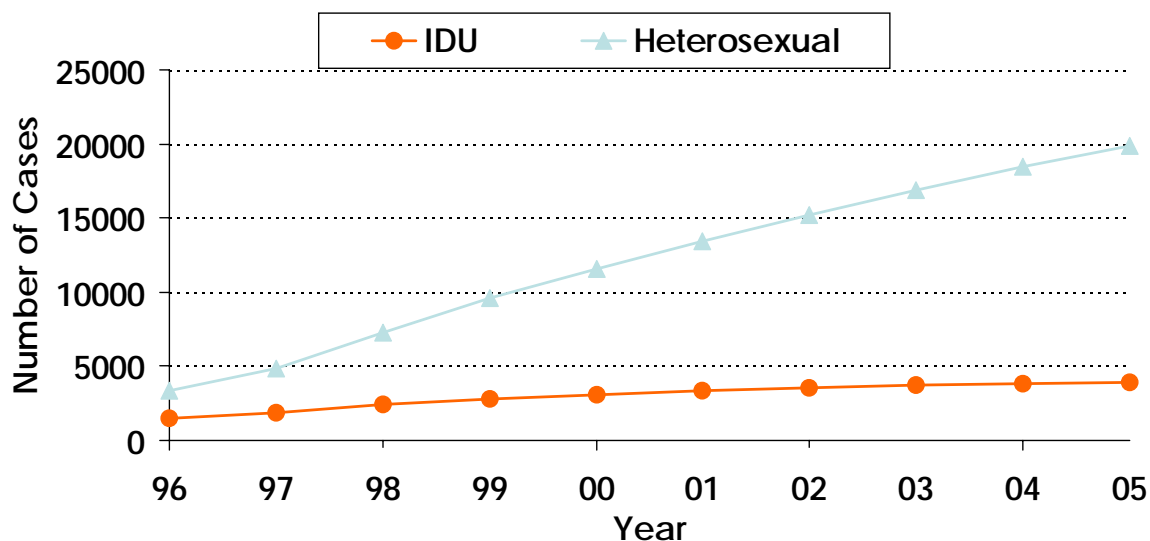
Figure 51. Annual Prevalence of Male HIV/AIDS cases by mode of exposure, by year of diagnosis, 1996–2005, Florida.



**Adjustments have been made to account for the redistribution of cases with no identified risk (NIR).
 MSM= male sex with male; IDU= injection drug use;
 **HIV infection reporting was implemented July 1997.
 Comment: PLWHA's represent those in need of care and secondary prevention initiatives to prevent further transmission. The increase in number of PLWHA's is due to a combination of factors: survival time is increasing, those recently reported are more likely to be alive, and the annual number of persons reported with HIV or AIDS exceeds the number of deaths. MSM is the predominant mode of exposure. MSM cases are increasing the fastest. (data as of 04/05/06).*

Much can be learned by conducting an age analysis of the HIV/AIDS data, as prevention messages appropriate to one group may not work for another. The trends that emerge this way may help contribute to the tailoring and prioritizing of HIV primary and secondary prevention messages and social marketing strategies. Persons living with HIV/AIDS (PLWHAs) by current age represent the current cohort of known HIV-infected persons who are in need of care and secondary prevention to prevent further transmission (prevention for positives), consistent with CDC's Advancing HIV Prevention initiative.

Figure 52. Annual Prevalence of Female HIV/AIDS cases by mode of exposure, by year of diagnosis, 1996–2005, Florida.



***Adjustments have been made to account for the redistribution of cases with no identified risk (NIR). IDU=injection drug use.**

****HIV infection reporting was implemented July 1997.**

Comment: PLWHA's represent those in need of care and secondary prevention initiatives to prevent further transmission. The increase in number of PLWHA's is due to a combination of factors: survival time is increasing, those recently reported are more likely to be alive, and the annual number of persons reported with HIV or AIDS exceeds the number of deaths. Heterosexual cases are increasing the fastest. (data as of 04/05/06).

Among male PLWHAs, those with a history of male-male sexual contact predominate consistently over the past 10 years, regardless of age group, and are also increasing the fastest (Figure 53) (Note: In Figures 53-55, NIRs have been redistributed.) IDU PLWHAs have leveled off in the two younger age groups, both among males and females, but those with a history of injection drug use (not necessarily currently active users) are increasing in the 50+ category. These data suggest that to some extent injection drug use may be aging out of the epidemic. Other studies have suggested that competing patterns of non-injection drug abuse like crack cocaine may account for the diminishing appeal of injection drugs to youth. Nonetheless, it must be recognized that IDUs represent an important bridge population for heterosexual transmission to non-IDUs, particularly to women. Among women, the epidemic is fast becoming a heterosexual one for all ages, as it is somewhat for males aged 50+. With the proliferation of numerous medications for erectile dysfunction, relative sexual inactivity among the older age group can no longer be presumed, and in fact gonorrhea and chlamydia rates have been increasing in South Florida in recent years among those aged 55+ years. Condom usage, long avoided by those having sex with post-menopausal women, must be promoted to reduce HIV transmission in this vulnerable population.

DISEASE CONTROL DIRECTORY

SunCom

AIDS

Prefix

AIDS Case Reporting/Data Requests/

Surveillance 850-245-4430 205

AIDS Drug Assistance Program/

Patient Care Resources 850-245-4335 205

AIDS Education & Prevention 850-245-4336 205

HIV Counseling and Testing/

Seroprevalence & Special Studies 850-245-4424 205

HIV/AIDS Epidemiology/HIV Prevalence 850-245-4448 205

Legal Issues 850-245-4422 205

Hepatitis

Hepatitis Data Analysis/Vaccine and Testing/850-245-4334
205

Educational Materials

STD

ICCR Clerk 850-245-4325 205

STD Case Reporting/Data Requests/

STD Prevention and Control Main Number 850-245-4303 205

TB

TB Surveillance and Epidemiology/

Data Requests/TB Control

& Prevention Main Number 850-245-
4350 205

Other Important Numbers

Epidemiology 850-245-
4401 205

Florida AIDS Hotline 800-FLA-AIDS

National AIDS Hotline 800-342-AIDS

National Data Requests (CDC fax) 404-332-4565

TB Information Hotline 800-4TB-
INFO -----

..

Email Addresses

Below are contact email addresses should you need HIV, AIDS, STD or TB data.

HIV/AIDS Case Data

Lorene Maddox Lorene_Maddox@doh.state.fl.us
Tracina Bush Tracina_Bush@doh.state.fl.us
Allison Herring Allison_Herring@doh.state.fl.us

HIV/AIDS Epidemiology/HIV Prevalence

Spencer Lieb Spencer_Lieb@doh.state.fl.us

HIV Counseling and Testing Data

Melinda Waters Melinda_Waters@doh.state.fl.us

Sexually Transmitted Disease Case Reporting

Stacy Shiver Stacy_Shiver@doh.state.fl.us

Tuberculosis Case Reporting

Yvonne Luster-Harvey Yvonne_Harvey@doh.state.fl.us

You can access the Bureau of HIV/AIDS' website by going to:

http://www.doh.state.fl.us/disease_ctrl/aids/index.html.

HIV and AIDS 2005 fact sheets and selected slide sets are now on the Internet (list below). Please use the above site and follow the instructions below to view them.

For Slide Shows and Fact Sheets:

On the Bureau's homepage, click on "Trends and Statistics" and then click on either "Fact Sheets" or "Slide Shows". There you will see the slide presentations and fact sheets. These are saved in "Adobe Acrobat Reader". If you do not have Adobe Acrobat Reader, you may download this software from the Bureau's homepage. *The slide sets are now saved as PowerPoint presentations as well as in Acrobat Reader.* You will also see a link to the CDC HIV/AIDS slide sets.

These slide sets and fact sheets are updated on an annual basis.

Should you need a copy of any of the slide sets or fact sheets (saved as Office 2000 PowerPoint or Word files), or if you have any suggestions or comments for future slide sets or fact sheets, please e-mail Lorene Maddox (Lorene_Maddox@doh.state.fl.us) or Tracina Bush (Tracina_Bush@doh.state.fl.us). Or you may call them at (850) 245-4430 or SunCom 205-4430.

Fact Sheets

- HIV/AIDS Among Blacks
- HIV/AIDS Among Haitians
- HIV/AIDS Among Hispanics
- HIV/AIDS Among Men
- HIV/AIDS Among Pediatrics (2002 only)
- HIV/AIDS Among Women
- HIV/AIDS in Seniors
- HIV/AIDS in Young People
- United States and Florida HIV/AIDS Fact Sheet

Fact sheets in Spanish:

- HIV/AIDS Among Blacks
- HIV/AIDS Among Hispanics
- HIV/AIDS Among Men - **New**
- HIV/AIDS Among Women
- HIV/AIDS in Florida

Fact sheet in Creole:

- HIV/AIDS Among Blacks - ***New***
- HIV/AIDS Among Haitians
- HIV/AIDS Among Hispanics – ***New***
- HIV/AIDS Among Men – ***New***
- HIV/AIDS Among Women - ***New***

Epidemiologic Profiles

- 2003 Pediatric Epidemiologic Profile
- 2003 Adolescent Epidemiologic Profile
- Florida Epidemiologic Profile for HIV Community Planning 2000
- Florida HIV/AIDS Annual Report/Epidemiologic Profile –2002
- Florida HIV/AIDS Annual Report, 2003 – ***New***
- Epi Profile for Haitians 2003 - ***New***

Slide Shows

- Adolescents
- Age 50+
- Country of Birth
- Demographics & General Epidemiology
- Florida's First 22 Years of AIDS
- Florida Statistics
- Epidemiology of Men who have sex with Men
- Estimations of the Population of Men who have sex with Men, Florida
- HIV/AIDS among Florida's Deaf Population
- HIV and AIDS by Top 7 Counties
- HIV and AIDS by Ryan White Care Act Metropolitan Statistical Areas (MSAs) (2002 only)
- HIV/AIDS Mortality: Two Epidemiologic Studies
- HIV Prevalence Estimates, Florida, 2002 – State of the epidemic and goals, July 10, 2002
- Injection Drug Users
- No Identified Risk Update: January-June 2002
- Pediatrics (2002 only)
- Racial/Ethnic Minorities
- Resident HIV/AIDS Deaths
- UNAIDS and WHO
- US Deaths
- US and Florida
- Women

II. Community Services Assessment

A. Resource Inventory

B. Early Intervention Initiatives

C. Linkage and Coordination

D. Gap Analysis and Prioritization

- *Prevention needs of target populations*
- *Prevention activities/interventions*
- *Service gaps*

A. Resource Inventory

An overview of the current prevention resources existing in the state, including the number of people served.

Advancing HIV Prevention (AHP)

Category 1: Prevention for HIV-Infected Persons				
AIDS Services Association of Pinellas				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 5) Pinellas	\$167,049	White MSM Black MSM Black Hetero Black IDU Male White IDU Male	VOICES/VOCES PCM	160 60
Tampa-Hillsborough Action Plan				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 6) Hillsborough	\$150,000	Black Hetero Hispanic Hetero Black MSM White MSM Hispanic MSM	Healthy Relationships	144
Center For Drug-Free Living				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 7) Orange	\$175,000	Black MSM Hispanic MSM White MSM Black Hetero F White Hetero F Hispanic Hetero F	Healthy Relationships	75
Community Healthcare Center One, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$190,614	Black MSM White MSM Hispanic MSM	L.I.F.E. Health Relationships	40 96
South Beach AIDS Project				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$250,000	Black MSM White MSM Hispanic MSM	L.I.F.E.	120

South Florida AIDS Network				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$238,129	Black M/F (18-65)	PCM	48
Union Positiva				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$144,766	Hispanic MSM Hispanic F	PCM	48
AIDS Coalition of Volusia/Flagler				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 12) Volusia	\$155,604	Black MSM White MSM Black Hetero M/F Hispanic F	Healthy Relationships	147

Category 2: Prevention For High-Risk Negative Persons				
Big Bend Cares				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 2B) Leon	\$175,000	Black MSM(18-29) White MSM(18-29) Bisexual M(18-29) Black Hetero	Mpowerment VOICES/VOCES	1,536 1,800
Jacksonville Area Sexual Minority Youth Network (JASMYN)				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 4) Duval	\$123,801	Black MSM(13-23) White MSM(13-23) Hispanic MSM (13-23)	Mpowerment CTL POL	940 72 15
Hope and Help Center of Central Florida				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 7) Orange	\$174,445	Black MSM(18-29) White MSM(18-29) Hispanic MSM (18-29)	Mpowerment	993
Miracle of Love				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 7) Orange	\$175,000	Black MSM(18-30) Hispanic MSM (18-30)	Mpowerment	948

Community AIDS Network, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 8) Sarasota	\$173,297	Black Hetero Hispanic Hetero Black MSM White MSM Hispanic MSM	VOICES/VOCES PCM	720 45
United Deliverance Community Resource Center				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$147,000	Black Hetero (15-34)	RAPP	1000
Gay, Lesbian Community Center of Greater Fort Lauderdale (GLCC)				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$152,500	HIV Positive MSM	L.I.F.E Health Relationships	79
Broward House				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$150,671	Black MSM(18-30) White MSM(18-30) Hispanic MSM (18-30)	Mpowerment	810
Minority Development and Empowerment				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$184,381	Haitian Hetero (20-55)	VOICES/VOCES	2160
Village South, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$175,000	Black Hetero F	SISTA	140
AIDS Help, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11B)	\$163,827	White MSM Black MSM Hispanic MSM	Community Promise	1,600

Category 2: Prevention For High-Risk Negative Persons Building Organizational Proficiency Projects-BOPP				
Santa Rosa Minority HIV/AIDS Task Force, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 1) Santa Rosa	\$75,000	Black Hetero	VOICES/VOCES	480
Bradford County Faith Community Center				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 3/13) Bradford	\$75,000	Black Hetero	VOICES/VOCES	384
Category 3: HIV Counseling, Testing and Linkage Projects				
Lakeview, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 1) Escambia	\$140, 619	High Risk M/F Substance abusers	CTL	520
BASIC				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 2A) Bay	\$149,729	High Risk M/F	CTL	540
Metropolitan Charities				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 5) Hillsborough	\$150,000	White MSM Hispanic MSM Black MSM Black Hetero	CTL	480
Care Resource				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$149,986	Black MSM Hispanic MSM And their partners	CTL	804
HEP-C Alert				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$119,557	Black Hetero Black MSM and their partners	CTL	960
Hispanic Unity				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$225,000	Hispanic MSM Hispanic Females	CTL	996

Compass				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$150,000	White MSM Hispanic MSM Black MSM Black Hetero Hispanic Hetero	CTL	960
Project Response				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 15) St. Lucie	\$149,773	Black Hetero	CTL	1200
Health Planning Council				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 4) Duval	\$77,399	Black MSM Hispanic MSM Substance Abusers	CTL	1500
River Region				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 4) Duval	\$150,000	IDU Substance Abusers	CTL	1920

2006-2007 Closing The Gap (CTG)

Category 1: Prevention For HIV Infected Persons				
Glades Health Initiative, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$100,000	Black HIV Positive Hispanic HIV Positive	CRCS	39
United Deliverance				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$135,000	Black HIV Positive Hispanic HIV Positive	CRCS Healthy Relationships	39 45

Category 2 : Prevention For High-Risk Negative Persons				
Community Information Network				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 1) Escambia	\$135,000	Black Hetero	VOICES/VOCES SISTA	528 70
Minority Alliance for Advocating Community Awareness and Action (MAACA)				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 2B) Leon	\$100,000	Black Hetero	SISTA VOICES/VOCES	80 240
Three Rivers Legal Services, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 3) Alachua	\$53,418	Black Hetero	VOICES/VOCES	432
Mahogany Revue Research & Development Center				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 13) Marion	\$135,000	Black Hetero Hispanic Hetero	CRCS VOICES/VOCES	102 528
River Region Human Services, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 4) Duval	\$135,000	Black Hetero	SISTA VOICES/VOCES	70 484
Drug Abuse Comprehensive Coordination Office, Inc. (DACCO)				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 6) Hillsborough	\$135,000	Black IDU	Community Promise	1010
Center for Drug Free Living				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 7) Orange	\$100,000	Black Hetero Hispanic Hetero F	Community Promise	505
Island Coast AIDS Network, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 8) Lee	\$100,000	Black Hetero F Hispanic Hetero	SISTA VOICES/VOCES	135 1008
Comprehensive AIDS Program of Palm Beach County, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$100,000	Black Hetero Hispanic Hetero	VOICES/VOCES	672

Hispanic Unity of Florida				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$135,000	Hispanic MSM	Mpowerment	144
Community AIDS Resource d/b/a Care Resource				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$135,000	Black Hetero	SISTA	200
Positive Images Enterprises				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$135,000	Black Hetero F	VOICES/VOCES	624
Mujeres, Unidas, En Justicia Educacion y Reforma, Inc. (MUJER)				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$135,000	Black Hetero Hispanic Hetero	CRCS Community Promise	51 2017
Teen Pregnancy Prevention Center, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$135,000	Black Hetero	SISTA	200
South Beach AIDS Project				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$135,000	Black MSM and their partners	3MV	54
St. Lucie County Health Department				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 15) St. Lucie	\$100,000	Black Hetero	SISTA VOICES/VOCES	56 528

Category 3: Prevention Demonstration Projects For HIV Infected and High-Risk Negatives				
BASIC				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 2A) Bay	\$ 100,000	Black HIV Positive and their partners	CRCS ARTAS II	51 20

CDC Direct-Funded HIV/AIDS Prevention Providers

Okaloosa AIDS Support and Informational Services (OASIS)				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 1) Okaloosa	\$208,066	Black Hetero F (18-55)	Community Promise MPOWERment	1922
BASIC				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 2A) Bay	\$284,265	Black Hetero HIV Positive	SISTA VOICES/VOCES Healthy Relationships	120 224 98
SHISA				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 2B) Leon	\$230,395	Black Hetero	SISTA CTR	190 36
Minority AIDS Coalition (MAC) of Jacksonville, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 4) Duval	\$356,725	Black MSM Black Hetero	Community Promise CTR	2457 602
AIDS Service Association of Pinellas				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 6) Pinellas	\$209,641	Black MSM Hispanic MSM White MSM	POL CTR CRCS	0 738 5
Center for Multicultural Wellness & Prevention, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 7) Orange	\$322,658	Black Hetero F	CTR SISTA	330 201
Miracle of Love Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 7) Orange	\$364,643	Black MSM White MSM Hispanic MSM IDU-M	CTR 3MV VOICES/VOCES	452 66 134

Comprehensive AIDS Program (CAP) of West Palm Beach				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$353,795		CTR RAPP	698 5056
Glades Health Initiative Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$299,332	Black Hetero	CTR	772
Camilus Health Concern				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$407,207	Black Hetero Black IDU	CTR Safety Counts CRCS	445 92 24
Community AIDS Resource				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$242,092	Hispanic MSM Hispanic Hetero HIV Positive	Partnership for Health CRCS	3158 41
Empower-U Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$365,492	HIV Positive Black Hetero Black MSM Black IDU	Safety Counts CTR CRCS	21 420 19
Union Positiva				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$360,581	Hispanic Hetero Hispanic MSM HIV Positive	CTR Healthy Relationships MPOWERment	930 0 19
The Village South				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$245,503	HIV Positives	CRCS Healthy Relationships	153 20
Healthy Start Coalition, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 15) St. Lucie	\$339,869	Black Hetero F Hispanic Hetero F White Hetero F	CTR CRCS	347 128

MAI/ARTAS Providers

Tampa-Hillsborough Action Plan (THAP)				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 5) Hillsborough	\$140,000	Black HIV Positive Hispanic HIV Positive	MAI-ARTAS	140
Nehemiah Educational and Economic Development, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 7) Orange	\$ 122,678	HIV Positive	MAI-ARTAS	100
Manatee County Rural Health				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 6) Manatee	\$137,871	Black HIV Positive Hispanic HIV Positive	MAI-ARTAS	140
Comprehensive AIDS Program, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$130,497	Black HIV Positive Hispanic HIV Positive	MAI-ARTAS	135
United Deliverance				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$137,000	Black HIV Positive Hispanic HIV Positive	MAI-ARTAS	110
Broward House				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$114,340	Black HIV Positive Haitian HIV Positive Hispanic HIV Positive	MAI-ARTAS	90
Care Resource				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$139,242	Black HIV Positive Hispanic HIV Positive	MAI-ARTAS	140

Targeted Outreach for Pregnant Women Act (TOPWA)

Minority AIDS Coalition of Jacksonville, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 4) Duval	\$110,000	Pregnant Women	TOPWA	1,800
Tampa-Hillsborough Action Plan (THAP)				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 6) Hillsborough	\$135,000	Pregnant Women	TOPWA	1,800
Orlando Regional Healthcare (Hug-Me)				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 7) Orange	\$135,000	Pregnant Women	TOPWA	1,800
Farmworkers Association of Florida				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 7) Orange	\$85,000	Pregnant Women	TOPWA	1,620
Source of Light and Hope				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 8) Lee	\$75,000	Pregnant Women	TOPWA	1,800
Families First, Inc.				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 9) Palm Beach	\$165,000	Pregnant Women	TOPWA	3,000
Minority Development and Empowerment				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 10) Broward	\$160,00	Pregnant Women	TOPWA	2,400
Teen Pregnancy Prevention Center				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 11A) Dade	\$195,000	Pregnant Women	TOPWA	3,192
Healthy Start Coalition of St. Lucie County				
Area	Contract Amount	Target Population	Intervention	Total Clients
(Area 15) St. Lucie	\$110,000	Pregnant Women	TOPWA	1,800

B. Early Intervention Initiatives

This is a description of ongoing Early Intervention activities.

Early Intervention Projects

The Early Intervention Section oversees publicly funded counseling, testing and linkage services around the state, ensuring that persons are given the facts about HIV disease, how to prevent transmission, offered partner counseling and referral services, and linked with early intervention and treatment. Early Intervention is also responsible for: coordinating Florida's Perinatal HIV Prevention Program; overseeing corrections initiatives; implementing and evaluating linkage programs, including the Minority AIDS Initiative; coordinating the substance abuse initiative; and conducting epidemiologic research, including behavioral surveillance and primary HIV infection studies.

Counseling, Testing and Linkage Initiatives

- HIV testing is key to preventing the spread of HIV and improving the quality of life for HIV-infected persons. Studies show that most people who learn they are HIV infected will take steps to avoid spreading the virus to their partners. People who are diagnosed early in the course of their infection and access medical care can live a long and productive life. Finding the partners of infected people is a high priority; once contacts are found, they are offered HIV testing and information on prevention and the benefits of early treatment with new medications. There are approximately 1,580 registered HIV counseling and testing sites statewide, including 244 anonymous sites; the Department of Health and community partners performed almost 295,000 HIV tests in 2005, with a large percentage among at-risk minorities. These tests are performed during community street outreach, jail screenings, at county health departments, drug treatment centers, and community-based organizations. The statewide positivity rate in 2005 was 1.8%.
- The use of new testing technology, such as OraSure and rapid testing, is an important part of ongoing efforts to increase accessibility and availability of HIV testing and counseling services among high-risk populations, and will continue to increase the proportion of HIV-infected persons in Florida who know their status.
- OraSure, which uses a swab to collect oral fluid instead of drawing blood, is widely used in Florida in outreach settings to reach those who would not otherwise access HIV testing. Positivity rates are higher among those tested with OraSure than those tested in the traditional manner. Almost 60,000 OraSure tests were done in 2005, with a positivity rate of 2.5%.
- Rapid testing has been extremely valuable in jails, where inmates are often released and lost to follow-up before traditional test results are available. Over 100 agencies, including drug treatment centers, community-based organizations, county health departments and mobile testing units are currently conducting rapid testing in many areas of the state. In 2005, almost 35,000 tests were recorded using rapid testing, up from 3,790 in 2003 when the program started. The statewide positivity rate using rapid testing increased from 2.2% in 2003 to 2.5% in 2005.

- The Early Intervention Section partners with the Substance Abuse Program Office in the Department of Children and Families. We work closely with them to implement the federal rapid testing initiative, led by the Substance Abuse and Mental Health Services Agency. The goal is to bring rapid HIV testing and linkage services to persons accessing substance abuse treatment centers. We also work closely with the substance abuse community to ensure HIV and hepatitis services are fully integrated into their programs.
- AISAP stands for Acute Infection Screening and Prevention. This study is funded through a grant from the CDC to the Bureau of HIV/AIDS, Bureau of STD, and Bureau of Laboratories. The purpose of the grant is to study the use of Nucleic Acid Amplification Testing (NAAT) on blood samples collected for HIV testing from four counties; Duval, Orange, Pinellas, and Hillsborough. The Jacksonville state laboratory will conduct all testing for AISAP. Information obtained from this study, which began in the spring of 2006, will add to the body of knowledge about using HIV RNA molecular tests as a diagnostic tool.
- In an effort to improve the quality of HIV counseling, testing and linkage services (CTL), a Client Satisfaction Survey (CSS) was conducted for the first time in 2002. The results of this client survey were instrumental in assessing strengths, identifying client concerns, and determining opportunities for improving the services that we provide. The survey was repeated in 2004 and again in 2006. Client satisfaction with services was very high in each of the surveys. A full report can be found on the bureau's website at: http://www.doh.state.fl.us/disease_ctrl/aids/testing/testing.html
- As a part of EI's commitment to disseminate information about the prevention of HIV, two publications, *Data at a Glance* and *Woman's Time*, are distributed quarterly focusing on useful and timely HIV data and analysis in a brief and user-friendly format and women's HIV/AIDS information and news respectively. (Located on the web at www.doh.state.fl.us. Choose subject: AIDS/HIV. Choose: Newsletters for *Woman's Time* or Trends and Statistics for *Data at a Glance*.)
- National HIV Testing Day is observed June 27 every year. For several years, the Early Intervention Section provided long-distance phone cards as incentives to get tested for HIV. The phone cards offer a 5-second prevention message (in English Spanish and Creole), along with the Florida AIDS Hotline number, and were distributed by HIV testing programs around the state. More recently we have provided red rubber bracelets with a testing message to encourage testing.
- The Early Intervention Section has developed a brochure describing Partner Counseling & Referral Services (PCRS) in Florida. Over 100,000 of these brochures have been distributed throughout the state to inform the public that these services are free, confidential and available through the county health department. The importance of notifying partners of their potential exposure is also discussed. Posters with a similar message have also been produced and distributed. This is part of a broader initiative to implement PCRS statewide.

Women and Children Initiatives

- Another EI focus is preventing HIV infection in women and their children. Most of the approximately 200,000 women who give birth each year in Florida are tested for HIV prenatally, receive adequate prenatal care and go on to deliver healthy babies. Without appropriate medical therapy, about 30 percent of babies born to infected mothers in Florida will be HIV infected. Infection can occur at anytime during pregnancy and can also occur through breastfeeding. With proper prenatal care and treatment, including antiretroviral therapy, approximately 2 percent of babies born to HIV-infected women will become infected. Consequently, Florida's comprehensive perinatal HIV prevention program is two-pronged, targeting both health care providers and consumers. Further information, reports, and data may be accessed at www.doh.state.fl.us/disease_ctrl/aids/Perinatal/PERINATAL.html
- The Targeted Outreach for Pregnant Women Act (TOPWA) program was established to find at-risk or HIV-infected pregnant women who are not receiving adequate prenatal care and link them with services. The Department of Health contracts with community-based organizations to provide services in Miami-Dade, Broward, Palm Beach, Hillsborough, Pinellas, Orange, Duval, St. Lucie, Lee, Hendry and Glades counties. TOPWA clients are located through outreach in high-risk neighborhoods and linkages with community agencies such as substance abuse centers, domestic violence shelters, homeless shelters and county jails. All women screened for TOPWA are provided information on HIV prevention, and offered free on-site HIV and pregnancy testing. Enrolled women are assessed to determine their level of risk, linked to and assisted in accessing needed services, and followed through the birth of the infant. Several TOPWA agencies are now providing services in their local county jails.
- The Department of Health contracts with the Florida/Caribbean AIDS Education and Training Center (AETC) to educate health care providers who care for pregnant women about Florida's HIV testing laws and current treatment guidelines. The AETC also assists hospital labor and delivery units in developing HIV testing and treatment protocols and procedures, and in particular the implementation of rapid testing. Social marketing materials, including brochures and wall posters in English, Spanish, and Creole are available from the AETC perinatal project.
- The Bureau of HIV/AIDS has initiated a number of projects to address the underlying issues that place pregnant women at risk for HIV and to develop an integrated perinatal HIV prevention program. Through enhanced collaborative activities with maternal and child health programs and other state partners, information on the importance of HIV testing and the availability of treatment for HIV-infected pregnant women is being disseminated to health care providers and consumers statewide, and barriers to the care and treatment of HIV-infected pregnant women are being addressed at both the community and state levels.
- In 2005 a law was passed that changes the way HIV testing is provided to pregnant women. Testing for certain STDs, including HIV, must now be provided to pregnant women on their initial prenatal visit and again at 28-32 weeks gestation unless the woman refuses. The woman must be notified that the testing will be done and of her right to refuse testing. This model of opt-out testing does not require specific informed consent. Testing must also be provided for women at the time of labor and delivery when documentation of prior HIV testing is not available.

Linking HIV-Infected People to Care

- Linking people who test positive for HIV to appropriate services is another EI priority. It is essential that HIV-infected people be linked to appropriate services as soon as possible. These services include: medication through the AIDS Drug Assistance Program (ADAP), primary medical care, housing, substance abuse and mental health treatment, and a variety of other appropriate services. These services are often coordinated by case managers in local health departments and HIV service organizations.
- In keeping with Early Intervention priorities, seven community programs have been funded around the state through the Minority AIDS Initiative (MAI). These programs identify minorities who are HIV infected and not accessing available medical care. Clients are assisted in obtaining medical care utilizing the Antiretroviral Treatment Access Study (ARTAS) model that emphasizes client's strengths to empower them to become their own medical advocate. Each client either newly diagnosed or out of care, is encouraged to identify goals that are important to them with the ultimate goal of obtaining medical care and treatment. They then have a maximum of five (5) face-to-face visits where the care coordinator helps them tap into their own abilities to achieve these goals.
- Through prevention funds we have established ten projects within community agencies to provide counseling, testing and linkage (CTL) services to persons of unknown HIV status. These projects are unique in that they offer comprehensive linkage services to individuals found to be HIV infected as well as those who are negative but self-report continued behavior that puts them at risk for acquiring the virus. They are referred to services to address identified needs including medical care, substance abuse treatment, mental health services, etc. Staff from the CTL project then follows up to find out if the client was successful in getting the needed service, offering further assistance if indicated.

Corrections Initiatives

- There are multiple Jail Linkage Projects around the state that provide HIV testing to inmates in county jails. Persons who test positive for HIV are linked to available medical and support services in their communities upon release. Since many jail inmates are released within 24 hours of their arrival, rapid testing is being utilized in many of the facilities to ensure inmates get their test results. These projects have resulted in many more individuals getting tested in jails.
- The primary objectives of these jail release linkage projects are:
 1. Increase the number of inmates identified with HIV, hepatitis, and STDs.
 2. Provide prevention education for inmates who are at risk for contracting HIV, hepatitis, or STDs as well as for infected inmates.
 3. Establish linkages for inmates to necessary care, treatment and social services through discharge planning and follow-up after the inmate is released into the community.
- To achieve these objectives, the jails collaborate with community-based organizations throughout their counties to ensure a link to necessary services for the released HIV-

infected inmates. Several programs, in order to plan activities and to ensure quality of services, have formed a consortium of collaborating agencies that meet on a regular basis.

- Inmates are referred to a wide variety of services determined by in-depth risk and needs assessments conducted while the inmate is still incarcerated. These services include, but are not limited to, housing, mental health, substance abuse, medical, social security/disability, psycho-social, and vocational training services upon release.
- The Florida Department of Corrections (DC) houses approximately 88,000 inmates in prisons around the state. Of those, it is estimated that 4% – 5% are infected with HIV. Through a contract with DC, we provide five regional pre-release planners to assist inmates who are within six months of release to find support services in the community in which they are planning to reside. Appointments are made with the HIV medical provider in their area so that they may not have a lapse in care or medication upon their release.
- Legislation passed in 2002 requires that all inmates be tested for HIV prior to release from the DOC prison system. Persons who test positive for HIV are linked with services upon release.
- The Bureau of HIV/AIDS supports the Corrections Infections Workgroup, a multi-disciplinary team that works on issues related to infectious diseases in correctional facilities. Members of the workgroup represent HIV, STD, TB, hepatitis, substance abuse, the Department of Corrections, the Department of Juvenile Justice, and the Correctional Medical Authority. This group meets quarterly and provides a forum for collaboration and brainstorming. The group also produces *Disease Lockdown*, a semi-annual publication designed to educate correctional officers and health staff that work with incarcerated persons and ex-offenders.

Behavioral Surveillance

- In 2003, CDC funded the bureau to develop and implement a surveillance system to monitor behaviors that place people at risk for HIV infection. This system is called the National HIV Behavioral Surveillance system (NHBS). NHBS consists of a repeated, cross-sectional survey of men who have sex with men (MSM), injecting drug users (IDU), and high-risk heterosexuals (HRH) from 25 metropolitan statistical areas (MSAs). NHBS was initiated to help state health departments establish and maintain a surveillance system to monitor selected behaviors and access to prevention services among groups at highest risk for HIV infection. The overarching goal of NHBS is to help direct and evaluate local and national prevention efforts by identifying the prevalence and trends of sexual and drug-use risk behaviors among MSM, IDUs, and HRH and their exposure to and utilization of HIV testing and other prevention services funded by the CDC and state and local health departments. Findings from NHBS will be used to enhance understanding of risk and testing behaviors, and to develop and evaluate HIV prevention programs that provide services to these groups.
- The bureau is collaborating with the CDC and the University of Miami to conduct NHBS activities in Miami-Dade and Broward counties. The project is known locally as ACXION (Assessing Characteristics of population X In ON-going surveillance). NHBS activities are being implemented in multiple cycles. During the first cycle of data collection (December 2003 – December 2004), surveillance activities focused on MSM. NHBS-MSM is a survey of men who attend MSM-identified venues within locally defined geographic areas. Survey methods are based on an application of time-space sampling that has been proven successful in obtaining large and diverse samples of MSM. In Miami-Dade and Broward counties, 1,540 MSM (defined as men who had one or more male sex partners in the past

twelve months) participated in NHBS. Data from this cycle are currently being analyzed and staff from the bureau and the University of Miami has done several presentations on the findings at local, state, and national forums.

- The focus of the second cycle (January 2005 – December 2005) is on injecting drug users. The sampling method used for NHBS-IDU was Respondent-Driven Sampling (RDS), which is similar to snowball sampling. RDS is based on the recognition that peers are better able than outreach workers or researchers to locate and recruit other members of a hidden population. Data from this cycle are currently being analyzed. The third cycle (January 2006 – December 2006) focuses on high-risk heterosexuals using a venue-based sampling method in selected areas of the two counties. These cycles will be repeated over time such that data are collected from any given risk group every three years.

C. Coordination

A description of how proposed activities are linked to activities that prevent or delay the onset of illness in persons with HIV infection. Plus a description of how governmental and non-governmental agencies coordinate to provide comprehensive HIV prevention services within the state.

Coordination: The FCPN Leadership, made up of the community and public health co-chairs of the three planning groups: prevention, patient care, and hepatitis, met in June 2006. The various planning groups updated each other on their activities. Several advisory groups (consumer, black, and Latino) provided reports and recommendations.

Common recommendations from all participants were to increase the frequency of information exchange through: better partnering with universities, pharmaceutical companies, and patient care programs; at least one face to face meeting of the FCPN Leadership Committee per year; and a combined comprehensive meeting of all the planning groups each year.

The advisory groups also presented the following recommendations to the FCPN Leadership Committee: to have an update from each group as a standing agenda item at each of the different section's planning group meetings; to ensure that the advisory groups' recommendations were incorporated into the various comprehensive plans; and to provide the financial support for advisory group members to attend the various planning group meetings.

The revised planning process has streamlined and focused Florida's planning effort, with only a small trade off in the overall knowledge of each of the statewide planning groups. The oversight offered by the FCPN should help correct the needs in our existing model.

Coordination: The Florida HIV/AIDS Comprehensive Planning Network (FCPN) ensures an exchange of information on HIV/AIDS issues across governmental and non-governmental organizations. The FCPN identifies the need to link with special areas of interest and established at-large seats to bring a more comprehensive view of those infected and affected by HIV/AIDS to the table. These seats include representation from substance abuse, behavioral science, and youth.

The FCPN ensures the coordination of the planning process among: prevention, patient care, and hepatitis. The co-chairs of the various planning groups attend the other planning group meetings as frequently as possible. The planning groups' minutes and newsletters also help coordinate planning efforts across the sections. The Bureau of HIV/AIDS has a position dedicated to the coordination and interweaving of these programs and plans.

Coordination: The Black Leaders' Advisory Committee, composed of blacks from across Florida, includes representation among: Persons Living with HIV/AIDS (PLWHA), minority community-based organizations (CBOs), community minority advocates, religious groups, and the Department of Health (DOH).

This group undertook the responsibility to adopt an action plan in order to assist the Bureau of HIV/AIDS in the elimination of barriers, which impede the fight against HIV/AIDS prevention in the black community. The issues and recommendations shared by the Black Leaders' Advisory Committee were addressed in the statewide comprehensive plan.

To date, the Black Leaders' Advisory Committee has produced 38 recommendations regarding: cultural competency; minority hiring at the state and local level; the provision of skill building for minority CBOs; capacity building contract management training; as well as skill building for receiving and sustaining funding.

The Black Leaders' Advisory Committee helped increase the number of CBOs, which receive HIV Prevention funding and assisted the Bureau in the development of a process that provides feedback to CBOs that apply for funding through a competitive process, such as ITN or RFP. How many new CBOs? What is the process?

The Black Leaders' Advisory Committee will continue to mobilize the black community to prevent the spread of HIV/AIDS and to work with the Bureau of HIV/AIDS in an effort to close the gap between black and white HIV infection rates.

Black Leaders Advisory Committee Recommendations

Recommendation: Support CHD in conducting science-based interventions and having service agreements.

Bureau Response: The Bureau of HIV/AIDS prevention section is assisting county health departments in implementing the science-based interventions. Trainings are currently being held with county health department staff as a prerequisite for implementation.

Status: ONGOING

Recommendation: The Black Leaders should be consulted to review plans for Florida's HIV/AIDS Academy for Prevention Leadership HIV/AIDS Academy.

Bureau Response: Members from the Black Leaders Advisory Committee, Latino Leaders Advisory Committee, community planning, community-based organizations, county health departments, Centers for Disease Control and Prevention and others have been consulted numerous times during the development of the academy.

Status: COMPLETED

Recommendation: The bureau should ensure that minority agencies have received technical assistance and have information technology (IT) capabilities prior to the transition to Program Evaluation and Monitoring System (PEMS).

Bureau Response: Training will be provided to all agencies prior to implementation regardless of funding source. The bureau will explore options to address the IT needs of minority and other community-based organizations.

Status: IN PROGRESS

Recommendation: Create prevention messages that are diverse not data driven and risk specific.

Bureau Response: The bureau will begin conducting focus groups to assist the bureau in developing HIV prevention messages for radio and print. In addition, we will continue to use media messages produced by Viacom, KNOW HIV/AIDS campaign.

Status: ONGOING:
The bureau continues to seek input from community members prior to and during the creation of prevention messages.

Recommendation: **Require representatives from STD and HIV programs to participate in community planning and consortia meetings.**

Bureau Response: The bureau supports representation from STD and HIV during community planning and consortia meetings. HIV/AIDS program managers were reminded during a recent conference call to have the appropriate HIV/AIDS staff participate during meetings. In addition, this issue will be raised again during the November 2005 HIV/AIDS Program Managers Meeting. A meeting will be scheduled with the bureau chief of the STD Program to encourage STD participation during local planning meetings.

Status: **IN PROGRESS**

Recommendation: **The community-planning role needs to be continued and clarified in the community assessment and planning process.**

Bureau Response: Due to a continual reduction in prevention funding from CDC to the state, the bureau held a discussion with the Prevention Planning Group (PPG) membership who supported the decision to discontinue funding the production of a local prevention plan by local community planning partnerships in favor of maintaining direct services in HIV prevention and early intervention. Activities of the prevention-planning group will continue and they will maintain responsibility for writing the statewide plan. Local input is still important to us, therefore the bureau is working with an ad-hoc committee of the PPG to develop a framework for maintaining community participation and contribution to the state's HIV prevention plan. We hope to have a draft process to share with you soon. We have heard from many partners that they intend to continue prevention planning activities and we are gratified by such commitment. Our community partners remain very important for implementing an effective response to HIV prevention in the state. We look forward to a continued partnership. There is also discussion on the federal level. At the September NASTAD Executive Committee meeting, CDC indicated its willingness to reconsider some of the guidelines around community planning. This came in response to concerns raised by members regarding resources required for the process and the ultimate utility of planning as CDC has become more directive.

Status: **ONGOING**

Recommendation: **Allow specific funding to be allocated for traditional interventions.**

Bureau Response: This is not allowable under the Cooperative Agreement with CDC. The bureau will submit a request to the CDC Project Officer to ascertain if they will consider this recommendation. The bureau chief is working at the national level to address this and other issues related to Diffusion of Effective Behavioral Interventions (DEBI)/Replicating Effective Programs (REP). The bureau will make a request to the National Alliance of State and Territorial AIDS Directors (NASTAD) to see what interventions outside of DEBI/REP are being used in other states and directly funded cities.

Status: **ONGOING**

Recommendation: **Initiate a fast track adaptation of CDC approved interventions and tailoring for Haitians/Hispanic populations.**

Bureau Response: This is a nationwide issue. We are working with the Centers for Disease Control and Prevention and the National Institute of Health to address this issue for blacks, including Haitians and also Hispanics. The Miami-Dade County Health Department was recently in the NASTAD Bulletin for their research on the intervention "CHICA." CHICA is an intervention that targets Hispanics. In addition, the intervention VOCES is an approved intervention for Hispanic/Latinos. The bureau will make a request to NASTAD to see what interventions targeting blacks that are outside of DEBI/REP are being used in other states and directly funded cities.

Status: **IN PROGRESS**

Recommendation: **The Black Leaders Advisory Committee acknowledges the bureau's progress in hiring senior and other management staff but sees room for improvement.**

Bureau Response: When positions become available, the Bureau of HIV/AIDS is required to advertise all vacant positions, pay grades 20 and above, in local minority newspapers. When positions become available, the department hires the best applicant for the job according to the Equal Opportunity /Affirmative Action Act. To date, the last two vacant HAPC positions were filled by African Americans and an African American filled the HIV Prevention Program Administrator position.

Status: **ONGOING**

Recommendation: **There should be linkages between the Black and Latino Leaders Advisory Groups.**

Bureau Response: During the November 2005 Advisory Group meetings, the Black and Latino groups will attend a combined session to listen to common issues that affect both communities.

Status: **ONGOING**

Recommendation: **Improve contract managers partnering skills during contract negotiations.**

Bureau Response: This is an ongoing process and contract managers continue to be trained bi-monthly on conference calls and during annual meetings.

Status: **ONGOING**

Recommendation: **County health department (CHD) patient care staff should receive cultural competence training.**

Bureau Response: The bureau will encourage CHD patient care staff to attend cultural competence training. All case managers receive a "Nuts and Bolts Training" which includes a piece on how to deal with clients. The bureau is in the process of requiring a new employee orientation for all patient care staff that will include contract providers. The bureau will explore including cultural competency as a section of the new employee training. Many AIDS program staff have attended cultural competency training as part of our ongoing efforts to improve employees professional knowledge, skills and abilities.

Status: **IN PROGRESS**

Recommendation: **Improve contract managers partnering skills during contract negotiations.**

Bureau Response: This is an ongoing process and contract managers will continue to receive training bi-monthly on conference calls and during annual meetings. In addition, the contract unit discusses this issue with Bureau of HIV/AIDS program administrators and their staff. We will continue to address this issue and other issues during our quarterly HIV/AIDS Program Coordinators meetings. In addition, the training “**Partnering for Success: New Contract Providers Training**,” implicit theme was centered on partnerships.

Status: **ONGOING**

Recommendation: The bureau should hire key contract management staff that are sensitive to needs of minority CBOs in order to improve the process.

Bureau Response: The Department of Health is required to advertise all vacant positions, pay grades 20 and above, in local minority newspapers. When positions become available, the department hires the best applicant for the job according to the Equal Opportunity /Affirmative Action Act. The bureau will continue to expand training to contract managers in order to increase their knowledge and sensitivity to the needs of minority CBOs. To date, the last two vacant HPAC positions were both filled by African Americans.

Status: **ONGOING**

Recommendation: **Examine HIV/AIDS contract management process across the state and plan to make the process uniform statewide.**

Bureau Response: The bureau of HIV/AIDS has scheduled several meetings to address this issue. We discussed this issue at the April 2002 HAPC meeting. The bureau’s contract management workgroup has convened and the bureau conducts monthly conference calls with contract managers to discuss issues related to contract management. The bureau is developing manuals for contract managers and CBOs that stresses the vision and the culture of the bureau. It is the bureau’s goal to ensure the success of all of our contract providers.

Status: **ONGOING**

Recommendation: **Conduct survey to assess the contract management process**

Bureau Response: The bureau is in the process of developing satisfaction surveys for contract providers and contract managers. The bureau is negotiating with a third party to assist us in administering the survey. We anticipate that the survey will be administered early next year to all contract providers regardless of funding source.

Status: **IN PROGRESS**

Recommendation: **Provide community-based organizations with more information about the contract management process.**

Bureau Response: The bureau has developed and distributed a contract provider handbook. The handbook will be distributed each time there is a new provider. The handbook is being revised and will be distributed early next year to all of our providers. In addition, the bureau hosted a training entitled **“The Partnering for Success: New Contract Providers Training,”** February 24-25, in Orlando. The training included topics on programmatic and administrative monitoring, technical assistance, capacity building, and understanding your HIV prevention contract. Additional training will be provided.

Status: **ONGOING**

Recommendation: **Train contract managers to foster a partnership with CBO’s.**

Bureau Response: The bureau discussed this issue at the April 2002 HAPC meeting. The bureau held a two-day AIDS contract manager training to discuss the issue. The bureau made personnel changes in one area. In addition, the bureau conducts monthly conference calls with contract managers to discuss issues related to contract management and customer service. The bureau provides contract managers with tips and best practices to improve job skills. The bureau is exploring how to incorporate this training into the contract manager’s orientation. The training **“Partnering for Success: New Contract Providers Training,”** implicit theme was centered on partnerships.

Status: **ONGOING**

Recommendation: **Create a checklist of expectations for CBO’s.**

Bureau Response: The contract managers are trained to educate the provider on what is expected of them once the provider enters into the contractual agreement.

Status: **ONGOING**

Recommendation: **Encourage site visit reports that state both findings and recommendations.**

Bureau Response: The department has created a monitoring tool, which requires department staff to address both findings and recommendations during official monitoring visits.

Status: **COMPLETED**

Recommendation: Implement changes to standardize the process.

Bureau Response: The Bureau of HIV/AIDS has scheduled several meetings to address this issue. We discussed this issue at the April 2002 HAPC meeting. The bureau’s contract management workgroup has convened and the bureau conducts monthly conference calls with contract managers to discuss issues related to contract management.

Status: **ONGOING**

Recommendation: **Develop a process for the CBO to voice concerns about local contract managers.**

Bureau Response: The provider satisfaction survey will allow for feedback. In addition, the provider can contact the local supervisor. If local resolution cannot be

accomplished, contact the contract office in Tallahassee. This process will be discussed with all contract providers.

Status: ONGOING

Recommendation: Provide cultural competency and sensitivity training to HAPC's and contract managers.

Bureau Response: The bureau provided a one-hour presentation by Dr. B.J. Jarmon on Oct. 12, 2000, on Strategies for Developing Cultural Competence When Working with HIV/AIDS Communities. The bureau has scheduled five-cultural competency trainings and encouraged participation by the HAPC's and contract managers. The department has also conducted trainings on Contracts/Ethics. This training focused on negotiation, how to listen so everyone is in a win-win situation. In addition to the trainings mentioned above, other trainings were held at AETC and in local areas to address cultural differences. The trainings are highly recommended to all of our key staff. Cultural competency and sensitivity trainings will be provided throughout the year by national capacity building providers in which we highly recommend staff to attend.

Status: ONGOING

Recommendation: Recruit and hire qualified HAPC's and contract managers from the targeted population, when positions become available.

Bureau Response: The Department of Health is required to advertise all vacant positions, pay grades 20 and above, in local minority newspapers. When positions become available, the department hires the best applicant for the job according to the Equal Opportunity /Affirmative Action Act. To date, the last two vacant HAPC positions were both filled by African Americans.

Status: ONGOING

Recommendation: The bureau will educate CBO's on how to request advance payment contracts and how to manage cost reimbursement contracts in order to facilitate smooth financial operations.

Bureau Response: The bureau's prevention section has this outlined in the contract provider's handbook. Ongoing education and training is provided throughout term of the contract.

Status: ONGOING

Recommendation: Conduct a statewide grantee's meeting to include HAPCs, contract managers, and newly funded providers. In addition, the language should be included in the providers contract making it mandatory for them to participate.

Bureau Response: The bureau hosted a training entitled "*The Partnering for Success: New Contract Providers Training*," February 24-25, in Orlando. The training included topics on programmatic and administrative monitoring, technical assistance, capacity building, and understanding your HIV prevention contract.

Status: COMPLETED

Recommendation: The bureau should standardize its contract monitoring procedures/process.

Bureau Response: The department Contract Administration unit will be responsible for all monitoring of contract providers. The Contract Administration unit will use certified public accountants to conduct a thorough monitoring of providers and reports their findings to the bureau for corrective action.

Status: **ONGOING**

Recommendation: **The bureau should share the department/bureau policy regarding how they determine what providers receive as cost reimbursement or fixed price contract.**

Bureau Response: **This is a Bureau of HIV/AIDS Policy.** The bureau will grant a fixed price contract to agencies that have established a history of service with the bureau without any documented corrective actions. All other providers that do not meet this criterion will receive a cost reimbursement contract.

Status: **COMPLETED**

Recommendation: **The Bureau of HIV/AIDS and local county health departments should foster/support collaboration. The department should create an environment that promotes collaboration. Agencies should be able to collaborate with other agencies across the state as long as the collaboration makes sense.**

Bureau Response: The Bureau of HIV/AIDS will continue our efforts to support and cultivate collaborative relationships with all of our community partners. In addition, through our capacity building initiative, we will continue to support and encourage collaborative efforts between community-based organizations, county health departments and other governmental agencies.

Status: **ONGOING**

Recommendation: **Create an official definition for minority community-based organization (CBO).**

Bureau Response: All agreed that a minority CBO is one that has 51 percent board and 51 percent racial/ethnic minority staff in management positions and a history of service to racial and ethnic populations.

Status: **COMPLETED**

Recommendation: **Make the role of the HAPC consistent throughout the state.**

Bureau Response: Core roles and responsibilities for the HAPC's are in place and are consistent with the bureau's goals. Because each county health department is different, it is not feasible to require all to have identical position descriptions.

Status: **COMPLETED**

Recommendation: **Place concerns raised at Black Leaders meetings on the next HAPC meeting agenda.**

Bureau Response: The bureau discussed the Black Leaders concerns during a breakout session at the April 2002 HAPC meeting. The concerns of the group will continue to be emphasized during future meetings. The bureau is in the process of developing a method to share the work of this group with department staff and other advisory group.

Status: **ONGOING**

Recommendation: Publish HAPC responsibility list.

Bureau Response: Provided June 2002.

Status: **COMPLETED**

Recommendation: Publish RMAC responsibility list.

Bureau Response: Provided June 2002.

Status: **COMPLETED**

Recommendation: Address problems in CHD's with patient care, as it relates to staff discrimination.

Bureau Response: Direct all complaints of discrimination to the Department of Health, Equal Opportunity and Minority Health Office.

Status: **COMPLETED**

Recommendation: Explore doing cooperative agreements.

Bureau Response: Federal project officers advised the bureau against issuing cooperative agreements.

Status: **COMPLETED**

Recommendation: Create an African American Advisory Committee.

Bureau Response: The Black Leaders Advisory Committee was established August 2003.

Status: **COMPLETED**

Recommendation: Forward copies of the NASTAD Monograph entitled "*HIV/AIDS: African American Perspectives and Recommendations for State and Local AIDS Directors and Health Departments*" to staff and community partners.

Bureau Response: Distributed March 8, 2002.

Status: **COMPLETED**

Coordination: The Latino Leaders' Advisory Committee, comprised of Latinos from across Florida, includes representation among: PLWHA, minority CBO, minority treatment providers, community advocates, the religious community, and the Department of Health. Like the other advisory groups, the Latino Leaders' Advisory Committee shares their recommendations with the Bureau of HIV/AIDS and the three statewide planning groups: prevention, patient care, and hepatitis.

The Latino Leaders' Advisory Committee formed in July 2004 as part of the restructuring of Florida's Prevention Planning Group (PPG). This group brings together Latino leaders in an advisory role and allows them to discuss the issues being faced in the provision of HIV/AIDS prevention and patient care services to the Latino community. The issues and recommendations shared by the Latino Leaders' Advisory Committee were addressed in the statewide comprehensive plan.

The Latino Leaders' Advisory Committee, with the assistance of the statewide Latino AIDS Coordinator, created a document entitled, "Call to Action in the Middle of the Decade... the Next Five Years" and developed a Latino media campaign. Since the inception of this group, testing

among Latino males has increased by 57.5% and, even more remarkable, testing among females has increased by 97.3%.

The Latino Leaders' Advisory Committee will continue to mobilize the Latino community to prevent the spread of HIV/AIDS and to work with the Bureau of HIV/AIDS in an effort to close the gap between the Hispanic (1/176) and white (1/346) HIV infection rates.

Florida Latino Leaders Advisory Committee Recommendations
--

Recommendation: Allow input from Latinos in the creation of the Florida Department of Health, Office of Minority Health.

Bureau Response: Tom Liberti participated on the interview committee for the selection of the director of the Office of Minority Health. Currently, that position remains vacant. We have an outstanding relationship with the Office of Minority Health. Ronald Henderson and Vanessa Crowther work closely with the current director, Melvin Herring. With the appointment of the new Secretary of the Department of Health, we are uncertain about the time frame for the appointment of the director of the Office of Minority Health.

Status: **IN PROGRESS**

Recommendation: The Bureau of HIV/AIDS should form a Latino component within the Florida HIV/AIDS Academy for Prevention Leadership to reach Hispanics/Latinos.

Bureau Response: The Bureau of HIV/AIDS will include in the Florida HIV/AIDS Academy for Prevention Leadership, an organizational capacity building component tailored to Latino community-based organizations. The purpose of this capacity building is to develop and enhance the leadership abilities of the executive/administrative staff of Latino CBOs.

Status: **IN PROGRESS**

Recommendation: The Bureau of HIV/AIDS should create a Spanish capacity-building component for Latinos as part of its capacity-building training.

Bureau Response: The Bureau of HIV/AIDS will include in the Florida HIV/AIDS Academy for Prevention Leadership, an organizational capacity building component tailored to Latino CBOs. The purpose of this capacity building is to develop and enhance the leadership abilities of the executive/administrative staff of Latino CBOs.

Status: **IN PROGRESS**

Recommendation: The Department of Health should explore utilizing other prevention interventions to fill the HIV prevention gaps that are available through the current Diffusion of Effective Behavioral Interventions (DEBI)/Replicating Effective Programs (REP).

Bureau Response: The bureau will submit a request to the Centers for Disease Control and Prevention Project Officer to ascertain if they will consider this recommendation. The bureau chief is working at the national level to address this and other issues related to DEBI/REP. In addition, the bureau will make a request to the National Alliance of State and Territorial

AIDS Directors (NASTAD) to see what interventions outside of DEBI/REP are being used in other states and directly funded cities.

Status: ONGOING

Recommendation: The Bureau of HIV/AIDS should require all community-based organizations to take the Bridging Theory and Practice training prior to responding to the department's Invitation to Negotiate (ITN).

Bureau Response: The Bridging Theory and Practice trainings are currently being conducted throughout the state. The bureau will begin scheduling capacity-building providers to conduct the trainings prior to the Florida Department of Health, Office of Minority Health, Closing the Gap ITN.

Status: IN PROGRESS

Recommendation: The Bureau of HIV/AIDS should research science and evidence-based HIV prevention intervention for Latinos.

Bureau Response: The bureau chief is working at the national level to address this and other issues related to DEBI/REP. The bureau will make a request to CDC and NASTAD to see what interventions outside of DEBI/REP are being used in other states and directly funded cities.

Status: IN PROGRESS

Recommendation: The Department of Health should explore other prevention interventions that work in the Latino community and implement them.

Bureau Response: The bureau chief is working at the national level to address this and other issues related to DEBI/REP. The bureau will make a request to CDC and NASTAD to see what interventions outside of DEBI/REP are being used in other states and directly funded cities.

Status: IN PROGRESS

Recommendation: The Bureau of HIV/AIDS should invite a representative from the Institutional Review Board (IRB) to the next Latino Leaders Consultation to hear the group's concerns.

Bureau Response: During the next Latino Leaders Advisory meeting, we will schedule Dr. Paul Arons, Medical Director for the Bureau of HIV/AIDS and a member of the Institutional Review Board to meet with the advisory committee in order to discuss IRB process.

Status: IN PROGRESS

Recommendation: The committee would like the bureau to explore the possibility of conducting a press conference after each consultation to share their concerns.

Bureau Response: The Department of Health, Office of Communications has advised the Bureau of HIV/AIDS not to conduct a press conference after advisory committee meetings. However, there was a successful press conference for National Latino AIDS Awareness Day where members of the Latino Advisory Committee released the Call to Action document that highlighted the recommendations made by the committee. We will continue to use as appropriate, national observances to allow the advisory committee to meet with the press.

Status: COMPLETED

Recommendation: **The Bureau of HIV/AIDS should reinstate the demonstration projects and evaluate them for their effectiveness in reaching the target population.**

Bureau Response: Because the CDC guidelines for HIV prevention are prescriptive, we will explore the possibility of establishing demonstration projects with the CDC project officer.

Status: **IN PROGRESS**

Recommendation: **The bureau should add “Nosotros Hacemos La Diferencia” to the search engine for the media campaign website for Spanish speaking only persons.**

Bureau Response: The media campaign provider stated that they could use the Spanish translation of “We Make The Change” to direct users to our minority website. The provider advised against the use of “Nosotros Hacemos La Diferencia” because all of the media campaign resources are in “We Make The Change” and that translation would not direct users to the website.

Status: **IN PROGRESS**

Recommendation: **The bureau should develop HIV prevention messages for the media campaign that focus on Latino Men who Have Sex with Men.**

Bureau Response: Anson Stoner created a script for a radio spot for Latino Men who Have Sex With Men. The radio script did not meet the approval of the bureau’s internal/external review committee and the provider is in the process of creating more scripts for review.

Status: **IN PROGRESS**

Recommendation: **Create a website in Spanish.**

Bureau Response: The bureau’s minority media campaign website has a Spanish link on the home page that directs users to information that is displayed in Spanish. The bureau’s website does not include a Spanish link. The bureau is exploring the feasibility of creating a Spanish link and the translation of materials on the bureau’s main website.

Status: **IN PROGRESS**

Recommendation: **Create and develop messages and materials in Spanish.**

Bureau Response: The Bureau of HIV/AIDS is developing written Internal Operating Procedures for the creation of Spanish materials and messages. The written procedure will be developed with input from the Latino Advisory Committee. All Spanish messages and materials will be created and tested. The bureau is contracting with Anson Stoner to create radio advertisements in Spanish to be aired statewide. The bureau is purchasing promotional items for National Latino AIDS Awareness Day. Staff is currently drafting a policy regarding messages and materials. Once policy has been drafted, it will be forwarded for committee review and comments.

Status: **IN PROGRESS**

Recommendation: **Include community representation in developing messages (e.g., focus groups, peer review, advisory committee, etc.).**

Bureau Response: Effective immediately, the Miami-Dade County Health Department in conjunction with community partners, will create and/or develop ethnically/culturally specific materials and messages. The Miami-Dade County Health Department has the largest diverse population of Hispanic/Latinos employee of any county health department in the state.

Status: **IN PROGRESS**

Recommendation: **Create low literacy level messages and use cultural idiosyncrasies.**

Bureau Response: The Miami-Dade County Health Department in conjunction with community partners will create and/or develop ethnically/culturally specific materials and messages.

Status: **ONGOING**

Recommendation: **Use television and radio media more effectively; specifically during prime time hours to reach large sectors of the Latino community.**

Bureau Response: The media campaign contract provider purchases radio and television spots during peak times to reach the target populations. It is not economically feasible to purchase ads during prime time television.

Status: **ONGOING**

Recommendation: **Create various materials that target specific Latino populations and behavioral risk groups.**

Bureau Response: The Miami-Dade County Health Department in conjunction with community partners will create and/or develop ethnically/culturally specific materials and messages.

Status: **IN PROGRESS.**

Recommendation: **Develop initiatives that attract a bilingual/bicultural workforce**

Bureau Response: The Department of Health advertises all vacant positions through People First. In areas of the state where there is a large population of Latinos, "Bilingual Preferred" is noted on the advertisement. In addition, the Florida Department of Health is required to advertise all vacant positions, pay grades 20 and above, in local minority newspapers. When positions become available, the department hires the best applicant for the job according to the Equal Opportunity /Affirmative Action Act. The Bureau of HIV/AIDS has recently hired Latinos for key positions within the bureau and in other areas in the state. In addition, a Latino Statewide Latino HIV/AIDS Coordinator and a Regional Minority AIDS Coordinator was hired.

Status: **ONGOING**

Recommendation: **Provide translation services whenever possible.**

Bureau Response: The department has a contract with Interpretation and Translation Services (ITS). The contract has three major program components: interpreter training, telephonic interpretation services, and document translation services. The bureau will continue to utilize this contract provider for translation services.

Status: **ONGOING**

Recommendation: **Adapt and seek interventions tailored to meet the needs of Latinos.**

Bureau Response: This is a nationwide issue. We are working with the Centers for Disease Control and Prevention and the National Institute of Health to address this issue. The Miami-Dade County Health Department was recently in the National Alliance of State and Territorial AIDS Directors (NASTAD) Bulletin for their research on the intervention "CHICA." In addition, the intervention VOCES is an approved intervention for Hispanic/Latinos. We recently did an inventory on the number of Hispanic/Latino HIV counselors in the state. It was determined that there is at least one Hispanic/Latino HIV counselor in every county.

Status: **ONGOING**

Recommendation: **Conduct cultural competency trainings throughout the state**

Bureau Response: This training is included under the Florida HIV/AIDS Academy for Prevention Leadership. The HIV/AIDS Academy for Prevention Leadership consists of two programs: The Prevention Leadership Institute and the Capacity Building Enterprise Center. The Prevention Leadership Institute's main objective is to develop HIV/AIDS prevention leaders and is intended for prevention program directors. The Institute offers an intensive, comprehensive, capacity building educational program that includes instruction in four tracks: Intervention, Organizational Capacity Building, Proficiency/Minimum Standards and Program Design. The Capacity Building Learning Center represents a consolidation of the bureau's capacity building workshop series. The Center offers in-depth training in each subject covered in the Prevention Leadership Institute, one track at a time. The purpose of the Center is to equip participants with the knowledge and skills needed to increase their core capacity so that they can translate what they've learned into their organization's action plan and/or implement new strategies.

Status: **IN PROGRESS:**

The bureau is currently developing the Florida HIV/AIDS Academy for Prevention Leadership. While the academy is being developed, the bureau will contract with a technical assistance provider to offer the trainings.

Recommendation: Create mechanisms that focus on empowering Latinos and putting them in leadership positions.

Bureau Response: With the creation of the Latino Advisory Committee, the bureau is educating and empowering Latinos/a in Florida to become advocates for their communities. The Bureau of HIV/AIDS has recently hired Latinos for key positions with the bureau and in other areas in the state. In addition, a Latino Statewide Latino HIV/AIDS Coordinator and a Regional Minority AIDS Coordinator was hired. We will begin working with Latino organizations to provide advocacy trainings to individuals and groups and.

Status: **ONGOING**

Recommendation: **Hold elected and appointed Latino Leadership accountable.**

Bureau Response: Tom Liberti, Chief, Bureau of HIV/AIDS, met with the newly appointed State Representative, Anitere Flores, to educate her on HIV/AIDS in Florida. State Representative Marco Rubio will become the Speaker of the House in the upcoming legislative session. Representative Rubio is a strong advocate for Latino HIV/AIDS issues. Throughout the year, Mr. Liberti and staff at the AIDS Institute are educating legislators on HIV/AIDS issues, and funding. Mr. Liberti had the opportunity to meet with United States Senator, Mel Martinez's staff, while in Washington, D.C. Mr. Liberti was able to discuss HIV/AIDS issues in Florida.

Status: **ONGOING**

Recommendation: **Meet with community leaders, elected representatives, and leaders within state and local government in an attempt to get them to take action on addressing the AIDS epidemic among Latinos.**

Bureau Response: The Bureau of HIV/AIDS will continue to identify local, state, and national Hispanic/Latino organizations to educate and empower them to take action on Latino HIV/AIDS issues.

Status: **ONGOING**

Recommendation: Create coalitions and groups that support Latino leadership development.

Bureau Response: This is a very critical issue and the bureau will continue to work with the Latino Leaders Advisory Committee, local, state, and national Hispanic/Latino organizations to support Latino Leadership development. In addition, Florida's HIV/AIDS Academy for Prevention Leadership will work with Latino individuals and groups to support and develop Latino leadership.

Status: **ONGOING**

Recommendation: **Cultivate existing leadership and develop incentives to create and sustain leadership.**

Bureau Response: It is the bureau's expectation that the Florida HIV/AIDS Academy for Prevention Leadership will serve as a model program to develop and sustain leadership. In addition, with the establishment of the Latino Leaders Advisory Committee, we hope to help foster leadership skills within the committee.

Status: **ONGOING**

Recommendation: **Share the work of all of the Bureau of HIV/AIDS advisory/planning groups with others throughout the state.**

Bureau Response: The Bureau of HIV/AIDS web page is under construction to develop a site to place recommendations. We are creating a link for the Florida Comprehensive Planning Network. Under that heading, we will list all of our advisory/planning groups, to include a list of members, meeting minutes, accomplishments and ongoing activities. Site should be operational by Fall 2005. In addition, we are bringing members from the Black Leaders Advisory Committee and the Consumer Advisory Committee together to a consultation in November 2005 in order to share information. Members from the Latino, Consumers and Black Advisory committees will continue to share information during the Prevention Planning Group meetings.

Status: **IN PROGRESS**

Recommendation: **Recruit and hire a statewide HIV/AIDS Latino coordinator.**

Bureau Response: The Bureau of HIV/AIDS is in the process of filling a position to serve as a statewide Latino AIDS coordinator. The position will have lead responsibility for Hispanic/Latino-focused activities relating to prevention, care, early intervention, etc., throughout the state. The primary responsibilities of this position include coordinating HIV/AIDS programs and initiatives that impact Hispanics/Latinos statewide. A major portion of time is spent ensuring that HIV/AIDS programs and services are directed to Hispanics/Latinos. The position is assigned to and stationed at the Miami-Dade County Health Department and will report to the Statewide Minority AIDS Coordinator in the Bureau of HIV/AIDS.

Status: **COMPLETED.**

Recommendation: **Explore turning the group's recommendations into written policies.**

Bureau Response: Not all of the recommendations will require a written policy. The bureau will begin developing Internal Operating Procedures for Latino recommendations that require a written policy or procedure.

Status: **IN PROGRESS**

Recommendation: **Use the approved materials that have been created by Latino organizations for the minority media campaign and other activities statewide.**

Bureau Response: Materials created by Educational Management Services are be evaluated for use on the bureau's minority media campaign website.

Status: **IN PROGRESS**

Coordination: Prior to the addition of the Regional Minority AIDS Coordinators (RMACs), the Bureau of HIV/AIDS recognized that many minority CBOs, although well intentioned in the provision of HIV prevention, intervention and care services, needed guidance in the area of establishing an organizational infrastructure. In response to this need, the Bureau established the HIV/AIDS Minority Network, a statewide body composed of minority community based agencies within the local service areas.

The HIV/AIDS Minority Network's principal role is to ensure the viability of minority community based organizations that provide HIV/AIDS prevention and patient care services to minority populations. The network accomplishes this aim through peer-based support, mentoring both from member organizations and the fourteen minority network liaisons, and the Bureau's coordination of the provision of expert technical assistance.

The fourteen minority network liaisons assist minority CBOs and provide guidance in many areas through peer-based support, mentoring, and information exchange between members. The duties of the liaison include:

- Participation in monthly conference calls with the Bureau of HIV/AIDS, Prevention Section.
- Dissemination of information to minority and other providers in the community.
- Cultivation and enhancement of the link between the network liaisons and the RMACs by meeting at least once a month to facilitate the provision of peer-to-peer support, mentoring and exchange of ideas from experienced CBOs to new and emerging CBOs.
- Documentation of the completion of roles and responsibilities as it relates to the network.

Since November 1999, the HIV/AIDS Minority Network has conducted many regional capacity building workshops throughout Florida. Most of the participants came from minority CBOs and faith-based organizations (FBOs). These workshops have provided relevant hands-on training to small groups of executive directors, accountants, book keepers, board members, and others directly involved with minority based agencies and organizations.

Coordination: The Regional Minority AIDS Coordinators (RMACs) play an important role in the coordination of services provided in their area. There are nine RMACs in Florida, who take the lead responsibility for minority focused activities relating to prevention, patient care, early intervention, and education. The primary responsibilities of the RMACs are to provide technical assistance and consultation to prevention CBOs and the local community planning groups, specifically as it relates to minority needs and activities.

RMACs provide assistance to the statewide coordinator regarding the local implementation of a minority media campaign. They also recruit focus group participants and monitor prevention services. The RMACs assist with community outreach as it relates to the work of the Minority Task Force, as well as, working and collaborating with the Florida HIV/AIDS Prevention Planning Group and local community planning groups. These activities further stress the importance of local individuals and agencies working together to coordinate HIV activities in relation to ethnic minorities.

In several areas, the HIV/AIDS Program Coordinator (HAPC), the Early Intervention Consultant (EIC) and the RMAC work as a team coordinating each of their HIV programmatic aspects. With each team member having a specific focus, this allows for less duplication of services as well as an opportunity to focus on previously neglected subjects and concerns.

Coordination: Florida has had an extremely active media campaign since 1999, when the state kicked off the minority campaign entitled, "We Make the Change". Florida views media as the framework, which promotes community mobilization and individual change. As the name, "We Make the Change" implies, Florida uses the media as a call to action. This campaign encourages individuals to get tested, to access care, and to resolve to stay HIV negative.

Florida's media efforts are often driven from the ground up at the local level. On national awareness days (black, Hispanic, National Testing Day, World AIDS Day) community and agency activities generate local media coverage, which blanket the state and thus, tie local efforts to statewide and national efforts.

In the past, Florida has utilized local celebrities to produce TV, radio and billboard advertisements. For example Tracey Mourning, wife of Miami Heat Basketball star Alonzo Mourning, and Christina, the Latina talk show host from Univision, Hispanic TV, appeared in media campaigns which extended beyond the local level and tied in with state and national efforts.

In addition to the 1000 unique hits that Florida's www.WeMakeTheChange.com website gets each month, our English, Hispanic, and Creole culturally specific prevention messages have been distributed on billboards, posters, key chains, phone cards, pens, and church fans. Active participation from black, Hispanic, and Creole communities when choosing both the type of media and the messages presented explain the success of Florida's campaign.

Among the most recent innovative activities are:

- Partnering with the Kaiser Family Foundation and BET via a Memorandum of Understanding to air two new TV ads: "Number One" and "Security". The contact information for the Florida Department of Health and local information for testing is included in these ads. In this way, Florida maximizes its dollars and delivers high quality TV products. The ads have been aired in Florida's ten media markets since January 16, 2006. To select what TV ads are more appropriate in Florida, we conducted three assessments, which allowed members of the black community to rank several HIV/AIDS TV Public Service Announcements (PSAs). They decided which ads should be placed this year.
- During this contract year Florida developed a radio ad in Spanish for Hispanic MSM entitled "Carlos and Javier", an ad about the 'down low' (DL) in black communities entitled "Lives in Danger", and a radio ad both in English and Spanish for the general population entitled "No".
- During an average month Florida places over 2,000 minority educational HIV/AIDS ads on the air throughout the State. This media activity includes radio in all ten of Florida's major-media markets, network television in five markets, and cable television in seven markets.

In addition to the "We Make the Change" campaign, the Bureau administers the contract with Hispanic AIDS Awareness Program (HAAP). The HAAP provides informational and educational services to the Hispanic population through the utilization of television, development of Public Service Announcements (PSAs), radio activities, and print media in diverse Spanish newspapers.

D. Prioritization/Gap Analysis

- a. Priority Setting Process**
- b. Local area Priorities**
- c. Successes and Challenges**
- d. Local Interventions/Trainings**
- e. Florida Top Seven Prioritized Populations/
Interventions**
- f. Gap Analysis**

This is a description of the priority setting process which includes prioritized populations and interventions. This section includes interventions used in each area and training opportunities that have been provided. Finally the top seven populations ranked for the state of Florida.

a. PRIORITY SETTING PROCESS

The current priority setting methodology was designed and implemented by the Prevention Planning Group (PPG) in 2006 to ensure the selection of target populations and the allocation of resources were in a fair and uniform manner across the state. Guidelines to use the Four-Fold Part Methodology tool were developed by the PPG workgroup. Revisions to the guidelines were conducted in April 2006 and issued to local community planning bodies. The purpose of the guidelines was to assist each partnership to assess a local population's need for prevention efforts. All local prevention planning groups submitted prioritized populations for their areas.

The four fold path methodology consists of the following:

A. Path 1: HIV Case Data

Rationale: Priority should be given to those populations where HIV infection is occurring.

CDC requires priority setting to be "data driven." HIV case data is a stronger indicator of where new infections are occurring than AIDS case data. In the past, since HIV case reporting was just being implemented, the PPG included other "marker" data (i.e. STDs). At this point, HIV case reporting has been in place for 7 years.

B. Path 2: Disproportionate Impact

Rationale: Priority should be given to those populations that are disproportionately impacted by HIV.

In the past, PPG used "size of population" and "disproportionate impact" as factors in determining priorities. This methodology relies on disproportionate impact to assist in prioritizing populations. The greater the impact of HIV on a particular population, the larger priority it will become. As the impact of HIV on a population decreases, the population will move lower on the priority list.

C. Path 3: Resource Disparity

Rationale: Each population deserves HIV prevention efforts, and every infection averted is important. When resources are scarce and can't be distributed to every population, an attempt should be made to fill in service gaps for those populations that are receiving a lower share of resources than the disease burden they carry.

CDC requires the Prevention Plan to include a gap analysis. This approach takes into account the recent impact of HIV on each population (HIV case data) and the number of people in each population reached with HIV prevention interventions (resource inventory data). Populations with the largest gap between impact and services are ranked as the highest priority, and populations with the smallest gaps between impact and services are ranked as the lowest priority.

D. Path 4: Community Planning Partnership Deliberation

Rationale: Community Planning Partnerships consist of people “in the field”—prevention specialists, health planners, community members, behavioral scientists, epidemiologists, and others invested in making a discernible difference in this disease. Their expertise should be utilized in setting priorities.

After review of the results of the four part methodology furnished by the local planning groups, the PPG Writing Team decided that the method to identify the state wide priority populations should be determined by using HIV case data alone as the four fold path methodology needs additional development and adjustment to properly reflect the needs of the entire state of Florida. As determined by examination of the HIV case data, the following table reflects Florida’s current priority populations for HIV/AIDS prevention.

State of Florida Top Seven Target Populations	
1	HIV Positives
2	Black Heterosexual
3	White MSM
4	Black MSM
5	Hispanic MSM
6	Black IDU
7	Hispanic Heterosexual

In an effort to maximize the efficiency, effectiveness and allocation of limited HIV prevention resources throughout the state, the PPG decided to focus on seven priority populations, HIV prevention for Positives and the top six (6) prioritized by local communities. This will allow a concentrated focus statewide in delivery of HIV prevention resources to the communities and target populations most in need of HIV prevention services in each area.

In 2007, the Florida HIV/AIDS Prevention Planning Group, in collaboration with the Bureau of HIV/AIDS, will evaluate the process used this year to prioritize target populations and continue refining and improving the developed tools. By standardizing this process at the local community planning level, the state is able to demonstrate the shifting of the HIV/AIDS epidemic from one population to another, and provide goals, objectives and strategies, which are relevant, effective, efficient and productive to our HIV/AIDS prevention efforts. The Bureau of HIV/AIDS will submit an updated plan in 2007 to reflect changes in prioritization process.

The local community planning groups completed their work on the four fold path methodology in early July 2006. Community planning group's experience with the four fold path methodology resulted in comments concerning both the use of the methodology as well as the resulting population rankings. Comments included the following:

- A. Multiple deadline changes and data changes confused the local prevention planning groups.
- B. Reducing the number of populations being ranked was confusing.
- C. Input from the planning groups does not receive sufficient weight.
- D. Too much weight is given to the resource disparity category.
- E. Additional time was needed to complete the various tools.
- F. Planning groups wanted their input to affect the state plan priority populations.

Table (b) identifies the local prioritized populations. Each area will have Prevention for Positives as the number one priority population.

b. LOCAL AREA PRIORITIES

Population	Black Hetero	White Hetero	Hispanic Hetero	Black MSM	White MSM	Hispanic MSM	Black IDU	White IDU	Hispanic IDU
Area 1	3	8	9	1	2	5	4	6	7
Area 2A	3	8	9	1	2	5	4	6	7
Area 2B	2	7	8	1	4	5	3	6	9
Area 3/13	4	8	9	1	3	5	2	7	6
Area 4	4	7	9	1	3	8	2	6	5
Area 5/6/14	3	8	9	1	2	4	5	7	6
Area 7	6	9	8	1	3	2	4	7	5
Area 8	1	8	6	3	2	4	5	9	7
Area 9	5	9	7	1	3	2	4	8	6
Area 10	5	8	6	1	2	4	3	9	7
Area 11A	4	9	6	1	5	2	3	8	7
Area 11B	4	7	5	2	1	3	9	6	8
Area 12	5	9	8	1	3	2	4	7	6
Area 15	1	7	8	2	4	6	3	5	9

c. Successes and Challenges to the Four Fold Path Methodology by Area

Area 2A- The methodology skews toward populations which may be more important in other areas of the state. For example, Hispanic infections are on the rise in the state. We have only a few; yet when that is plugged into the methodology, for some reason Hispanics are given far more priority than one might expect given the very low incidence, and given the day to day experience with the epidemic in our area. Populations which are targeted through interventions can score lower in priority because of the available resources, but that does not make them a lesser priority because they are being addressed. Changing priorities without leaving room for reinforcing interventions among a population leads to actually diluting resources and causing the epidemic to grow in area where there are no or fewer resources.

Area 2B- The tool proposed challenges for Area 2B. Even with community input, the highest priority for the area, black heterosexuals was ranked number three. Areas such as disproportionate impact and resource disparity should not receive equal weight with "sound" data such as HIV case data. The tool doesn't take into consideration other indicator data such as gonorrhea or syphilis to show populations that are at highest risk

Area 4- Area 4 worked diligently on the Four Fold Path Methodology using the information supplied by the Bureau of HIV/AIDS. One of the challenges in Area 4 was the information that was sent by the Bureau.

The greatest success in the Four Fold process was during the April Prevention Planning Group meeting when the group agreed to add the counseling and testing data into the resource path. The group also agreed to get all the same information from the Bureau for each area, such as the case data, the resources, and the disproportionate impact. Area 4 took this information from the Bureau to the local Community Planning Group and completed the Four Fold Path Methodology.

Area 5, 6 & 14- The Area 5, 6 & 14 CPP did not have any problems with the four fold path methodology that we used for our streamlined plan. We had the chairs instruct the group to ignore the final priorities section until we added our local numbers. The full CPP then came to an agreement as to how to determine/prioritize our target populations for the section on local input. We then plugged those into the spreadsheet to determine our overall rankings. There were some minor changes in the top priorities, but this was also the first time we did one combined priority list rather than one for each of the three areas. We really appreciated all of the work done by the Bureau staff, particularly Lory Maddox, who completed our information early for the full combined partnership to coincide with our special priority setting meeting.

We also came to an agreement on each question of the technical assistance document. On a personal note, I would recommend that the local priorities sections are used somehow in the state's overall plan, allowing each section a 25% value vs. having the first three sections weighted at 33% each--even if the 14 partnerships' priorities are weighted equally to come up with a local ranking or some representation of local priorities into the plan. Please let me know if you have any questions or need additional information. Thanks for your attention.

Area 9-In our area, we had a challenge with the worksheet provided by the Bureau. As for the prioritization of populations, it appears that the CPP's rankings (community input) are similar to the final outcome--thus the data appears to match/mirror what the group believes to be the priorities. These have shifted over the last three years, but seem to be moving with the data.

1. The multiple deadline changes were very confusing, especially since the data and directions from the Bureau also changed.
2. In the end, the input from the areas becomes only 25% of the formula and could move a population up or down **one** rank from where the first three calculations placed it.
3. The end result for Area 9 made sense when compared to epi data.
4. We would like to know if the statewide rankings were based on statewide epi data, (If so, what was used for the "local" input?), or the sum of all area rankings "averaged" for the state. An option for "local" input would be the statewide "average" of either final area rankings or the "local" portion of area rankings.

Area 11B- We didn't have any major shifts, although our MSM population shifted downward in priority, which surprised us.

The major challenges were trying to understand exactly what the tool was communicating and how to implement strategies in line with the results. I think that more explanation would have helped me and would aid in action taken in line with the results.

Area 12-The Area 12 Partnership for Comprehensive HIV/AIDS Planning (PCHAP) first completed the recommended four-step process of prioritizing HIV Prevention target populations in January of 2006, in anticipation of developing a complete Comprehensive HIV Prevention Plan by the established deadline of April 15, 2006. The planning body members identified both strengths and weaknesses of the methodology at that time, including:

Strengths

- The tool was primarily based on actual case data versus subjective observations.
- The tool incorporated several data elements including actual case numbers, case rates among specific populations, and resources utilization rates; while still allowing for local expertise in the final decision-making.
- The population groups were slightly more general than the previous method, and were categorized specifically by cultural and behavioral differences. It was felt that this supported a larger array of activities and interventions by not focusing on smaller population groups.
- The methodology was relatively easy to follow and understand by all of the planning group members, regardless of education level or expertise.

Challenges

- The initial version of the tool provided by the Bureau of HIV/AIDS incorporated data from only one prevention resource in the area, that had served only 100 clients during the reported 12-month period - all of whom were already HIV-positive (as required to be eligible for the program); and who did not necessarily represent populations at high-risk for HIV. After identifying this as a significant limitation, the partnership chose independently to include HIV counseling and testing data as the primary indicator for the various existing prevention resources and which populations they reached most effectively. The

counseling and testing data was not yet available, however, in the breakdowns needed to use the tool as it was designed. The lead agency then provided technical assistance by calculating estimates for the percentages of the total persons tested among each of the needed population sub-categories. The partnership completed the remaining steps, utilizing that information.

- The PCHAP members observed that the recommended population sub-groups were limiting in that they did not account for other important social and behavioral considerations such as age, substance use and abuse habits, mental illness, homelessness, domestic violence and abuse, incarceration, poverty level, and education. Subsequently, a separate set of “special population” groups was also identified as a second tier of priorities in the local plan.
- The process also did not support special considerations regarding geographically underserved populations; which have been repetitively identified as populations of high need in Area 12. Subsequently, these groups were also included as a “special population,” mentioned but not prioritized in the local plan.

The new method resulted in primary grouping of the populations by behavior, with less weight given to cultural and gender differences. A significant difference that resulted was the higher ranking of IDU's from the new tool; a set of populations that was virtually absent from the 8 target populations listed in the 2004-06 plan. Simultaneously, minority heterosexual populations that had traditionally been recognized as high-priority target groups in previous plans were shifted downward in the new ranking. The planning body members did subsequently question the validity of ranking a Hispanic IDU population that had a total of 6 newly diagnosed positives in the three-year period of 2003-2005 above White heterosexuals who had nearly 6 times that number (n=29) of new cases during the same three-year period.

Additionally, since many of the CDC recommended prevention interventions do not specifically define target populations based on the same format and criteria that was used in the tool, the planning group felt a more generalized approach to defining local priorities would allow for greater flexibility in supporting funding applications for various programs. The planning body then opted to utilize the trend of grouping the populations by behaviors to produce a revised listing of local priorities. Since some of the defining characteristics in the resulting population groups differed slightly from the standardized format, the populations were submitted for inclusion in the state plan as shown above.

d. LOCAL INTERVENTIONS/TRAININGS

SUMMARY DESCRIPTIONS OF PRIORITIZED INTERVENTIONS

INTERVENTIONS FOR PERSONS LIVING WITH AIDS:

Comprehensive Risk Counseling & Services (CRCS--formerly Prevention Case Management)

Comprehensive Risk Counseling and Services aims to help clients who have multiple, complex psychosocial challenges and risk-reduction needs adopt and maintain HIV risk-reduction behaviors. It provides intensive and ongoing, client-centered prevention counseling, support, and it helps clients to access other services. Priority is given to HIV-infected persons who are having, or are likely to have, difficulty initiating or sustaining practices that reduce or prevent HIV transmission and reinfection. It helps clients initiate and maintain behavior change to prevent the transmission of HIV while addressing competing needs that may make HIV prevention a lower priority. It addresses the relationship between HIV risk and other issues; e.g., substance abuse, mental health, social and cultural factors, and physical health.

Core Elements:

- Provide CRCS as intensive HIV risk-reduction counseling combined with case management for those clients for whom case management services are not otherwise available.
- Base CRCS on the premise that some people may not be able to prioritize HIV prevention when faced with problems perceived as more important.
- Focus on persons living with HIV who have multiple, complex problems and risk-reduction needs who are having, or are likely to have, difficulty initiating or sustaining HIV-prevention practices.
- Recruit persons who have some level of commitment to participating in ongoing
- risk-reduction counseling.
- Hire case managers with appropriate training and skills to complete CRCS activities within their job description.
- Develop clear procedures and protocols for your agency's CRCS program.

Healthy Relationships

Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.

Core Elements:

- Help clients develop awareness and identify feelings, thoughts and actions.
- Teach, model, and practice 4 core skills (emotional regulation, SMART problem solving, goal setting, and assertiveness).
- Reinforce positive client behavior through the use of thanks tokens.
- Help clients identify their ideal self to help motivate and personalize behavior change.
- Deliver sessions in highly participatory, interactive small groups.

Holistic Health Recovery Program (HHRP)

Holistic Health Recovery Program, formerly Holistic Harm Reduction Program, is a 12-session, manual-guided, group-level program for HIV-infected and HIV-negative injection drug users. The primary goals of HHRP are harm reduction, health promotion, and improved quality of life. HHRP is based on the information-motivation-behavioral skills (IMB) model of HIV prevention behavioral change.

Core Elements:

- Teach skills to reduce harm of injection drug use and unprotected sexual activities.
- Teach negotiation skills to reduce unsafe sexual behaviors with sex partners, and teach skills to heal social relationships.
- Teach decision-making and problem-solving skills using cognitive remediation strategies.
- Teach goal-setting skills and develop action plans to achieve goals.
- Teach skills to manage stress, including relaxation exercises, and help clients understand what aspects of a stressful situation can and cannot be controlled.
- Teach skills to improve health, health care participation, and adherence to medical treatments.
- Teach skills to increase clients' access to their own self-defined spiritual beliefs, in order to increase motivation to engage in harm-reduction behaviors.
- Teach skills to increase awareness of how different senses of self can affect self-efficacy and hopelessness.

Together Learning Choices

Together Learning Choices (TLC) is an effective intervention for young people, aged 13 to 29, living with HIV, and it is delivered in small groups. This program helps young people living with HIV identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life. It emphasizes how contextual factors influence ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals.

Core Elements:

- Help clients develop awareness and identify feelings, thoughts and actions.
- Teach, model, and practice 4 core skills (emotional regulation, SMART problem solving, goal setting, and assertiveness).
- Reinforce positive client behavior through the use of thanks tokens.
- Help clients identify their ideal self to help motivate and personalize behavior change.

INTERVENTIONS FOR PERSONS AT HIGH RISK FOR HIV INFECTION:

Community PROMISE

Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies) is a community level intervention model for any high-risk population in which there are established peer influences. Community PROMISE focuses on the influencing risk factors for a specific population and is based on theories that indicate that messages in role model stories can change behavior by influencing attitudes, beliefs, and norms through peer influence within social networks. The intent of this intervention is to increase condom use, condom carrying, bleach use, and drug-related risk-reduction behavior. Community PROMISE uses a community identification process; produces role model stories; recruits, screens, and trains peer advocates to distribute the stories; and uses continuous formative evaluation to keep up with community trends.

Core Elements:

- Conduct community identification (formative research to identify, prioritize, access, and understand populations).
- Write role model stories (printed personal accounts of others who have reduced their risk behavior).
- Recruit and train peer advocates (who distribute role model stories and reinforce the message of the role model story).
- Perform process evaluation and make programmatic changes as needed.

Many Men, Many Voices

Many Men, Many Voices (3MV) is a 7-session, group-level HIV/STD prevention intervention for black men who have sex with men (MSM). The intervention addresses factors that influence behavior specific to black MSM, including cultural, social, and religious norms; HIV/STD interactions; sexual relationship dynamics; and the social influences of racism and homophobia on HIV risk behaviors.

Core Elements:

- Enhance self-esteem related to racial identity and sexual behavior.
- Educate clients about HIV risk and sensitize them to personal risk.
- Educate clients about interactions between HIV and other STDs and sensitize to personal risk.
- Develop risk-reduction strategies.
- Build a menu of behavioral options for HIV and other STDs risk reduction, including those that one can act on individually and those that require partner involvement.
- Train in risk-reduction behavioral skills.
- Enhance self-efficacy related to risk-reduction behavioral skills.
- Train in partner communication and negotiation.
- Provide social support and relapse prevention.

Mpowerment

Mpowerment is a community-level HIV prevention intervention for young gay/bisexual men. The goal is to decrease unprotected anal intercourse practices among this population. This intervention is conducted by a core group of 12–20 young gay/bisexual men who work to bring about communitywide change by carrying out a set of 4 activities (formal outreach, M-groups, informal outreach, publicity campaign) that convey safer sex as the norm throughout social networks.

Core Elements:

- Mpowerment Program Structure and Components
- Recruit a core group of young gay/bisexual men to design and carry out project activities.
- Recruit volunteers to help deliver services and make decisions.
- Use project coordinators to oversee project activities.
- Establish a dedicated project space.
- Conduct formal outreach, including educational activities and social events.
- Conduct informal outreach to influence behavior change.
- Convene M-groups (peer-led, 1-time discussion groups).
- Conduct a publicity campaign about the project.
- Convene a Community Advisory Board.

Popular Opinion Leader (POL)

Popular Opinion Leader (POL) is an HIV/AIDS risk-reduction program that has been successfully implemented and evaluated with men who have sex with men (MSM) and at-risk populations other than MSM. Trusted, well-liked people (opinion leaders) endorse targeted risk-reduction behaviors by having casual, 1-on-1 conversations with peers in their own social network. These endorsements change social norms about HIV prevention.

Core Elements:

- Direct the intervention to an identifiable target population in well-defined community venues.
- Conduct community identification (formative research to identify, prioritize, access, and understand populations).
- Over the life of the program, train 15% of the target population found in intervention venues or social networks as opinion leaders.
- Teach opinion leaders skills for initiating HIV risk-reduction messages with friends and acquaintances.
- Teach opinion leaders characteristics of effective behavior change communication targeting risk reduction factors. Opinion leaders personally endorse the benefits of safer behavior and recommend practical steps needed to implement change.

- Hold weekly sessions with opinion leaders, using different methods to help them refine their skills and gain confidence in delivering HIV prevention messages to others.
- Have opinion leaders set goals to engage in risk-reduction conversations with friends and acquaintances.
- Review, discuss, and reinforce at subsequent training sessions the outcomes of the opinion leaders' conversations.
- Use logos, symbols, or other devices as conversation starters.

Real AIDS Prevention Project (RAPP)

The Real AIDS Prevention Project is a community-level HIV prevention intervention to help women and their male partners reduce their risks for HIV. Specifically, the goals are to increase consistent condom use, change community norms so that practicing safer sex is the acceptable norm, and involve as many people in the community as possible. In this intervention, women are helped to move toward consistent condom use by being given condoms and messages tailored to their stage of change. The program has 3 phases: (1) preimplementation, which consists of staffing and logistics, materials development, and the completion of a community assessment; (2) implementation, which is putting the core elements into action; and (3) maintenance, which is done when project activities are running and evaluation activities are occurring.

Core Elements:

- Recruit people from the community to talk to women and men about HIV prevention and related issues.
- Have 1-on-1 discussions with community members to find out their stage of change to begin or continue condom use.
- Write and disseminate role model stories about community members' decisions to change their behavior.
- Recruit local businesses, organizations, and agencies to support HIV prevention activities.
- Conduct small-group activities to promote safer sex, and host HIV/AIDS presentations

Safety Counts

Safety Counts is a cognitive-behavioral intervention with a primary goal of reducing risks for HIV and viral hepatitis among active drug users who are not enrolled in drug treatment. It helps clients understand how their drug-use behaviors are related to influencing factors that put them at risk for HIV infection and how to design a plan to reduce these risks. Safety Counts uses structured group and individual activities conducted over a period of 4 months. Safety Counts also uses a client-centered approach, which helps create a partnership based on trust and understanding between staff and clients.

Core Elements:

- Conduct 2 group sessions (to identify client's HIV risks and current stage of change, hear risk reduction success stories, set personal goal, and identify first step to reduce HIV risk).
- Conduct 1 (or more) individual counseling session (to discuss/refine the risk-reduction goal, assess client's needs, and provide referrals [if needed] to counseling and testing and to medical and social services).
- Hold 2 (or more) group social events (to share meals and socialize, participate in planned HIV-related risk-reduction activities that help clients achieve personal risk-reduction goal, and receive reinforcement for personal risk reduction).
- Conduct 2 (or more) planned follow-up contacts (to review client's progress in achieving risk reduction goal, discuss barriers encountered, identify concrete next step and possible barriers and solutions, and make referrals to HIV counseling and testing and to medical and social services).
- Conduct or refer to counseling and testing for HIV and hepatitis C.

SISTA

SISTA (Sisters Informing Sisters about Topics on AIDS) is a peer-led social skills training intervention to prevent HIV infection in African American women. Women are given the social and behavioral skills needed to adopt HIV risk-reduction strategies. SISTA includes discussions of self-esteem, relationships, and sexual health. This intervention is based on a theory that says that people need information, training in social and behavioral skills, and knowledge of norms to apply risk-reduction strategies. The intervention also examines a woman's willingness to adopt and maintain sexual risk-reduction strategies within heterosexual relationships according to how much power she has, her commitment to the relationship, and her role in the relationship. The information is delivered in the following 5 sessions: Ethnic/Gender Pride, HIV/AIDS Education, Assertiveness Skills Training, Behavioral Self-Management, and Coping Skills.

Core Elements:

- Gather small groups of women to talk about what they will learn from the program and the challenges and joys of being African American women and to learn skills.
- Use a facilitator who is well trained and skilled in leading groups.
- Use materials that reflect pride in being an African American woman (e.g., poetry, artwork by other African American women).
- Train women how to stand up for themselves and insist on safer sex (sexual assertion skills).
- Teach women how to use condoms.
- Discuss why it is hard to talk about safer sex with partners.
- Emphasize how important it is for women to get their partner's buy-in for safer sex.

Street Smart

Street Smart is an intensive HIV/AIDS and STD prevention program for homeless and runaway youth whose behaviors place them at risk of becoming infected. It is a multisession, manual-guided, small group intervention that teaches effective behavior change, problem-solving skills, and strategies for increasing safer sexual behaviors. Specifically, eight 90- to 120-minute group sessions address improving youths' social skills, assertiveness, and coping through exercises on solving problems, identifying triggers, and reducing harmful behaviors. CBO staff members provide 2 more opportunities in the form of an individual counseling session and a trip to a relevant community health provider. The intervention is based on social learning theory, which links feelings, attitudes, and thoughts to behavior change.

Core Elements:

- Increase clients' knowledge about HIV and its transmission, the benefits of HIV testing and knowing one's status, the role of stigma, and the changing epidemiology of the epidemic.
- Have clients identify peers' and partners' social norms and expectations to increase self-efficacy.
- Have clients recognize and take control of feelings and emotional responses.
- Have clients identify risk, and teach personal use of HIV/AIDS risk hierarchy.
- Use peer support to identify personal triggers to unsafe behavior.
- Build skills in problem solving and assertiveness in social situations to reduce HIV/AIDS risk.

VOICES

VOICES/VOCES (Video Opportunities for Innovative Condom Education and Safer Sex) is a single session, video-based workshop, in English and Spanish, for the prevention of HIV and other STDs. The intervention was designed to reach heterosexual African American and Latino men and women at very high risk for HIV/STDs during a "teachable moment." The goals are to encourage condom use and to improve condom negotiation skills. During VOICES/VOCES sessions, clients watch culturally specific videos, participate in small-group skill-building sessions, learn about condoms, and receive condom samples.

Core Elements:

- Show culturally specific videos portraying condom negotiation.
- Hold small-group, skill-building sessions to practice overcoming barriers to condom use.
- Educate clients about different types and features of condoms.
- Distribute condom types identified by clients as best meeting their needs.

OTHER EVIDENCE-BASED INTERVENTIONS:

HIV Counseling, Testing & Referral

HIV Counseling, Testing, and Referral (CTR) is a collection of activities designed to increase clients' knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate medical, prevention, and partner counseling and referral services. HIV CTR can be anonymous (client's name is neither known nor solicited) or confidential (client provides name). Clients can refer themselves or be referred to CTR, which can be accessed through clinics, dedicated sites, outreach, and other services.

Core Elements:

- Obtain informed consent before delivering CTR, which is a voluntary service.
- Provide information and education about risk for HIV transmission and how to prevent HIV, type of test used, meaning of test result (including window period), and where to get more information.
- Deliver client-centered counseling.
- Set clear standards for determining when clients are not competent to give informed consent.
- Use only HIV tests approved by the FDA.
- Deliver test results in a supportive and understandable way.
- Refer clients, as needed.
- Track referrals made and completed.

Partner Counseling, Testing & Referral (PCRS)

Partner Counseling and Referral Services is a public health strategy to control and prevent the spread of HIV and other STDs. PCRS is the practice of informing current and past partners that a person who is HIV-infected has identified them as a partner at risk (sex partner or injection-drug equipment-sharing partner). PCRS advises these informed partners to have HIV counseling and testing. For partners who are not infected with HIV, PCRS provides an opportunity for intervention to prevent them from becoming infected; for partners who are found to be infected, it provides an opportunity to link them to medical evaluation, treatment, and other services and an opportunity for intervention to prevent transmission to others.

Core Elements:

- Ensure that all services are voluntary and confidential.
- Identify and contact all persons with HIV (index clients) to offer PCRS.
- Interview index clients who accept PCRS to elicit names and locating information for partners.
- Locate named partners and notify them, providing HIV prevention counseling and recommending HIV testing.

- Provide HIV counseling and testing to partners; ensure that they receive test results.
- Link partners, especially those with positive test results, to appropriate medical evaluation, treatment, prevention, and other services.

ADAPTED EVIDENCE-BASED INTERVENTIONS (Compendium of HIV Prevention Interventions with Evidence of Effectiveness from the CDC's HIV/AIDS Prevention Research Synthesis Project)

Condom Skills Education

The adapted intervention is based on the premise that familiarity with condoms and skills in using condoms properly are necessary for increasing future condom use. The intervention consists of a condom skills education session that emphasizes important points for effective condom use, group discussion of how condoms should be used and a demonstration of how to put on a condom. A variety of condoms are shown and discussed with participants. The discussion is followed by a 10- to 15-minute question-and-answer session.

Intervention Goal(s): To determine the effects of a small group intervention on the incidence of sexually transmitted diseases (STDs).

Behavioral/Health Findings: Men and women who participated in the intervention were significantly less likely to visit an STD clinic within the subsequent 12 months.

Get Real About AIDS

The adapted intervention is primarily based on Social Cognitive Theory and the Theory of Reasoned Action. The adapted intervention consisted of a 1 or 2 session skills-based curriculum that covers the following topics: HIV functional knowledge (that is, knowledge that can be used to reduce risk), teen vulnerability to HIV, normative determinants of risky behavior, condom use, and skills designed to help students recognize, manage, avoid, or leave risky situations.

Intervention Goal(s): To determine the effects of a classroom intervention to postpone the initiation of sexual intercourse and to reduce the number of students engaging in unsafe sex and drug-using behaviors.

Behavioral Findings: Students who participated in the intervention reported fewer sex partners and greater frequency of condom use.

Group Discussion Condom Promotion

The adapted intervention uses the social context of small groups to encourage change in norms, expectations, and social skills and is delivered in a single group session with 10 – 25 participants.

The session begins with an appropriate video depicting condom use as socially acceptable. After the video the facilitator leads a group discussion on methods of preventing STDs and promoting condom use. This discussion includes the reasons why people like and dislike condoms and

helps participants develop condom negotiation skills. Participants are given free condoms or information on where to obtain free condoms.

Intervention Goal(s): To determine the effects of a small group intervention to promote safer sex and condom use.

Behavioral/ Health Findings: Men who participated in the intervention had a significantly lower STD reinfection rate.

HIV Education, Testing & Counseling

The adapted intervention consists of an educational component followed by a 1-on-1 HIV counseling & testing session. The educational component includes group discussion on safe and unsafe sexual acts, proper condom use, HIV-risk behaviors and promoted condom use as well as discussing the risk with sex partners. The counseling session focuses on assessing personal risk, discussing the elements of HIV testing, and answering any questions about HIV/AIDS or testing. Test results are given to intervention participants approximately 2-3 weeks later. The post-test session gives the same risk-reduction message as during the pretest counseling (for seronegative results) or in-depth counseling, referral and linkage services (for seropositive results).

Intervention Goal(s): To evaluate the effects of HIV education and testing on sexual risk behavior.

Behavioral Findings: Participants who received the HIV education and testing intervention reported significantly fewer occurrences of unprotected intercourse than did those in the comparison condition.

Informational and Enhanced AIDS Education

The adapted intervention draws primarily from Social Cognitive Theory and Relapse Prevention Theory, and also includes concepts from the Health Belief Model and Theory of Reasoned Action. The Informational/Enhanced Education intervention consisted of 1 or 2 sessions focusing on personal susceptibility, situation analysis and skills building. Participants engage in group discussions and practice skills they could use to reduce risk in various situations. Additional strategies include role-playing, trigger identification, peer feedback and condom skills exercises. Emphasis is placed on experiential learning techniques for the purpose of enhancing participants' self-efficacy regarding their ability to initiate and maintain AIDS harm-reduction behaviors.

Intervention Goal(s): To determine the effects of small group Informational and Enhanced Education interventions on drug- and sex-related HIV risk behaviors.

Behavioral Findings: Participants in the interventions reported significant reductions in drug- and sex-related risk behaviors.

Intensive AIDS Education in Jail

The adapted intervention is based on a problem-solving therapy model. The intervention consists of 1 or 2 sessions focusing on health education issues relevant to drug users with emphasis on HIV/AIDS. Topics include general health knowledge, HIV and AIDS knowledge, factors associated with initiation and continuance of drug abuse, types of sexual behavior and HIV risk, the relationship of drug use and sexual behavior, and strategies to access services and drug abuse treatment in the community. Facilitators adapted topics to the needs of the participants to include problem orientation, problem definition and formulation, generation of alternative solutions, decision-making and solution implementation.

Intervention Goal(s): To determine the effects of a small group intervention to reduce HIV drug- and sex-related risk behaviors.

Behavioral Findings: After release from jail, participants in the intervention were significantly more likely to use condoms during vaginal, oral, and anal sex and had fewer high-risk sex partners.

Reducing AIDS Risk Activities

The adapted intervention is based on theories of social learning, conservation of resources (including coping strategies and support skills), and communal support. The intervention consists of 1 – 2 sessions small groups. Sessions features videos or movie clips with actors from the target population. The participants practice assertiveness, negotiation skills and planning skills. Participants discuss the videos/clips and are asked to provide feedback on what could have been done to reduce the risks depicted in movie/clips. Participants create personalized prevention plans and conclusion of the intervention.

Intervention Goal(s): To determine the effects of a small group intervention to enhance AIDS knowledge, attitudes, and skills and, as a result, to influence behavior change.

Behavioral Findings: Participants in the intervention increased their use of condoms with their partners.

LOCALLY-DEVELOPED INTERVENTIONS:

Mujeres en Acción Contra el VIH (Women in Action against HIV)

Mujeres en Acción Contra el VIH (MACVIH) is an early intervention program for Hispanic women that are sexually active and could, therefore, be at risk for HIV infection. The intervention is comprised of two sessions. In the first session, women become aware of their risk for HIV infection and are encouraged to get tested for HIV. A video is used as a tool to promote discussion among Latino women, which in turn creates awareness of the impact of HIV in the Latino communities, specifically in the female population. The video, "Intimate Conversations Among Women," was developed by *Hispanic women for Hispanic women*.

The second session is a skills- building session in which women are taught communication and negotiation skills so that they may be able to communicate better with their partners and avoid

HIV infection by practicing safer sex. The purpose of the intervention is to increase awareness about the impact of HIV among Latino women and encourage HIV testing. Testing is offered after the viewing and discussion of the video. It is strongly recommended that the intervention be facilitated by Latino women because it encourages the women to ask questions and it is much safer to speak to another Latino woman about sexual issues. Enough counselors should be available for HIV testing immediately following the group discussion.

This is not an intervention that followed a research protocol. It is based on the results observed in South Miami and Central Florida.

The intervention has three main objectives:

- Increase knowledge about HIV among participants and create awareness about their risk of HIV infection;
- Promote and provide HIV counseling and testing to participants;
- Develop and/or enhance communication skills among participants so that they are better equip to negotiate safer sex with their sexual partners.

Results: In the past 15 months, 282 or 93% of the 303 women that have been through the intervention have been screened for HIV and have demonstrated an interest in participating in additional sessions.

PRIORITIZED INTERVENTIONS BY POPULATION

Target Population: Black Heterosexual

SUB-POPULATIONS OF CONCERN:

HIV-Infected
Substance Abusers
Pregnant

Incarcerated
Commercial Sex Workers
Youth

Homeless
Females
Males

PRIORITIZED INTERVENTIONS (DEBI/REP):

- Healthy Relationships
- Together Learning Choices
- Comprehensive Risk Counseling and Services
- Community Promise
- Real AIDS Prevention Project (RAPP)
- Safety Counts
- SISTA
- VOICES
- Street Smart

OTHER EVIDENCE-BASED INTERVENTIONS:

- HIV Counseling, Testing & Referral
- Partner Counseling, Testing & Referral (PCRS)

ADAPTED EVIDENCE-BASED INTERVENTIONS:

- Condom Skills Education
- Group Discussion Condom Promotion
- Get Real About AIDS
- Informational and Enhanced AIDS Education
- HIV Education, Testing & Counseling
- Reducing AIDS Risk Activities

Target Population: White Heterosexual

SUB-POPULATIONS OF CONCERN:

HIV-Infected	Incarcerated	Homeless
Substance Abusers	Commercial Sex Workers	Females
Pregnant	Youth	Males

PRIORITIZED INTERVENTIONS (DEBI/REP):

- Healthy Relationships
- Together Learning Choices
- Comprehensive Risk Counseling and Services
- Community Promise
- Real AIDS Prevention Project (RAPP)
- Safety Counts
- Street Smart

OTHER EVIDENCE-BASED INTERVENTIONS:

- HIV Counseling, Testing & Referral
- Partner Counseling, Testing & Referral (PCRS)

ADAPTED EVIDENCE-BASED INTERVENTIONS:

- Condom Skills Education
- Group Discussion Condom Promotion
- VOICES

- Get Real About AIDS
- Informational and Enhanced AIDS Education
- HIV Education, Testing & Counseling
- Reducing AIDS Risk Activities

Target Population: Hispanic Heterosexual

SUB-POPULATIONS OF CONCERN:

HIV-Infected	Incarcerated	Homeless
Substance Abusers	Commercial Sex Workers	Females
Pregnant	Youth	Males

PRIORITIZED INTERVENTIONS (DEBI/REP):

- Healthy Relationships
- Together Learning Choices
- Comprehensive Risk Counseling and Services
- Community Promise
- Real AIDS Prevention Project (RAPP)
- Safety Counts
- VOICES
- Street Smart

OTHER EVIDENCE-BASED INTERVENTIONS:

- HIV Counseling, Testing & Referral
- Partner Counseling, Testing & Referral (PCRS)

ADAPTED EVIDENCE-BASED INTERVENTIONS:

- Condom Skills Education
- Group Discussion Condom Promotion
- Get Real About AIDS
- Informational and Enhanced AIDS Education
- HIV Education, Testing & Counseling
- Reducing AIDS Risk Activities

LOCALLY-DEVELOPED EVIDENCE-BASED INTERVENTIONS:

- Intimate Conversations Among Women

Target Population: Black MSM

SUB-POPULATIONS OF CONCERN:

HIV-Infected
Substance Abusers
Transgender MTF

Incarcerated
Commercial Sex Workers
Youth

Homeless

PRIORITIZED INTERVENTIONS (DEBI/REP):

- Healthy Relationships
- Together Learning Choices
- Comprehensive Risk Counseling and Services
- Many Men, Many Voices
- Mpowerment
- Popular Opinion Leader (POL)

OTHER EVIDENCE-BASED INTERVENTIONS:

- HIV Counseling, Testing & Referral
- Partner Counseling, Testing & Referral (PCRS)

ADAPTED EVIDENCE-BASED INTERVENTIONS:

- Condom Skills Education
- Group Discussion Condom Promotion
- Informational and Enhanced AIDS Education
- HIV Education, Testing & Counseling

Target Population: White MSM

SUB-POPULATIONS OF CONCERN:

HIV-Infected
Substance Abusers
Transgender MTF

Incarcerated
Commercial Sex Workers
Youth

Homeless

PRIORITIZED INTERVENTIONS (DEBI/REP):

- Healthy Relationships
- Together Learning Choices
- Comprehensive Risk Counseling and Services
- Mpowerment
- Popular Opinion Leader (POL)

OTHER EVIDENCE-BASED INTERVENTIONS:

- HIV Counseling, Testing & Referral
- Partner Counseling, Testing & Referral (PCRS)

ADAPTED EVIDENCE-BASED INTERVENTIONS:

- Condom Skills Education
- Group Discussion Condom Promotion
- Informational and Enhanced AIDS Education
- HIV Education, Testing & Counseling

Target Population: Hispanic MSM

SUB-POPULATIONS OF CONCERN:

HIV-Infected
Substance Abusers
Transgender MTF

Incarcerated
Commercial Sex Workers
Youth

Homeless

PRIORITIZED INTERVENTIONS (DEBI/REP):

- Healthy Relationships
- Together Learning Choices
- Comprehensive Risk Counseling and Services
- Many Men, Many Voices
- Mpowerment
- Popular Opinion Leader (POL)

OTHER EVIDENCE-BASED INTERVENTIONS:

- HIV Counseling, Testing & Referral
- Partner Counseling, Testing & Referral (PCRS)

ADAPTED EVIDENCE-BASED INTERVENTIONS:

- Condom Skills Education
- Group Discussion Condom Promotion
- Informational and Enhanced AIDS Education
- HIV Education, Testing & Counseling

Target Population: White IDU

SUB-POPULATIONS OF CONCERN:

HIV-Infected
Substance Abusers
Pregnant

Incarcerated
Commercial Sex Workers
Youth

Homeless

PRIORITIZED INTERVENTIONS (DEBI/REP):

- Healthy Relationships
- Together Learning Choices
- Comprehensive Risk Counseling and Services
- Holistic Health Recovery
- Safety Counts
- Community Promise

OTHER EVIDENCE-BASED INTERVENTIONS:

- HIV Counseling, Testing & Referral
- Partner Counseling, Testing & Referral (PCRS)

ADAPTED EVIDENCE-BASED INTERVENTIONS:

- Get Real About AIDS
- Informational and Enhanced AIDS Education
- Intensive AIDS Education in Jail
- HIV Education, Testing & Counseling

Target Population: Black IDU

SUB-POPULATIONS OF CONCERN:

HIV-Infected
Substance Abusers
Pregnant

Incarcerated
Commercial Sex Workers
Youth

Homeless

PRIORITIZED INTERVENTIONS (DEBI/REP):

- Healthy Relationships
- Together Learning Choices
- Comprehensive Risk Counseling and Services
- Holistic Health Recovery
- Safety Counts
- Community Promise

OTHER EVIDENCE-BASED INTERVENTIONS:

- HIV Counseling, Testing & Referral
- Partner Counseling, Testing & Referral (PCRS)

ADAPTED EVIDENCE-BASED INTERVENTIONS:

- Get Real About AIDS
- Informational and Enhanced AIDS Education
- Intensive AIDS Education in Jail
- HIV Education, Testing & Counseling

Target Population: Hispanic IDU

SUB-POPULATIONS OF CONCERN:

HIV-Infected
Substance Abusers
Pregnant

Incarcerated
Commercial Sex Workers
Youth

Homeless

PRIORITIZED INTERVENTIONS (DEBI/REP):

- Healthy Relationships
- Together Learning Choices
- Comprehensive Risk Counseling and Services
- Holistic Health Recovery
- Safety Counts
- Community Promise

OTHER EVIDENCE-BASED INTERVENTIONS:

- HIV Counseling, Testing & Referral
- Partner Counseling, Testing & Referral (PCRS)

ADAPTED EVIDENCE-BASED INTERVENTIONS:

- Get Real About AIDS
- Informational and Enhanced AIDS Education
- Intensive AIDS Education in Jail
- HIV Education, Testing & Counseling

Interventions for Injecting Drug Users

Florida remains one of the many states that has no program addressing shared needle use, even though significant male HIV infected individuals (9% IDU and 4% MSM/IDU) and AIDS – diagnosed (11% IDU and 4% MSM/IDU), based on 2004 statistics. Among females, 16% report IDU as risk factor. Nationally, 34% of male and 62% of female cases have been attributed to IDU or sex with IDU partners.

The largest barrier to reducing HIV transmission among IDU is effective prevention programs. With only about 15% of IDU currently in treatment, comprehensive, multi-component outreach efforts need to be implemented. Referral to treatment, while a necessary component of outreach, is often not adhered to. Effective harm reduction programs understand that some IDU are unable and/or unwilling to stop using drugs. Peers (recovering IDU's) have proven to be effective in influencing behavior change. Drop in centers that focus on treatment adherence and education have also proven effective. However, a harm reduction program without syringe exchange or access to sterile syringes can only be partially effective. Programs in Oakland, San Francisco and New York have shown that community-based efforts can also be effective in addressing IDU as well as other health issues.

Testing Intervention-Rapid Testing

The Centers for Disease Control and Prevention began offering training on rapid testing for HIV antibodies in 2003. In 2004, CDC emphasized rapid testing as an important component of its funded programs through its program announcements. Rapid testing facilitates at-risk individuals who do not typically access health care services to learn their HIV status in a quick, painless method, in a community setting that is acceptable to them. Offering rapid testing with the traditional pre- and post test counseling services provides an opportunity to conduct risk assessments with at-risk individuals, and to provide client-centered counseling and instruction on methods to reduce HIV transmission risk.

In 2005, close to 12% of the HIV antibody tests conducted in Florida and reported to the Bureau of HIV/AIDS were rapid tests. As rapid testing can be an important tool in identifying new infections, the Prevention Planning Group encourages the use of rapid testing whenever feasible, especially for those populations who would not access traditional testing. With rapid testing technology moving in the direction of home-based testing, it is imperative that the Florida Department of Health support CBOs in conducting rapid testing in a wide variety of sites that meet the manufacturers' qualifications for conducting the tests. Doing so will help the public associate high-quality testing services with community organizations where they will receive adequate counseling and risk reduction instruction, and as a result, at-risk individuals will turn to CBOs instead of home-based testing methods when they are approved by the FDA.

Intervention for Farm workers

Among Florida's many diverse sub-populations are migrant farm workers. These groups are often from non-english speaking countries with little to no formal education. While some may speak Spanish a vast amount speak indigenous languages and/or dialects for which interpreters are scarce. Living conditions often include sub standard housing with an excess of residents sharing cramped quarters for 1/3 to 1/2 of their already low weekly wages. The males in this group often come into the country having left behind their wives and children and find it difficult to cope with the indefinite separation thereby seeking solace in local sex workers and/or each

other. A high occurrence of alcohol abuse and a strong sense of machismo play a major role in behavior and the creation of social norms which may encourage risky behaviors. The lack of health education messages in their countries of origin contribute to a reduced perception of risk. Female farm workers often feel disempowered having come from a male dominated society. When confronted with sexual propositions they see it as a means to survival. All of these factors contribute to increased risk for HIV and other STDs.

The existing DEBI/REPS do not address the unique needs of this population. Language issues make it very difficult to tailor and adapt the interventions as there are few marketing resources available in these indigenous languages. Simple translations do not account for cultural and educational needs. Cultural values such as machismo may present a barrier to the implementation of programs like VOICES/VOCES. Since the interventions were scientifically evaluated within specific populations, there is little evidence that these would be successful in rural migrant communities.

The very nature of migrant farm work is the constant changing of locations. Once the harvest season is over for one type of crop, the group moves on to another state to harvest another product. This makes it very difficult to engage individuals and develop trust which is the basis of making the interventions work.

While geographic cultures play an important role in the behaviors of this group, the culture of migrant farm worker life also contributes to the ineffectiveness of the existing DEBI/REPS for this population. These individuals often work 12-16 hours per day 6 days per week. This limits their ability to participate in multi-session interventions. Many times commercial sex workers don't stand on the street corners waiting for customers but rather go into the neighborhoods and even into the homes of these workers offering their services to all of the residents which can include 6 to 12 men in each home. The use of a barrier is often rejected as the sex worker will receive a higher payment if no protection is used.

In a lot of these rural towns, there is little to do in terms of recreation so the crew leaders will provide pornographic movies and alcoholic beverages as a form of entertainment. Once inebriated, the men engage in same sex activities without protection believing there is no harm because it is just a way to satisfy a need and one does not have to self identify as gay. Yet traditional MSM interventions are not designed with these situations in mind.

Migrant farm workers play a major role in Florida life. Many of the rural towns report up to double the population when migrant season comes around. It is vital that we reach this population with a message of prevention. We must be supplied with the appropriate tools if we are to make an impact in this community.

Local Implemented Interventions

MSM-Palm Beach County

HIV Cases

Between 2003 and 2005, 461 new cases of HIV were reported among MSM in Palm Beach County which represents 34% of all new cases identified during that time period. As in the heterosexual community, black MSMs are significantly over represented and account for 31% of cases reported in that time period. Caucasian MSMs accounted for 49% and Hispanic accounted for 14%. Trend data from 1999 to 2004 show that HIV cases regardless of AIDS status steadily increased among MSMs during that time period, with a slight fall from 2004-2005.

HIV/AIDS Case Prevalence

Epidemiological data shows that there is a prevalence of 1735 HIV/AIDS cases in Palm Beach County through the end of 2005. 54% of the cases were among Caucasians, 32% were among Blacks, and 14% among Hispanics.

Targeted Prevention Programs

There is one funded HIV Testing, Counseling & Linkage program that specifically targets MSMs in Palm Beach County. This program initiated at the beginning of 2005 conducted over 750 tests to MSMs in Palm Beach County with a positivity rate of 4.8%. Testing participants are routinely recruited from the internet, at local venues where MSMs congregate, and through special events and outreach activities. Rapid oral HIV testing commenced on October 1, 2005. This is the only funded program that targets MSMs in Palm Beach County and represents a significant resource disparity to this high risk population.

The State of Florida will continue to implement the Center for Disease Control and Prevention's approved prevention interventions contained with the compendium of effective intervention. However, implementation of these initiatives need to allow greater flexibility and offer the ability to implement other HIV Prevention interventions for that are evidence based and that are cultural and linguistically appropriate to meet the diverse needs of the various communities throughout Florida.

Florida has been very active in conducting training for DEBI/REP interventions during the period of 2004 through 2006. Both county health departments and local community based organizations have been offered numerous opportunities to have staff members trained. Local HAPC's and RMAC's have been of great assistance in this effort. These efforts have resulted in the following programs that have been implemented in the various local areas:

Area 1 - SISTA, Community Promise, and VOICES/VOCES, Mpowerment

Area 2A - CRCS, ARTAS II, SISTA, VOICES/VOCES, and Healthy Relationships

Area 2B - Mpowerment, CTR, VOICES/VOCES, SISTA, and Healthy Relationships

Area 3&13 - VOICES/VOCES

Area 4 - Mpowerment, CTR, VOICES/VOCES, SISTA, Community Promise, POL, Healthy Relationships

Area 5, 6 & 14 - CRCS, VOICES/VOCES, Community Promise, and Healthy Relationships, POL, CTR, POL, SISTA; Non-DEBI - MACVIH (Mujeres en Accion Contra el VIH)

Area 7 - CTR, VOICES/VOCES, Healthy Relationships, Community Promise, 3MV, SISTA, Mpowerment

Area 8 - VOICES/VOCES, SISTA, CRCS

Area 9 - CTR, and Healthy Relationships, CRCS, RAPP, VOICES/VOCES

Area 10 - Mpowerment, VOICES/VOCES, SISTA, and Healthy Relationships, Partnerships for Health, Life, POL

Area 11A - 3MV, Mpowerment, CTR, VOICES/VOCES, SISTA, and Healthy Relationships, Life, CRCS, Community Promise, Safety Counts, Partnership for Health; Non-DEBI – MACVIH (Mujeres en Accion Contra el VIH)

Area 11B - Community Promise, Healthy Relationships, VOICES/VOCES, SISTA, CRCS

Area 12 - Healthy Relationships, VOICES/VOCES

Area 15 - SISTA, VOICES/VOCES, CRCS, and CTR

Intervention Trainings 2004 – June 2006

Interventions Overview

Date & Location	Number of Participants
February 14-15, 2005 – St Petersburg	36
March 16, 2006 – Jacksonville	20
TOTAL	56

Community PROMISE

Date & Location	Number of Participants
February 16-18, 2005 – Key West	22
July 25-29, 2005 – Jacksonville	20
TOTAL	42

Healthy Relationships

Date & Location	Number of Participants
March 15-18, 2005 – Orlando	25
May 2-5, 2006 – Miami	21
TOTAL	46

LIFE

Date & Location	Number of Participants
Overview – January 10, 2005 – Miami	28
Contract Managers and Sups – January 13, 2005 – Miami	13
Implementers – January 11-12, 2005 – Miami	14
TOTAL	55

Mpowerment

Date & Location	Number of Participants
Overview – October 5, 2004 – Tampa	12
Implementation – October 6-8, 2004 – Tampa	11
Implementation – April 26-28, 2006 – Orlando	13
TOTAL	36

Prevention Case Management (now Comprehensive Risk and Counseling Services)

Date & Location	Number of Participants
October 18-20, 2004 – Miami	25
October 25-27, 2004 – Ft. Pierce	24
November 3-5, 2004 – Miami	25
January 11-13, 2005 – Tampa	30
October 18-20, 2005 – Tampa	26
February 22-24, 2006 – St Petersburg	24
TOTAL	154

Popular Opinion Leader

Date & Location	Number of Participants
March 9-10, 2006 – Ft. Lauderdale	22
TOTAL	22

RAPP

Date & Location	Number of Participants
April 17-21, 2006 – West Palm Beach	16
TOTAL	16

SISTA

Date & Location	Number of Participants
TOF – March 9-12, 2004 – Pompano Bch	9
TOF – March 22-25, 2004 – Gainesville	8
TOF – March 7-9, 2005 – Tallahassee	20
TOF – July 19-21, 2005 – Miami	23
Overview – July 29, 2005 – Tampa	27
TOF – October 12-15, 2005 – Orlando	17
TOF – November 2-5, 2005 – Tallahassee	10
TOF – May 17-19, 2005 – Orlando	11
TOTAL	125

(TOF = Training of Facilitators; Overview = Overview course)
VOICES/VOCES

Date & Location	Number of Participants
February 23-24, 2004 – Tallahassee	21
March 17-18, 2004 – Riviera Bch	15
April 29-30, 2004 – Miami	36
August 16-17, 2004 – Sarasota	20
September 20-21, 2004 – Jacksonville	21
March 10-11, 2005 -- Tallahassee	23
May 12-13, 2005 – Tampa	32
August 11-12, 2005 – Orlando	23
August 11-12, 2005 – Tallahassee	15
December 8-9, 2005 – Miami	16
December 15-16, 2005 – Miami	6
February 2-3, 2006 – Jacksonville	18
April 20-21, 2006 – Orlando	13
TOTAL	259

**Other Capacity-Building Trainings
2005 – June 2006**

Bridging Theory and Practice

Date & Location	Number of Participants
March 1-2, 2006 – Miami	25
March 7-8, 2006 – Miami	12
TOTAL	37

Community Assessment

Date & Location	Number of Participants
March 14-15, 2006 – Jacksonville	9
TOTAL	

Leadership

Date & Location	Number of Participants
April 11, 2006 – Jacksonville	24
May 24-25, 2006 – Orlando	13
June 8-9, 2006 – Sarasota	13
TOTAL	50

Logic Modeling

Date & Location	Number of Participants
January 17, 2006 – Orlando	27
March 9, 2006 – Orlando	15
TOTAL	42

Small Group Facilitation

Date & Location	Number of Participants
August 8-10, 2005 – Orlando	25
December 5-7, 2005 – Miami	27
January 23-24, 2006 – St. Augustine	23
April 24-26, 2006 – Orlando	16
May 22-24, 2006 – St Petersburg	13
TOTAL	104

e. FLORIDA TOP SEVEN PRIORITIZED POPULATIONS/INTERVENTIONS

The top seven target populations for the state are based on the state HIV case data. According to this data, the top seven state populations are:

1. HIV positive persons
2. Black Heterosexuals
3. White Men who have Sex with Men
4. Black Men who have Sex with Men
5. Hispanic Men who have Sex with Men
6. Black IDU
7. Hispanic Heterosexuals

The needs of these populations are based on

- Statewide epidemiological data
- Input from Prevention Planning Group writing team
- Research articles
- Recommendations from bureau advisory groups, specifically the MSM, Black Leaders, Latino leaders and Consumer workgroup

The needs of the respective populations are as follows:

HIV Positive Persons:

Prevention interventions targeted toward HIV positive individuals that meet DEBI/REP criteria. According to Kelly Knight article "Sexual Risk Taking Among HIV-Positive injection Drug Users", since the implementation of more effective treatment for HIV, there has been an increasing recognition of the need for prevention services and programs for HIV-sero-positive person (Jansen et al., 2001). Although new treatments have resulted in dramatic benefits, they also provide for prevention challenges as there are more opportunities for lapses in safer behavior (Vlahov et al., 2001). A recent report by the Centers for Disease Control and Prevention (CDC, 2004) suggests many reasons to focus prevention efforts on persons already infected with HIV. Sustained challenges with reducing HIV infection in the United States are highlighted by reported statistics such as (a) there was a 2.2% increase of AIDS diagnosis between 2001 and 2002, (b) the annual estimated number of new HIV infections has not decreased over the past 10 years, and (c) between 1999 and 2002, the number of newly diagnosed infections increase 17% among men who have sex with men (MSM) (CDC, 2004). Further cause for supporting programs for person infected with HIV comes from data on recent syphilis outbreaks among HIV-positive MSM, which suggest that risk behavior are increasing in this group (CDC, 2004) (Baskin)

NEED:

Kesteren, Hospers, Kok and Empelen conducted a study for the purpose of examining the psychological processes pertaining to sexuality and sexual risk behavior among HIV-positive

men who have sex with other men (MSM). Their findings suggest that sexual problems in HIV-positive MSM might primarily be caused by the perceived risk of transmitting HIV to others. Furthermore, safer sexual behavior seems to be related to feelings of personal responsibility for safer sex. This study illustrates that although some men might have a clear notion of personal responsibility for safer sex, contextual factors can influence whether behavior is consistent with their norms of personal responsibility.

In the AIDS Education and Prevention June 2003 Journal it is noted that prevention must include an understanding of the sexual needs and sexual need fulfillment experienced of each individuals. Other literature suggests that sexuality has many factors that contribute to sexual behaviors and that each individual draws from their own sexual desires and how one views their risk behavior. Health care providers and prevention specialist must increase their skills in identifying risk behaviors in positives and making accurate assessments for linkage to service providers such as mental health, adherence to antiretroviral therapy, and emotional support. These supportive services must include a more generalist approach to include individual level, family and community level services.

Black Heterosexuals:

Blacks comprise 14%* of Florida's adult (13+) population, but nearly half (49%) of the 101,013 AIDS cases and 53% of the 35,584 HIV cases reported through December 2005. In 2005, blacks accounted for 45% of AIDS cases in men and 70% of those in women. Blacks accounted for 42% of HIV cases in men and 66% of those in women. In Florida 81,657 adults are currently living with HIV/AIDS, 41,727 (51%) of whom are black. Black men have a reported AIDS 1,529 AIDS cases. Black women comprised 1,041 of the 1,486 reported AIDS cases among women in 2005 and 1,099 of the 1,670 women who were reported with HIV. The AIDS case rate among black women was 22 times higher than that among white women. Of the 1,876 pediatric HIV/AIDS cases through 2005, 80% were among blacks. Black children less than 13 years old made up 21% of Florida's population (under age 13) in 2005. In 2005 heterosexual men accounted for 26% of the HIV/AIDS cases. Heterosexual contact was the mode of transmission in 2005 for 65% of black women.

U.S. HIV cases are soaring among black women. Social factors make the group particularly vulnerable to the virus. That development, epidemiologists say, is attributable to socioeconomic and demographic conditions specific to many African American communities. Black neighborhoods, they say, are more likely to be plagued by joblessness, poverty, drug use and a high ratio of women to men, a significant portion of whom cycle in and out of a prison system where the rate of HIV infection is estimated to be as much as 10 times higher than in the general population. Fears (2005).

Other factors contributing to the increased rate of HIV is the astronomical number of black men that continue to go in and out of the jail and prison system. Black women are torn from relationships and go on to have "more concurrent relationships," or more than one partner in communities where more people are infected, according to an article, "Social Context, Sexual Networks and Racial Disparities in Rates of Sexually Transmitted Infections," written by Adimora and Victor J. Schoenbach, an associate professor in UNC's school of medicine. "Incarceration directly affects sexual networks through disruption of existing partnerships," Adimora and Schoenbach wrote. Black men entering prison are placed in an environment with "a pool of individuals among whom high risk sexual behaviors, HIV infection and other sexually transmitted infections are high."

HIV infection among prison inmates is estimated to be 8 to 10 times higher than that of the general U.S. population. "Health experts can't point to any study of male sexual preferences before and after prison sentences, or in behavior once outside," Adimora said. "Even if they could, she said, imprisonment and promiscuity in black communities are not the issue, the socioeconomic conditions that lead to prison are."

NEED:

According to C. A. Latkin and A. R. Knowlton, "a social ecological perspective must be applied to be effective and sustainable, HIV-prevention interventions need to be sufficiently powerful to counteract prevailing social norms and diffuse through the targeted community to provide social reinforcement for behavior changes. HIV prevention intervention for the Black heterosexual should be Science/evidenced based, culturally specific for the target population which includes: intensive and more comprehensive early counseling testing and linkages to other social service providers (i.e. drug treatment, risk of drug use and hepatitis). Injection drug use is the 2nd and 3rd leading cause of HIV infection for black women and men, respectively. Drug users are more likely to have unprotected sex when under the influence. Study indicates that HIV-infected people, 35% of black men reported bisexual behavior. However, only 6% of black women reported having a bisexual partner.

Culturally appropriate group and individual-level education and counseling is at the top of the reported need. The distinct cultural norms of the African American population is often contradict or inhibit safer sex and risk-reduction intentions, especially for the women in the population. African-American women, for example, report that male sexual partners often do not "like" to use condoms and exercise a common level of dominance within the population that enables them to virtually "force" women to practice unsafe sex. Many of these women report being made to feel "dirty" by family members, elders, and even peers on the basis that they were obviously planning to engage in pre or extramarital sex because they obtain or carry condoms. Strong religious and moral values among tight-knit African American communities further enforce these types of negative attitudes and perceptions.

Additionally, gay and bisexual men acknowledge that there is a significant proportion of minority male population that have sex with other men, but do not reveal this behavior to unsuspecting female sex partners. Severe stigma toward same-sex intercourse instills fear among many "closet" gay and bisexual men in the African America communities, preventing them from accessing appropriate information and services. Other data indicates that 56% of people who were diagnosed with AIDS within 1 year of testing positive for HIV were blacks further indicating late testing further justifying an increased need for a comprehensive approach for prevention.

White MSM:

In most developed countries it was gay men who were affected earliest and most severely by HIV. In the early 1980s, incidence rates of HIV of 20% a year were described, leading to a prevalence of up to 50% in gay men in some US cities. Death and disability became part of life in gay communities.

According to estimates by the Centers for Disease Control and Prevention (CDC), only 5% to 7% of men in the United States identify themselves as MSM, while MSM accounted for an estimated two-thirds of all HIV infections among men in the U.S. in 2003 (To view the CDC MSM Fact Sheet click on the link <http://www.cdc.gov/hiv/pubs/facts/msm.htm>.) Similarly, in

Florida, 68% of all reported HIV infections among men in 2004 were classified into the MSM and MSM/IDU risk categories, indicating a marked disparity. From 1998 to 2004, the annual number of reported HIV cases among MSM increased from 2,093 cases (51% of total male cases) in 1998 to 2,790 cases (64% of total male cases) in 2004, an increase in number of cases of 33%. During the same time period, HIV cases among MSM/IDUs decreased from 248 (6% of total male cases) in 1998 to 156 (4% of total male cases) in 2004. Through 2004, there were 31,227 MSM living with HIV/AIDS. Of those cases 50% were white, 26% were black, 23% were Hispanic and 1% was all others (this includes Asians/Pacific Islanders, American Indians, mixed race group). Through 2004, there were 2,830 MSM/IDUs living with HIV/AIDS. Of those cases 45% were white, 38% were black, 16% were Hispanic and 2% were all others. Large increases in MSM HIV cases from 1999 - 2004 are evident among whites and Hispanics: white MSM: +39%; black MSM: -4%; Hispanic MSM: +42%. Currently, there are syphilis outbreaks among MSM in several counties in Florida. In Miami-Dade County, MSM accounted for 11% of all cases of infectious syphilis in 1999, and 61% of such cases in 2004. In Broward County the corresponding numbers were 32% in 1999 and 76% in 2004. HIV/syphilis co-infection rates have been greater than 60% in these two counties. STD trends in South Florida often precede similar trends elsewhere in the state.

NEED:

As soon as AIDS was recognized as being a sexually transmissible infection, education and prevention campaigns were rapidly implemented. In many countries, these were mobilized by gay organizations in the face of government inaction. These campaigns led to large scale declines in the practice of unprotected anal intercourse, which had previously been the norm, and declines in the incidence of sexually transmissible infections, including HIV. This behavior change was so successful in reducing the incidence of HIV that gay communities became the example of what is possible in HIV prevention in the community. *BMJ* 2000;320:1487-1488 (3 June).

The USA today 02/05/2001 issue writes, many worry that homosexual men have grown complacent about catching HIV because effective treatments can hold the disease in check. Some of these gay men may be more likely to have risky sex, such as anal intercourse without condoms.

The new study does not reveal whether dangerous sex practices are growing among the young, but it does show that such habits are common. Almost half of the men surveyed admitted they had had unprotected anal sex during the previous six months.

The Miami Herald - July 8, 2002 writes, BARCELONA, [Spain](#) - (Reuters) - Three-quarters of young gay men with HIV infection in U.S. cities are unaware they are carrying the virus, the results of a study released Monday suggested.

And more than half of the HIV-positive men surveyed said they considered themselves to be at low risk of infection, lead researcher Dr. Duncan MacKellar, of the Centers for Disease Control and Prevention, told a world AIDS conference.

MacKellar and colleagues conducted an anonymous survey and HIV tests on 5,719 gay or bisexual men between the ages of 15 and 29 who lived in Los Angeles, Seattle, Dallas, Baltimore, Newark or Miami.

Of the 573 men who tested positive for HIV infection, 440 were unaware of it and might have inadvertently transmitted the virus to their partners, the researchers said.

Michael Gross's second article "the Second Wave Will Drown Us" (citing a Centers for Disease Control statistic of a 14% increase of HIV/AIDS among homosexual men in the United States between 1999 and 2001), provided data from California and New York (two states that were excluded from the CDC report), which includes unprecedented outbreaks of syphilis and alarming rates of rectal gonorrhea. Gross concludes, "Behavior interventions to promote condom use as the only strategy currently available to stem the MSM epidemic-are failing."

Black MSM

The incidence of human immunodeficiency virus (HIV) infection among young black men who have sex with men (MSM) is among the highest of all risk groups in the United States. Brown (1978). More than 2 decades after the first reports of the HIV/AIDS epidemic in the United States, men who have sex with men (MSM) still account for the largest number of cases of AIDS and a growing number of new cases of HIV infection (Blair, Fleming, & Karon, 2002; Catania et al., 2001; Centers for Disease Control and Prevention [CDC], 2002, 2003; Koblin et al., 2000; MacKeller et al., 2002; Stall, Hays, Waldo, Ekstrand, & McFarland, 2000; Valleroy et al., 2000). Studies in recent years find that the burden of AIDS and incidents of HIV infection have continued to shift from White men who have sex with men to younger men of color, particularly African American MSM (Bingham, et al., 2003; Blair, et al., 2002; Brooks, Rotheram-Borus, Bing, Ayala, & Henry, 2003; CDC, 2001, 2002; Karon, Fleming, Steketee, & De Cock, 2001; Koblin et al., 2000; Shehan, Freeman, & Kazda, 1999). These emerging data signal not only the changing face of the HIV/AIDS epidemic to one that is increasingly associated with racial/ethnic minorities, but the data also serve as a reminder of the ways that social inequality based on race, ethnicity, economic status, and sexual orientation in the United States is confounded with HIV transmission and infection (Cochran & Mays, 1987; Zierler & Krieger, (1997).

According to the Florida Comprehensive HIV Prevention Plan for the CPG, March 2003, the Black, non-Hispanic population is undeserved, and is therefore over-represented in the current AIDS epidemic. More than other race/ethnic groups, blacks tend to be diagnosed with HIV infection within a month of developing AIDS, and to die within a month of AIDS diagnosis – two important indicators of not accessing early testing and treatment. Blacks comprise 12% of Florida's adult population, but 45% of the nearly 75,000 AIDS cases reported through 1999. In 1999, blacks accounted for 48% of newly reported AIDS cases among men, and 73% of cases among women.

Statistics show that of all the newly documented HIV cases in the United States the Black MSM population represent the majority of the cases. Michael Gross's editorial, "When Plagues Don't End," (p 861-862) focuses on the resurgence of HIV/AIDS among homosexual men in the United States. The highest rates of HIV transmission are among African-American and Hispanic men who self-identify as gay. Those rates are devastating. Gross notes, "To prevent HIV transmission, we have little more today than we had two decades ago, when it became clear that the virus causing AIDS is sexually transmitted: behavioral intervention."

Black men who have sex with men in the United States are more than twice as likely to be HIV-positive as white and Latino MSM, according to a study published in the June 24 issue of... [CDC's *Morbidity and Mortality Weekly Report*](#), [Reuters Health](#) reports. Dr. Francisco Sifakis of [Johns Hopkins Bloomberg School of Public Health](#) and colleagues from CDC's [National HIV](#)

[Behavioral Surveillance](#) system tested 1,767 MSM at bars, clubs, organizations and other venues in five cities and found that overall, 25% tested HIV-positive. However, the percentage differed among racial groups, with 46% of black MSM testing HIV-positive, compared with 21% of white men and 17% of Latino men. About 48% of all the men who tested positive were unaware of their status. Of this group, 64% were black, 18% were Latino and 11% were white. Although most men in the study group had been tested for HIV in the past, 58% of the men who were unaware of their HIV-positive status had not undergone testing during the previous year. These men said they avoided HIV testing because they feared learning that they had the virus and were afraid that others would discover their test results. "We know that persons who are aware of their HIV status take measures to seek treatment and reduce risk behaviors, which underscores the importance of annual testing, particularly among African-American MSM," Stephanie Behel of CDC said, adding that informing individuals in advance that they can learn their test results in 20 minutes will encourage testing. "We have to increase our prevention messages to help people understand about the benefits of treatment and that people are living longer and healthier lives even with HIV infection," she said.

NEED:

The Federal Centers for Disease Control and Prevention (CDC) recently conducted a random study of men, 18 years and older, from 5 cities that participate in the National HIV Behavioral Surveillance system. The cities were Baltimore, Los Angeles, Miami, New York and San Francisco. The participants in the study were also tested for HIV after giving informed consent.

The findings suggest that the HIV seroprevalence among black men who have sex with men is higher than was seen in the earlier studies and is higher than the rate for other racial and ethnic groups. HIV prevalence was 46% among the black participants. In contrast, HIV prevalence among white participants was 21%. The HIV prevalence for all participants was 25%. Another disturbing finding was that of all participants who tested positive, 48% were unaware that they were HIV positive prior to participating in the study. Of those who were unaware of their HIV status, 64% were black.

According to the Centers for Disease Control and Prevention (CDC) publication (Preventing HIV Among Latino and African American Gay and Bisexual Men) a report that found that, despite declining rates of syphilis overall in the United States, African Americans, Latinos and MSM are at a disproportionately higher risk of getting syphilis. In fact, African Americans were 30 times more likely to have syphilis than whites in 1999. And co-infection with HIV and an STD like syphilis can make HIV easier to transmit.

In 1993 Human Organization article, Jerome Wright called for more research on African American male sexual behavior and the risk for HIV infection. Specifically, there has been limited HIV prevention intervention among rural Blacks residing in Florida.

When the epidemic first began, scientists sought to understand the HIV disease by using traditional epidemiologic and surveillance procedures (Mays, 1992). According to the Center for Disease Control (CDC) most community-based organizations focusing on HIV/AIDS prevention were formed at a time when the best line of defense against the spread of infection was thought to be broad-based prevention education programs targeted to entire communities and gay men. Undoubtedly, these programs contributed to the decline in the number of new HIV cases and deaths with AIDS reported in the U.S. by the late 1990s. Since 1998, however, over 40,000 new cases of AIDS and 21,000 new cases of HIV have been reported each year. Additionally,

since the early 1990s, population trends of those affected by or at risk for infection and disease have shifted significantly to include higher percentages of people of color. Many of those at the greatest risk today are members of hard-to-reach populations who may not be aware of their HIV status.

Professionals in the field agree that before implementing any successful behavior change, an assessment must be done to identify barriers and opportunities that are unique to the culture [which would allow the behavioral change to successfully reach the target population]. Thus far research specifically targeting the uniqueness and complexity of the African American MSM has not been done. Mays, Cochran and Zamudio assert, "to stop the epidemic, we need to somehow find the behaviors that increased the likelihood of transmission and classify those individuals most likely to engage in these behaviors." This need to categorize people still, in view of the diversity of African American men who have sex with men (gay men, MSM, homo thugs, and men on the down low), shows a weakness in how we approach prevention (Mays et al., 1992).

In an anonymous piece written by a Jamaican gay man, he states, "if the Black church were to remove every homosexual from its ranks there would be no more choir, half the pastors would vanish, and some of the sisters would not be getting it as regularly as they currently do. " As it relates to geographically to the south, many of the rural African Americans churches in North Florida have been reluctant to provide and accept HIV prevention intervention especially when prevention relates to the Black MSM population. The prevalence of HIV/AIDS among the African American MSM population supports the need for churches to become involved in HIV/AIDS prevention interventions. According to C. A. Latkin and A. R. Knowlton, "a social ecological perspective must be applied to be effective and sustainable, HIV-prevention interventions need to be sufficiently powerful to counteract prevailing social norms and diffuse through the targeted community to provide social reinforcement for behavior changes."

Hispanic MSM

In the United States, MSM have been the most impacted group with HIV/AIDS and continue to drive the epidemic. It is estimated that MSM represent 70% of all HIV-infected men in the U.S. with 42% of new infections occurring in this population. In Florida, MSM accounted for 35% of HIV (regardless of AIDS status) and 32% of AIDS cases in 2004. Among Latinos, MSM accounted for 41% of all AIDS cases and 46% of all HIV (regardless of AIDS status) cases in 2004.

The rate of reported HIV and AIDS cases among Latino MSM in Florida follow similar trends throughout the country. Latino and other MSM of color have some of the highest HIV seroprevalence rates, incidence rates and rates of unprotected sex of any group in the county. Latino gay and bisexual men live in environments that permeate HIV stigma, racism, and homophobia. For some, these oppressive settings are compounded with poverty, violence and dis-empowering surroundings. Studies on Latino gay men and HIV have demonstrated that these oppressive forces lead to social isolation, alienation and personal shame. These studies have also demonstrated a direct correlation between such oppressive forces and increased risks for HIV infection. In fact a study conducted in 2001 of Latino gay men in urban settings (conducted in three cities: New York, Los Angeles and Miami) found that men who reported high-risk behavior also reported significantly higher rates of financial hardship, experiences of

racism and homophobia, incidence of domestic violence and a history of coercive childhood sexual abuse. Such dynamic leads many men to hide their sexuality.

March & Simon (1959) cite that risk behaviors are not randomly distributed within a population; rather, risk behaviors are generated and perpetuated through socially or environmentally structured social interactions. This piece of information helps to explain why HIV, as well as other infectious diseases, is often found within a certain sub-population. Researches found other barriers in trying to reach this sub-population. Their views of risk behaviors and their definition of protected and unprotected sex greatly differ across each sub-population.

NEED:

The HIV/AIDS epidemic is a serious threat to the Hispanic community. In addition to being a population seriously affected by HIV, Hispanics continue to face challenges in accessing health care, prevention services, and treatment. In 2002, HIV/AIDS was the third leading cause of death among Hispanic men aged 35 to 44 and the fourth leading cause of death among Hispanic women in the same age group. An assessment of Latino gay men show that sexual enhancement was a primary reason for methamphetamine use, thereby indicating a solid link between methamphetamine use and sexual risk among MSM (Public Health Report, March-April, 2006).

A cross-sectional survey with a multistage probability sample of unmarried adult MSM living in households was conducted by the Department of Public Health, college of Health and Urban Affairs, Florida International University, Miami, Florida; and the Center for AIDS Prevention Studies, University of California, San Francisco, California and found that Hispanic

HIV-related stigma, discrimination, and homophobia impede community-based efforts to combat HIV disease among Latino and African American gay and bisexual men. Some strategies includes: (1) addressing social biases present in a community that can hinder, and even prohibit, utilization of effective HIV prevention programs; (2) recasting HIV prevention messages in a broader social or health context; (3) developing culturally appropriate HIV prevention messages; (4) exploring new modalities and venues for delivering HIV prevention messages that are appropriate for gay and bisexual men of color and the communities in which they live; and (5) broadening the target of HIV prevention services to include service providers, local institutions and agencies, and the community at-large.

In the United States, the annual number of new HIV infections has declined from a peak of more than 150,000 during the mid-1980s and has stabilized since the late 1990s at approximately 40,000. Populations of minority races and ethnicities are disproportionately affected by the HIV epidemic. To reduce further the incidence of HIV, CDC announced a new initiative, [Advancing HIV Prevention](#), in 2003. This initiative comprises 4 strategies: making HIV testing a routine part of medical care, implementing new models for diagnosing HIV infections outside medical settings, preventing new infections by working with HIV-infected persons and their partners, and further decreasing prenatal HIV transmission.

CDC provides 15 awards to community-based organizations that focus primarily on Hispanics and provides funding through state, territorial, and local health departments to organizations serving this population. The following are examples of CDC-funded programs focused on Hispanics

- An organization with many locations in California uses outreach teams to provide hard-to-reach populations with information on health screenings and linkages to services.
- An organization in Chicago assists persons with disabilities and their families (including those affected by HIV/AIDS) by assessing their needs and designing a plan to best meet those needs.
- An organization in Massachusetts offers many programs and support services.

CDC, through the [Minority AIDS Initiative](#), supports efforts to reduce the health disparities experienced in communities of persons of minority races or ethnicities who are at high risk for HIV infection.

The following are examples of scientifically based interventions that CDC provides to organizations.

- Many Men, Many Voices (3MV), an intervention to prevent sexually transmitted disease, including HIV infection, among gay men of color, addresses cultural and social norms, the dynamics of sexual relationships, and the social influences of racism and homophobia.

ADAPT (Adopting and Demonstrating the Adaptation of Prevention Techniques) provides funding to agencies to adapt and evaluate interventions that have proven effective in communities of color

Black IDU

Reported by: Local, state, and territorial health depts. The Division of HIV/AIDS, National Center for Infectious Diseases, CDC. Among males who were racial/ethnic minorities, the most common modes of HIV exposure were male-male sex (39%) and injecting-drug use (IDU) (38%). IDU was the principal HIV exposure among blacks; most (60%) IDU-associated cases among blacks were reported in the Northeast and Puerto Rico. Among black females, IDU was the most common exposure in the District of Columbia and 23 (52%) of 44 states that reported AIDS cases among black females, and heterosexual contact was the leading exposure in 20 (45%) states.

Injection drug users (IDUs) are particularly susceptible to HIV-related risks. According to the Florida department of health HIV surveillance report 2005 injection drug use is the 2nd and 3rd leading cause of HIV infection for black women and men, respectively. Drug users are more likely to have unprotected sex with under the influence.

Douglas Longshore (2006), conducted a theory based prospective test of predictors of sexual risk reduction among drug-using men and women. Their findings demonstrated the usefulness of the ARRM as a theoretical “test bed” for comparing psychosocial antecedents of sexual risk reduction across gender. Alternative models might have been equally plausible (MacCallum et al., 1993). Measurements of baseline sexual risk behavior (the latent factor for women and the behavior risk index for men) were significant predictor of follow-up sexual risk behavior, thus supporting the need for behavior based interventions.

Safer sex commitment led to reduction in sexual risk behavior in both gender groups. Women scored high than men on safe sex commitment, but the effect of this factor was similar in both groups. The path from self-efficacy to safer sex commitment was significant for women but not

men. Moreover, both of these factors were related to AIDS knowledge more closely for women than for men. These findings suggest that women realize the importance of sexual risk avoidance and are aware that their sexual risk taking is not entirely under volitional control.

Gender differences in the pathways to sexual risk reduction imply that intervention to promote sexual risk reduction should be designed to address such differences. Commitment to safer sex was related sexual risk reduction among drug-using men. Intervention with this population should therefore target safer sex commitment such as: commitment-building exercises included counter attitudinal advocacy, declarations or written statements of commitment, and behavior contracts (Strecher et al., 1995).

For drug-using women, safer sex commitment was related to sexual risk reduction. Women's interventions should seek to raise commitment to safer sex by strategies such as those described for men. Van Uchelen, (2000), noted that the most effective strategy may be one that addresses both self-efficacy and peer norms. *AIDS and Behavior*, Volume 10, No. 1 January 2006.

NEED

One of the greatest challenges for the HIV prevention community in the 21 century is the shift to an HIV prevention approach that addresses individual in the needs of the contexts of their own lives, with a focus on a broader side of issues. A harm reduction approach acknowledges that people engages in unhealthy behaviors and seeks to reduce the harm that results from that behavior. (*AIDs Education and prevention* (August 2005) volume 17.)

HIV prevention programs are tailored to selected groups based on an understanding of the distribution of risky behaviors in the population and the association between these risky behaviors and infection. (*HIVAIDS Special Surveillance Report* 2001). Other programs for Risk Reduction through Knowledge of Self (WORKS) intervention program offered a series of four HIV prevention workshops, in conjunction with sexually transmitted infection (STI) and HIV counseling and testing to female injecting drug users (IDUs) or the partners of IDUS. This community collaboration was to integrate the strengths of researchers and service providers in a comprehensive approach to prevention evaluation, (Brown, Luna, Ramirez, 2005).

Any harm reduction program must recognize that there are steps which include an individualized approach. This approach includes: 1) Individuals are treated with dignity as normal human beings. Harm reduction attempts to recognize and removed judgments about any other person or group. 2) Each participate actively participate in setting their own goals both short and long term; and that any reduction in harm is a step in the right direction. Quality of life and well-being are criteria for measuring success. 3) Harm reduction prevention must also have an array of linkages of service providers in an attempt to assure that goals are obtainable. Community service provides must engage the total community empowering collaborative partners and researchers to overcome their preconceptions about each other in order to create a successful HIV prevention intervention and evaluation study for injection drug in the targeted communities.

Finally, HIV prevention programs are tailored to selected groups based on an understanding of the distribution of risky behaviors in the population and the association between these risky behaviors and infections. Implementation, and evaluation of HIV prevention services to men who have sex with men (MSM) and injection drug users (IDU). HIV testing remains an

important component of prevention activities; learning one's HIV status is the key stepping stone into care or ongoing behavioral risk reduction services (Janssen et al, 2001; CDC, 2003).

Hispanic Heterosexual

Hispanics comprise 18%** of Florida's adult (13+) population, 16% of the 99,509 adult AIDS cases and 18% of the adult 35,214 HIV (not AIDS) cases through December 2005.

In 2005, Hispanics accounted for 20% of AIDS cases in men and 14% of those in women.

In 2005, Hispanics accounted for 28% of HIV cases in men and 15% of those in women.

In 2005, the reported AIDS case rate and HIV case rate among Hispanic men were 51.6 and 64.1 per 100,000 populations, respectively. Both rates were more than twice the rate among white males.

In 2005, the rate of HIV for adult Hispanic females was 19.2 and 15.4 for AIDS. Hispanic women were more than 3 times as likely as white women to be reported with HIV.

Between 2001 and 2004, the percentage of adult AIDS cases remained stable each year, starting with 17% in 2001 and ending with 17% in 2004. However, for the first time since 2000, there was a 1% increase between 2004 and 2005 in Hispanic AIDS cases.

Cumulatively, 120 (8%) of Florida's 1,504 pediatric AIDS and 51 (14%) pediatric HIV (not AIDS) cases are Hispanic.

Among living Hispanic male HIV/AIDS cases reported through 2005, men who have sex with men was the leading mode of exposure with 67% of cases; 15% were attributed to heterosexual contact and 13% to IDU.

83% of all living Hispanic female HIV/AIDS cases reported through 2005 were infected through heterosexual contact, 16% were attributed to IDU.

NEEDS

A number of cultural, socioeconomic, and health-related factors contribute to the HIV epidemic in the Hispanic community. Because Hispanic Americans or their parents have emigrated from many Latin countries, there is no single Hispanic culture in the United States. Research shows that behavioral risk factors for HIV/AIDS differ by country of birth. For example, data suggest that Hispanic born in Puerto Rico is more likely than other Hispanics to contract HIV as a result of injection drug use. By contrast, sexual contact with other men is the primary cause of HIV infections among men born in Mexico (CDC fact sheet June 2006).

Socioeconomic issues and denial both increase the likelihood of increase in the cases of HIV/AIDS in the Hispanic community. Other strategies are implementation of culturally and linguistically appropriate HIV prevention and treatment interventions, adaptation and tailoring of HIV prevention interventions to meet the diverse cultural and linguistic diversity of the Latino community. Enhance targeted outreach to include a broader framework thereby reaching Latino MSM, Latinas, migrant farm workers and increase HIV counseling, testing, care support and linkages for treatment, social services and prevention/risk reduction services. Build and strengthen collaborative efforts among social service providers. Design mobile health units to

track migrant workers and provide integrated OB/GYN and HIV/AIDS prevention and care services as well as pregnancy testing and outreach to Latinas. The Latino Advisory group further states that community forums and the need for conducting on-going needs assessments in an effort to acknowledge and address the challenges faced by newly arrived immigrants such as racism, homophobia, stigma and the many other challenges posed by poverty and social marginalization. Additionally standards regarding bilingual materials and front-line staff, as well as culturally competency training must be part of the fight against the HIV/AIDS virus.

Special Populations

Glades-Palm Beach County

The western area of Palm Beach County is commonly referred to as “the Glades Community.” When the residents of the Glades Community are compared to Palm Beach County, this geographically isolated, rural area of western Palm Beach County is home to some of the worst health indicators among the population. HIV data shows disparities among the HIV population in Palm Beach County, clear disparities in regards to access, race, and health status. While the HIV case is striking in Palm Beach County as a whole, the situation in Western Palm Beach County is even more urgent.

Belle Glade has a disproportionate rate of the AIDS cases in Palm Beach County, a rate almost 5 times greater than the rest of the county; in addition, over 90% of the cases occur in African-American.

While there have been recent improvements, in terms of decreases in new HIV/AIDS infection rates for this county, this phenomenon still presents a rather bleak picture for our community with a clear disparity in regards to HIV/AIDS rates. Home to nearly 37,000 residents, the Glades is rural/geographically isolated from resources that are available to the coastal communities of Palm Beach County.

In the Glades area, a population generally comprised of racial and ethnic minorities represents almost the entire population in this area. Approximately 75 percent of residents in the targeted service area are of varying ethnic backgrounds; including African-American, Haitian, Hispanic, Guatemalan-Mayan, and Jamaican. The population of the Glades area is comprised primarily of minorities with an uninsured rate of 26%. 62% percent of the target population in the Glades area resides at or below 200 percent of the federal poverty level and 36% reside at or below 100 percent of the federal poverty level (FPL). It is important for staff working with this population to speak their language and to understand their cultural norms. Many of the population are migrant workers.

f. GAP ANALYSIS

GAP ANALYSIS

Gap Analysis was determined examining:

- 1) Current resource distribution related to populations and interventions versus needed population/intervention resource distribution.
- 2) Current geographic resource distribution versus most effective geographic resource distribution.
- 3) Societal obstacles that affect service access and maximum effectiveness.
- 4) Systemic obstacles that affect service access and maximum effectiveness.
- 5) Current level of HIV prevention resources versus “ideal” level of HIV prevention resources.

Current resource distribution related to populations and interventions versus needed population/intervention resource distribution:

Though improving, there are still geographic resource gaps (i.e., gaps related to equitable distribution of resources among urban, suburban and rural areas.) More resources are needed in rural areas in order to; 1) bring prevention efforts up to the level of non-rural areas; and 2) cover additional costs related to rural prevention, e.g., transportation, phone charges, etc.

Current geographic resource distribution versus most effective geographic resource distribution:

This section describes gaps related to current level of HIV prevention resources versus the “ideal” level of HIV prevention resources. Although the ideal level of resources is difficult to quantify, many areas utilize the CDC estimate of 4.1% of the population at risk of HIV infection derived from the Behavioral Risk Factor Surveillance System Activities. Census numbers and the number of persons reached through interventions are compared with this estimate. The conclusion of all areas is that prevention resources (i.e., funding) are insufficient for necessary HIV prevention activity. In comparing costs for HIV prevention versus costs of lifetime care for an individual who is HIV positive, *many areas emphasize the public cost savings, as well as the human cost savings, that could result from increased funding for prevention activities.* If the CDC estimate is compared with the estimated percentage of Floridians who are served through Florida Department of Health funded prevention efforts statewide (3%), *the missed opportunity for public cost savings (as well as human cost savings) is evident.*

Societal obstacles that affect service access and maximum effectiveness:

In each area, there are gaps related to societal obstacles that affect service access and maximum effectiveness for clients such as:

- The effects of poverty, unemployment and lack of education.
- Lack of transportation and day care.
- Fears that prevent persons from accessing prevention (i.e., fear of being identified as an MSM, fear of being arrested for drug use, etc.).

Systemic obstacles that affect service access and maximum effectiveness:

Gaps related to systemic obstacles that affect service access and maximum effectiveness are:

- Insufficient jail programs/limited access to inmates in jails.
- Slow progress towards facilitating continuity in prevention and patient care activities.
- Resistance in some arenas to a comprehensive prevention education, by choosing an abstinence only education program.
- Lack of culturally-sensitive programs, which include an appreciation and respect for diverse characteristics such as race, ethnicity, gender, lifestyle, religion, traditions, regional characteristics, etc.
- Communication and language barriers, including various spoken languages, sign language and Braille.
- Insufficient HIV prevention research and interventions for some populations.
- Increased need for further collaboration between HIV prevention programs/agencies and social service providers.

Gaps in Prevention Services

- There is a gap between the actual number of Men who have Sex with Men and the number of Men who have Sex with Men who are reached through prevention interventions.
- Three of the six top priority populations are Men who have Sex with Men. The Resource Inventory indicates only 19% of agencies reporting serve men who have sex with men. If the agencies reported correctly, then there is a gap between the percentage of agencies serving MSM and the percentage of agencies that need to serve the MSM population.
- Although black populations are well represented in terms of populations currently reached, there is a still a gap between the actual number of blacks reached through prevention efforts and the number of blacks who need to be reached through prevention interventions. Four of the six top priority populations are subgroups of the black population in Florida.
- Agencies serving minority populations represent 69.4% of the agencies funded by state prevention funds. However, since five of the six top priority populations are minority populations, it is likely that there is a gap between the current and necessary percentage of agencies serving minority populations.
- The numbers of agencies that report utilizing prevention case management interventions and prevention for positives are lower than the numbers of agencies reporting that they use other prevention interventions. As these are research-based interventions for the priority populations, and since the CDC and the bureau will be emphasizing these interventions in upcoming years, this indicates an important gap between the current level and the needed level of these services in Florida.

III. Technical Assistance Needs Assessment and Plan

This is an HIV prevention technical assistance needs assessment that identifies the needs of the local community planning partnerships.

STATE and LOCAL TECHNICAL ASSISTANCE NEEDS

As part of the local planning process, the fifteen local prevention planning partnerships were surveyed regarding their technical assistance needs. A summary of their needs follows:

<u>Need</u>	<u>Partnerships in need</u>
Recruitment and Retention	8
AHP/DEBI/REP	7
Disease area training	5
Community needs assessment	4
Information dissemination/communication	3
Developing a streamlined local plan	3
Using and interpreting EPI data	2
Cultural competency	1
Community planning overview	1

The Bureau of HIV/AIDS will work with CDC and local county health departments to identify expertise to assist local planning groups with TA request.

Other TA Needs

The statewide prevention planning body and the state EPI section are in need of technical assistance in refining the denominator of the high risk heterosexual populations

The Bureau has requested technical assistance from CDC for the PPG to determine population size for High Risk Heterosexuals (HRH), Men who have Sex with Men (MSM), and Injecting Drug Use (IDU).

IV. References

- Adams C. L., & Kimmel, D. (1997). Exploring the lives of older African American gay men. In B. Greene (Ed.), *Ethnic cultural diversity among lesbian and gay men* (pp. 132-151). Thousand Oaks, CA: Sage.
- Amaro, H. (1995). Love, sex, and power: Considering women's realities in HIV prevention. American Psychologist, 50(6), 437-447.
- Baldwin, J. (1963). The fire next time. New York: Vintage.
- Bancroft, J., Janssen, E., Strong, D., & Vukadinovic, Z. (2003). The relation between mood and sexuality in gay men. *Archives of Sexual Behavior*, 32(3), 231-242.
- Bingham, T. A., Harawa, N. T., Ford, W., & Gatson, B. (1999). *Do differences in risk Behaviors account for the disparity in HIV prevalence across race/ethnicity in a sample of young men who have sex with men in Los Angeles County?* (Abstract). University Wide AIDS Research Program, 2nd annual meeting, San Diego, CA.
- Bingham, T. A., Harawa, N. T., Johnson, D. F., Secura, G. M., MacKellar, D. A., & Valleroy, L. A. (2003). The effect of partner characteristics on HIV infection among African American men who have sex with men in the Young Men's Survey, Los Angeles, 1999-2000. *AIDS Education and Prevention*, 15(1A), 39-52.
- Blair, J. M., Fleming, P. L., & Karon, J. M. (2002). Trends in AIDS incidence and survival among racial/ethnic minority men who have sex with men, United States, 1990-1999. Journal of Acquired Immune Deficiency Syndromes, 31, 339-347.
- Bonell, C., Hickson, F., Hartley, M., Keogh, P., & Weatherburn, P. (2000). By any means necessary? Reflecting on how HIV prevention interventions work and the changes they bring about. London: Sigma Research.
- Boykin, K. (1996). One more river to cross: Black and Gay in America. New York: Anchor. Brooks, R., Rotheram-Borus, M. J., Bing, E. G., Ayala, G., & Henry, C. L. (2003). HIV and AIDS among men of color who have sex with men and men of color who have sex with men and women: An epidemiological profile. *AIDS Education and Prevention*, 15(1A), 1-6.
- Brotman, S., Ryan, B., Jalbert, Y., & Rowe, B. (2002). The impact of coming out on health and health care access: The experiences of gay, lesbian, bisexual and two-spirit people. Journal of Health and Social Policy, 15(1), 1-29.
- Brown, G. W., & Harris, T. (1978). Social origins of depression. London: Tavistock.
- Byrd, R. P., & Guy-Sheftall, B. (2001). Traps: African American men and sexuality. Bloomington: Indiana University Press.
- Catania, J. A., Osmond, D., Stall, R. D, Pollack, L., Paul, J. P., Blower, S., et al. (2001). The continuing HIV epidemic among men who have sex with men. American Journal of Public Health, 91(6), 907-914.
- Coxon, P.M., (1993) "Sex Role Separation in Diaries of Homosexual Men, AIDS" pp. 877—882.

- Grossman A, & Kerner, M. (1998) Self-esteem and supportiveness as predictors of emotional distress in gay male and lesbian youth. Journal of Homosexuality. 35. (2). pp 25-37.
- Hospers, H., & Blom, C. (1998). HIV prevention activities for gay men in the Netherlands 1983-93. In T. Sandfort (Ed.), The Dutch response to HIV: Pragmatism and consensus (pp.40-60). London: UCL.
- Kesteren, N, Hospers, H, Gerjo, K. and van Empelen, P. (2005) Sexuality and Sexual Risk Behavior in HIV-Positive Men Who Have Sex With Men. Qualitative Health Research, Vol. 15 No.2, February 2005, pp 145-168: Stage Publications.
- March, J.G., & Simon, H.A. (1959). Organizations. New York: John Wiley.
- Snape, D. and Spencer, W. (2003). Sexual Orientation Research Phase 1: A Review of Methodological Approaches. Scottish Executive Research
- Gross, Michael, "When Plagues Don't End," American Journal Public Health. 2003; 93: (pp. 861-862)
- Gross, Michael, "the Second Wave Will Drown Us," American Journal Public Health. 2002; 93: (pp. 665-670)
- Katz MH, Schwarcz, SK, Kellogg TA, et al. Impact on highly active antiretroviral treatment on HIV seroincidence among men who have sex with men: San Francisco. American Journal Public Health. 2003;93:(pp 926-932).
- Koblin, BA, Chesney, Margaret, Husnik, Marla, Bozeman, S, Celum Connie L, Buchbinder, Susan, Mayer, K, McKirnan, D, Judson, FN, Huang, Y, Coates, TJ, and the EXPLORE Study Team. High-Risk Behaviors Among Men Who Have Sex With Men in 6 US Cities: Baseline Data From the EXPLORE Study American Journal Public Health 2003 93: (pp 926-932).
- Koblin, B. A, Torian, L. V., Guilin, V., Ren, L., MacKellar, D. A., & Valleroy, L. A.
(2000). High prevalence of HIV infection among young men who have sex with men in New York City. *AIDS*, 14, 1793-1800.
- Kurtz, S. P. (1999). Butterflies under cover: Cuban and Puerto Rican gay masculinities in Miami. *The Journal of Men's Studies*, 7(13), 295-315.
- Latkin, C., Mandell, W., Oziemkowska, M., Celentano, D., Vlahov, D., Ensminger, M., et al. (1995). Using social network analysis to study patterns of drug use among urban drug users at high risk for HIV/AIDS. *Drug and Alcohol Dependency*, 38(1), 1-9.
- Mays, V. M. (1992). Identity, consciousness and pre-convention in vulnerable communities. Invited State of the Art Address, at the Seventh International Conference on AIDS/III STD World Congress, Amsterdam, and the Netherlands.

- Anderson, C. D. (1996). Understanding the inequality problematic: From scholarly rhetoric to theoretical reconstruction. *Gender and Society*, 10, 729-746.
- Bean, Carl. Pew Forum: Religion and Public Life. Witness Magazine. Vol. 88. Number, May, 2005.
- Bem, S. L. (1974). The measurement of psychological androgyny. *Journal of Consulting and Clinical Psychology*, 42, 155-162.
- Blascovitch, I., and Tomaka, J. (1991). Measures of self-esteem. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (pp. 115-160). San Diego, CA; Academic Press.
- Browders, Faith Under Fire.
- Brown, E.J., Gubrium, A., & Ogbonna-Hicks, G. (2004). Rural Floridians' perceptions of health, health values and health behaviors. Southern Online Nursing Research Journal.
- Brown E. J. (2002). "Recruitment feasibility and HIV prevention intervention acceptability among rural North Florida Blacks." Journal of Community Health Nursing, 19(3), 147-160.
- Brown, G. HIV/AIDS among African Americans and US women: minority and young women Minority Nurse Newsletter, Fall, 2003 by Geraldine Brown
- Campbell, C. A. (1995). Male gender roles and sexuality: Implications for women's AIDS risk and prevention. *Social Science and Medicine*, 41, 197-210.
- Campbell, D. P. (1966). Revised manual for strong vocational interest blanks. Stanford, CA: Stanford University Press.
- Carey, M. P., Maistro, S., Kalichman, S. C., Forsyth, A. D., Wright, E. M., & Johnson, B. T. (1998). Enhancing motivation to reduce the risk of HIV infection for economically disadvantaged urban women. *Journal of Consulting and Clinical Psychology*, 6, 531-541.
- Centers for Disease Control and Prevention (1999). More HIV cases in women and minorities. Atlanta, GA: Author.
- Centers for Disease Control and Prevention. (2000). HIV/AIDS surveillance: US AIDS cases reported through February, 1998. Atlanta, GA: Author.
- Centers for Disease Control, National Center for Health Statistics, *Table 42: Death Rates for Human Immunodeficiency Virus (HIV) Disease, According to Sex, Race, Hispanic Origin, and Age: United States, Selected Years 1987-2001*, Health United States (2003): 177-78
- Connell, R. W. (1987). *Gender and power*. Stanford, CA: Stanford University Press.
- Day, R.F. is a peer educator for the Prisoners for AIDS Counseling and Education (PACE) Program at Eastern Correctional Facility in Napanoch, New York.

- Doyle, J. J., and Moore, R. J. (1978). Attitudes toward male's role scale (AMR): An objective instrument to measure attitudes toward the male's sex role in contemporary society. *JSAS Catalogue of Selected Documents in Psychology*, 8, 35.
- Dreyer, N. A., Woods, N. F., & James, S. A. (1981). ISRO: A scale to measure sex role prevention. *Sex Roles*, 7, 173-182.
- du Guerny, J., & Sjoeborg, E. (1993). Inter-relationship between gender relations and the HIV/AIDS epidemic: Some possible considerations for policies and programmes. *AIDS*, 7, 1027-1034.
- Fears, D. U.S. HIV Cases Soaring Among Black Women. Social Factors Make Group Vulnerable. Washington Post Staff Writer. Monday, February 7, 2005; Page A01
- Fisher, J., & Fisher, W. (1992). Changing AIDS risk behaviors. *Journal of Psychological Bulletin*, 111, 455-474.
- Franklin, C. & Gilbert, D. J. (2003). Qualitative Assessment Methods. In Jordan, C., & Franklin, C. (pp. 139-178). *Clinical Assessment for Social Workers: Quantitative and Qualitative Methods*, 2nd Edition, Lyceum Press C, & Franklin, C. (pp. 139-178). *Clinical Assessment for Social Workers: Quantitative and Qualitative Methods*, 2nd Edition, Lyceum Press.
- Frankel, P. (1974). Sex-role attitudes and the development of achievement need in women. *Journal of College Student Personnel*, 15, 114-119.
- Fraser-Howze, D. National News for Black Women, Stopping HIV States with Self-Respect. NNPA update March 13, 2003
- Fullilove, M. T., Fullilove, R. E., Haynes, K., & Gross, S. (1990). Black women and AIDS prevention: A view towards understanding the gender rules. *Journal of Sex Research*, 27, 47-65.
- Gomez, C., & Marin, B. V. (1996). Gender, culture, and power: Barriers to HIV-prevention strategies for women. *Journal of Sex Research*, 33, 355-362.
- Hawkins, D. On the frontline of the HIV/AIDS epidemic: with infection rates still escalating among African Americans, researchers, scholars and activists wonder if the battle is a losing one. [Black Issues in Higher Education](#), [March 24, 2005](#)
- HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons (Montreal: McGill Centre for Law, Medicine, and Ethics, February 1994), 55–56. See also R. Jurgens, "AIDS in Prisons in Canada," in *AIDS in Prison*, P. A. Thomas and M. Moerings, eds. Aldershot, U.K.: Dartmouth Press, 1994, pp. 126–127.
- Helmreich, R., Spence, J., & Gibson, R. (1982). Sex-role attitudes: 1972-1980. *Personality and Social Psychology Bulletin*, 8, 656-663.

- Hetherington, S. E., Harris, R. M., Bausell, R. B., Kavanagh, K. H., & Scott, D. E. (1996). AIDS prevention in high-risk African American women: Behavioral, psychological, and gender issues. *Journal of Sex and Marital Therapy*, 22, 9-21.
- Kaiser, H. F. (1960). The application of electronic computers to factor analysis. *Educational and Psychological Measurement*, 20, 141-151.
- Kalichman, S. C., Kelly, J. A., Hunter, T. L., & Tyler, R. (1993). Culturally tailored HIV-AIDS risk-reduction messages targeted to African-American urban women: Impact on risk sensitization and risk reduction. *Journal of Consulting and Clinical Psychology*, 61, 291-295.
- Lenney, E. (1991). Sex roles: The measurement of masculinity, femininity, and androgyny. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (pp. 573-660). San Diego, CA; Academic Press.
- Lipman-Blumen, J. (1972). How ideology shapes women's lives. *Scientific American*, 226, 34-42.
- Marin, B. V., Gomez, C., Tschann, J. M., & Gregorich, S. E. (1997). Condom use in unmarried Latino men: A test of cultural constructs. *Health Psychology*, 16, 458-467.
- McLoyd, V. C. (1990). The impact of economic hardship on Black families and children: Psychological distress, parenting, and socioemotional development. *Child Development*, 61, 311-346.
- Miller, R. L. & Solomon, E. E. (1996). Assessing the AIDS-related needs of women in a Brooklyn housing development. In R. Reviere, S. Berkowitz, C. C. Carter, & C. G. Ferguson (Eds.), *Needs assessment: A practical and creative guide for social scientists*. (pp. 93-119). London: Taylor & Francis.
- National Institute of Allergy and Infectious Diseases, *HIV Infection in Women*, National Institutes of Health, U.S. Department of Health and Human Services, May 2004
- Tyler, V., Martin, M. Tyler, E, The National Institute of Mental Health AIDS Office. WAVE Project,
- Wingood G.M, DiClemente R.J. Pattern influences and gender-related factors associated with no condom use among young adult African American women. *American Journal of Community Psychology*. 1998;26, 29-52.
- Wingood G.M, DiClemente R.J. Consequences of having a physically abusive partner on the condom use and sexual negotiation practices of young adult African-American *American Journal of Community Psychology*.
- Wyatt, G.E., Transaction Sex and HIV Risks: A Women's Choice? HIV Infection in Women: Setting a New Agenda, Washington, D.C. (February 22-24, 1995): S2, abstract Number WA1-1.
- Yates, E. L., Survival at stake: University of North Carolina's Dr. Adaora Adimora searches for answers into HIV transmission among African Americans. [Black Issues in Higher Education, March 24, 2005](#)

V. Glossary of Terms

ASO: AIDS services organization

CBO: Community-based organization

CPP: Community planning partnership(s) – Florida is divided into fourteen areas for the purpose of the community planning process. Each partnership produces and local prevention plan.

DOH: Department of Health

Early Intervention: Efforts aimed at identifying and linking individuals infected with HIV to primary medical care and other essential services. This includes HIV antibody counseling and testing, as well as targeted outreach efforts to specific populations (such as pregnant women, incarcerated individuals, substance abusers, etc.)

FCPN: Florida Comprehensive Planning Network – Initiated in January 2004, the evolution of the FCPG, which will include separate bodies for HIV prevention, early intervention, patient care, and Hepatitis.

HAPC: HIV/AIDS Program Coordinator – There are sixteen HAPCs, all DOH staff, who each coordinate all HIV/AIDS activities in seventeen specific areas.

HIV: Human immunodeficiency virus – The virus that cause AIDS.

HHRP- Holistic Health Recovery Program. A 12- session, manual-guided, group –level program for HIV-infected and HIV-negative injection drug users.

Intervention: A specific, planned effort to reduce HIV infection in a targeted population. Common examples include street and community outreach, group sessions, and community mobilization.

Many Men, Many Voices- A 7-session group-level intervention program to prevent HIV and sexually transmitted diseases among black men who have sex with men who may or may not identify themselves as gay.

MPowerment- A community-level HIV prevention program that is run by a core group of 12 to 20 you gay and bisexual men from the community and paid staff coordinators.

Outreach: HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach usually includes distribution of condoms, sexually responsibility kits and educational materials. An outreach contact will last for a period of at least five minutes to encourage or reinforce a focus on a specific behavior change with clients.

PPG: Prevention Planning Group – one of the separate bodies of the Florida Comprehensive Planning Network focused to compose the statewide prevention plan.

POL- Popular Opinion Leader is an HIV/AIDS risk-reduction program in which groups of trusted, well-liked people are recruited and trained to conduct a novel and particular type of outreach.

RAPP- Real AIDS Prevention Project is a community-level HIV prevention intervention designed to help sexually active women and their male partners reduce their risk for HIV infection.

RMAC: Regional Minority AIDS Coordinator – There are eight RMACs, all DOH staff, who are responsible for minority HIV/AIDS activities in the area they cover.

Safety Counts- Safety Counts is an intervention to prevent HIV and viral hepatitis, designed specifically for person who are using illicit (not prescribed) drugs and who are not read or not willing to enroll in drug treatment programs.

SISTA- Sisters Informing Sisters about Topics on AIDS is a peer-led, skill-building intervention project to prevent HIV infection in Africa-American women.

STD: Sexually transmitted disease – Any of several diseases which include: syphilis, gonorrhea, Chlamydia, herpes simplex Type II, human papaloma virus (HPV or venereal warts) and others.

Street Smart- Street Smart is an intensive program to prevent HIV/AIDS and other sexually transmitted disease among homeless and runaway youth (11-18 years of age).

TLC-Together Learning Choices is an evidence-based HIV prevention intervention and health promotion intervention for young people (13-29 years of age) living with HIV.

VOICES/VOCES- Video Opportunities for Innovative Condom Education and Safer Sex is a single-session, video-based program for the prevention of HIV and other sexually transmitted diseases.

VI. Attachments



2006 HIV Prevention Community Planning Tools

COMPONENTS OF THE LOCAL HIV PREVENTION PLAN

For Revisions/Updates to the 2007–2009 HIV Prevention Plan

Each Community Planning Partnership or the Community Planning Process (CPP) is required to follow the guidelines provided by the Florida HIV/AIDS Prevention Planning Group (PPG) when writing the components of their multi-year 2007-2009 local prevention plan (see attached components). Any revisions to these guidelines will be forwarded by the bureau. Local area contributions towards the statewide 2007-2009 Prevention plan are due *to the bureau no later than April 15, 2006*. **Please submit plans to Leisha McKinley at Leisha.McKinley@doh.state.fl.us or by mail to 4052 Bald Cypress Way, Bin A09, Tallahassee, FL 32399-1715**

Listed below are the required and optional components that local areas are to submit for compilation into the state prevention plan:

1. Epi Profile:

The epidemiologic profile outlines the HIV/AIDS epidemic in the state of Florida and includes data from a variety of sources collected throughout the state. This information is provided to each partnership by the surveillance staff of the Department of Health, Bureau of HIV/AIDS. Building on the information completed in 2005 for the local plan, each local area CPP *may* provide input regarding local trends or emerging needs, if it chooses to do so.

2. Priority Setting:

Local areas should prioritize the target populations in their area that have the greatest need for prevention services, using the tool provided. The tool includes four components—three of them are “data driven” (HIV case data, disproportionate impact and resource disparity) and the final factor is based on community input.

3. Interventions:

The State Plan will include REP and DEBI interventions approved by the CDC. If a local area would like to submit an evidenced based intervention for consideration in the State Plan, it may do so, using the tool provided. This is optional.

4. Technical Assistance and Capacity Building:

Technical assistance and training needs should be identified as related to HIV prevention planning and implementation. See enclosed tool, “Technical

Assistance Assessment Plan- Suggested Minimum Standards,” for information and guidance.

FLORIDA HIV/AIDS PREVENTION PLANNING GROUP 2006-2007 PREVENTION PLAN TIMELINE

January 2006	PPG updating priority setting tools and drafting streamlined prevention plan for local areas
April 15, 2006	Local prevention plan updates due to Tallahassee
April 27 & 28, 2006	PPG Meeting – Review CPP local plan progress
July 2006	Writing the 2007-2009 Prevention State Plan – Writing Team
August 2006	Prevention State Plan update completed PPG Meeting - Concurrence on 2006 Cooperative Agreement Final DRAFT Cooperative Agreement routing in bureau
September 2006	Cooperative Agreement due to CDC



SECTION I: EPIDEMIOLOGY

There is no specific tool for this section. Areas may choose to submit a narrative as follows:

The bureau provides the epidemiologic profile for your area prepared by the Bureau of HIV/AIDS. Your area may submit additional information regarding epi-data in your area to be considered for inclusion in the State Plan. Information you may wish to submit includes: local analysis of trends, a description of emerging issues, locally conducted studies related to HIV/AIDS transmission and the populations impacted. To submit this information to the writing team, please send to: Leisha_McKinley@doh.state.fl.us

SECTIONS II & III: PRIORITIZING TARGET POPULATIONS

<p>Path 1: HIV Case Data</p> <p>Rationale: Priority should be given to those populations where HIV infection is occurring.</p> <p>CDC requires priority setting to be “data driven.” HIV case data is a stronger indicator of where new infections are occurring than AIDS case data. In the past, since HIV case reporting was just being implemented, the FCPG included other “marker” data (i.e. STDs). At this point, HIV case reporting has been in place for 7 years.</p>	<p>Path 2: Disproportionate Impact</p> <p>Rationale: Priority should be given to those populations that are disproportionately impacted by HIV.</p> <p>In the past, FCPG used “size of population” and “disproportionate impact” as factors in determining priorities. This methodology relies on disproportionate impact to assist in prioritizing populations. The greater the impact of HIV on a particular population, the larger priority it will become. As the impact of HIV on a population decreases, the population will move lower on the priority list.</p>
<p>Path 3: Resource Disparity</p> <p>Rationale: Every population deserves of HIV prevention efforts, and every infection averted is important. When resources are scarce and can’t be distributed to every population, an attempt should be made to fill in service gaps for those populations that are receiving a lower share of resources than the disease burden they carry.</p> <p>CDC requires the Prevention Plan to include a gap analysis. This approach takes into account the recent impact of HIV on each population (HIV case data) and the number of people in each population reached with HIV prevention interventions (resource inventory data). Populations with the largest gap between impact and services are ranked as the highest priority, and populations with the smallest gaps between impact and services are ranked as the lowest priority.</p>	<p>Path 4: Community Planning Partnership Deliberation</p> <p>Rationale: Community Planning Partnerships consist of people “in the field”—prevention specialists, health planners, community members, behavioral scientists, epidemiologists, and others invested in making a discernible difference in this disease. Their expertise should be utilized in setting priorities.</p> <p>In the past, the FCPG included “subjective” categories, such as barriers to accessing services, barriers to providing services, and “community input” in the priority-setting process. This method values the expertise of Community Planning Partnerships and asks each group to bring their community experience and knowledge to the priority setting process by ranking the populations as they believe they should be ranked in order to best meet local needs.</p>

METHODOLOGY and Advancing HIV Prevention (AHP)

Step 1: HIV cases for the past 3 years, with NIRs distributed by bureau

Indicate percentages in each cell.

	<i>Heterosexual</i>	<i>MSM</i>	<i>IDU</i>
<i>Black</i>			
<i>Hispanic</i>			
<i>White</i>			

Place the population with the largest percentage in the first position, the next largest percentage in the second position, etc. down to the lowest percentage in the final position.

<i>HIV Case Data</i>		
<i>Rank</i>	<i>Population</i>	<i>% of cases</i>
<i>1</i>		
<i>2</i>		
<i>3</i>		
<i>4</i>		
<i>5</i>		
<i>6</i>		
<i>7</i>		
<i>8</i>		
<i>9</i>		

Step 2: Using latest available census data, estimate the size of each population, and include percentage in each cell (may not total 100% since not all races/ethnicities are included). Local area to determine percentage to use for MSM and IDU figures, can seek guidance from bureau, local resources, past experience.

	<i>Heterosexual</i>	<i>MSM</i>	<i>IDU</i>
<i>Black</i>			
<i>Hispanic</i>			
<i>White</i>			

**PRIORITY SETTING TOOL FOR FLORIDA’S PREVENTION PLANNING GROUP
FOUR FOLD PATH METHODOLOGY and Advancing HIV Prevention
(AHP)**

Step 3: Disproportionate impact: Divide case percentages (in step 1) by population percentages (in step 2), and rank order populations by the results: the larger the number, the higher the disproportionate impact, thus, the higher the rank.

<i>Disproportionate Impact</i>		
<i>Rank</i>	<i>Population</i>	<i>Score</i>
<i>1</i>		
<i>2</i>		

3		
4		
5		
6		
7		
8		
9		

Step 4: Use resource inventory to estimate the number of people in the population reached in past year. Include all sources possible, and estimate when hard data isn't available (i.e., SAMHSA, Ryan White Outreach, etc.) (Convert to percentage of total people reached to display "percentage of effort/resources allocated to each population.")

	<i>Heterosexual</i>	<i>MSM</i>	<i>IDU</i>
<i>Black</i>			
<i>Hispanic</i>			
<i>White</i>			
<i>Other</i>			

*Step 5: Resource Disparity: Divide the resource percentages (step 3) by the case percentages (step 1), and rank order populations by the results: The larger the number, the greater the resources allocated to that population currently, thus **the lower** the rank will be.*

<i>Resource Disparity</i>		
<i>Rank</i>	<i>Population</i>	<i>Score</i>
<i>1</i>		
<i>2</i>		
<i>3</i>		
<i>4</i>		
<i>5</i>		
<i>6</i>		
<i>7</i>		
<i>8</i>		
<i>9</i>		

**PRIORITY SETTING TOOL FOR FLORIDA'S PREVENTION PLANNING GROUP
FOUR FOLD PATH METHODOLOGY and Advancing HIV Prevention
(AHP)**

Step 6: CPP Rankings: The full CPP should convene and hold a discussion to rank order the priority of the populations. Items to be included in the discussion are: barriers to reaching the population, barriers for the population in accessing services, local factors that impact populations differently, locally derived data and studies, etc.

<i>CPP Ranking</i>	
<i>Rank</i>	<i>Population</i>
1	
2	
3	
4	
5	
6	
7	
8	
9	

Step 7: Final Priorities: Add the ranks (not scores) of each population from each of the following charts: HIV Case Data, Disproportionate Impact, Resource Disparity, and CPP Ranking. Divide the total sum for each population by 4. Place the populations into the following table, lowest number to highest number. If there is a tie between two or more populations, place them in the order in which they appear in the HIV case data chart.

<i>Final Priority Populations</i>	
<i>Rank</i>	<i>Population</i>
1	
2	
3	
4	
5	
6	
7	
8	
9	

**PRIORITY SETTING TOOL FOR FLORIDA’S PREVENTION PLANNING GROUP
FOUR FOLD PATH METHODOLOGY and Advancing HIV Prevention
(AHP)**

<i>Populations</i>	<i>HIV</i>	<i>Disproportionate</i>	<i>Resource</i>	<i>CPP</i>	<i>Sum of</i>	<i>Divided</i>	<i>Final</i>
--------------------	------------	-------------------------	-----------------	------------	---------------	----------------	--------------

	<i>Case Data Rank</i>	<i>Impact Rank</i>	<i>Disparity Rank</i>	<i>Rank</i>	<i>each of the Ranks</i>	<i>by 4</i>	<i>Priority Rank</i>
<i>Black Heterosexual</i>							
<i>Black IDU</i>							
<i>Black MSM</i>							
<i>Hispanic Heterosexual</i>							
<i>Hispanic IDU</i>							
<i>Hispanic MSM</i>							
<i>White Heterosexual</i>							
<i>White IDU</i>							
<i>White MSM</i>							

GUIDANCE ON INCLUDING OTHER EVIDENCE BASED INTERVENTIONS INTO THE STATE PLAN

As a matter of principle, the state of Florida utilizes the CDC REP and DEBI interventions, with local adaptation and tailoring. However, some local areas may have designed, implemented, and evaluated HIV prevention interventions that show evidence of success in preventing HIV transmission that they would like to have included in the State Plan. Submission of this form is optional.

1. Intervention Name:

2. Intended Target Population (be as specific as possible—gender, age range, race/ethnicity, risk factors):

3. Organization(s) that designed/implemented/evaluated the intervention:

4. Time period that the intervention was implemented (begin/end dates):

5. Number of participants completing the intervention:

6. Description of the intervention (include as much detail as possible—individual level, group level, community, how many sessions, special instructions. If possible, include a copy of curriculum or checklists used for the intervention. Describe how the intervention was

delivered—number and type of staff required, special supplies/materials needed, etc. Attach additional sheets as necessary.)

7. Describe the intended client level outcomes of the intervention:

8. Describe how the outcomes were measured during the evaluation of the intervention:

9. Describe the results/findings of the evaluation:

10. Provide contact information for a person that the writing team can reach to further discuss the intervention, if necessary. (Name, phone, email.)



SECTION IV: TECHNICAL ASSISTANCE ASSESSMENT PLAN GUIDANCE

Documenting the Technical Assistance needs of each Partnership:

Each partnership should conduct an assessment of the technical assistance and training needs of the partnership. Technical assistance and training needs should be identified as it relates to HIV prevention planning and implementation.

TECHNICAL ASSISTANCE NEEDS ASSESSMENT

SUGGESTED STANDARDS

**Florida Department of Health, Bureau of HIV/AIDS
Community Planning Partnership or Process (CPP)
Technical Needs Assessment, 20__**

1. Community Planning Partnership/Process for Area _____
2. Mailing Address: _____
3. CPP Chair or Representative completing survey: _____
4. Phone number: _____
5. Fax number: _____

The bureau is interested in knowing more about the type(s) of capacity building that might be helpful to you.

1. Using the scale below, please indicate the level of importance for the various types of capacity building training your program may need. For those areas identified as extremely important, please provide a brief explanation.

IMPORTANCE

	Does Not Apply 1	Not At All 2	A Little 3	Somewhat 4	Very Important 5	Extremely Important 6	Don't Know 7		
A Recruitment & retention strategies			1	2	3	4	5	6	7
Comments: _____									
B Meeting facilitation/Roberts Rules of Order			1	2	3	4	5	6	7
Comments: _____									
C Using/interpreting epi data and priority setting tools			1	2	3	4	5	6	7
Comments: _____									
D Developing a streamlined local area plan									
Comments: _____									
E Information dissemination/communication			1	2	3	4	5	6	7
Comments: _____									
F Community needs assessment			1	2	3	4	5	6	7

Comments: _____

G	Community planning overview	1	2	3	4	5	6	7
---	-----------------------------	---	---	---	---	---	---	---

Comments: _____

H	AHP/DEBI/REP overview	1	2	3	4	5	6	7
---	-----------------------	---	---	---	---	---	---	---

Comments: _____

I	Disease area training/overview such as HIV/AIDS, STD, Hepatitis	1	2	3	4	5	6	7
---	---	---	---	---	---	---	---	---

Comments: _____

J	Other (s) please specify	1	2	3	4	5	6	7
---	--------------------------	---	---	---	---	---	---	---

Comments: _____

2. For those types of capacity building training or technical assistance needs identified as very and extremely important in question #4, please rank the top three, with A being most important.

A. _____

B. _____

C. _____

3. Capacity building training courses and technical assistance vary in length. In your opinion, what length of training best suits your CPP's needs? Please check the one best answer.

- A. 1/2 day training 8:00a.m.–12:00p.m. ___ 1:00p.m-5:00p.m. ___ 5:00p.m-9:00p.m.
- B. 1 day training
- C. 1 1/2 day training
- D. 2 days of training
- E. 3 days of training
- F. 4 days or more of training
- G. Don't know/not sure
- H. Other (Please specify) _____

If you would like to get further clarification on any part of this survey, please feel free to call the Prevention Section at (850) 245-4336.

**Florida HIV/AIDS Comprehensive Planning Network
Member Nomination Procedure**

To expedite nominations submitted by local partnerships for recommendation to an FCPN position, it is requested that all of the required information be submitted together.

To nominate an individual for a position, the following documentation is required unless specified otherwise:

1. A letter of nomination from the partnership (for the Prevention representative), consortia (for the Patient Care representative) or CHD director or his/her designee (for the Department of Health representative).
2. A copy of the nominee's resume (requested, but not required)
3. A completed FCPN member/professional disclosure.
4. A completed conflict of interest form
5. A completed FCPN Nominee Selection Criteria form

Please feel free to make as many copies of this material as needed.

Please select the FCPN Nominee Selection Criteria form that pertains to your area from the Florida Comprehensive Planning Network website

http://www.doh.state.fl.us/disease_ctrl/aids/compln/fcpn/index.html.

Upon completion of the required information, please forward all of the information to:

Leisha McKinley
Department of Health
Bureau of HIV/AIDS
4052 Bald Cypress Way, Bin #A09
Tallahassee, FL 32399-1715
(850) 245-4444, Ext 2621
SC 205-4444, Ext 2621

FLORIDA HIV/AIDS PREVENTION PLANNING GROUP

Nominee Selection Criteria

Partnership 11A
Prevention Representative

Instructions: This form should be completed by the individual seeking nomination to the Florida HIV/AIDS Prevention Planning Group. Individuals completing this form may choose to skip any question. Nominations are determined based on the total score.

All information is based on Area 11A Presumed Alive HIV/AIDS Cases reported through 2005 developed by the Surveillance Unit of the Bureau of HIV/AIDS.

Race/Ethnicity: The three race/ethnicity categories most impacted in your community are:

Race/Ethnicity	%	Nominee Score	Points
Black, Non-Hispanic	50%	If the nominee is Black, Non-Hispanic, he/she receives	3
Hispanic	36%	If the nominee is Hispanic he/she receives	2
White	13%	If the nominee is White, Non-Hispanic, he/she receives	1
If the nominee is in another race/ethnicity category, he/she does not receive any points			
NOMINEE'S SCORE:			_____

Age Groups: The three Age Groups most impacted are:

Age Groups	%	Nominee Score	Points
40-49	39%	If the nominee is within the age range of 40-49, he/she receives	3
30-39	23%	If the nominee is within the age range of 30-39, he/she receives	2
50-59	21%	If the nominee is within the age range of 50-59, he/she receives	1
If the nominee is in another age group, he/she does not receive any points			
NOMINEE'S SCORE:			_____

Gender: The % for each gender is

Gender	%	Nominee Score	Points
Male	69%	If the nominee is male, he receives	2
Female	31%	If the nominee is female, she receives	1
NOMINEE'S SCORE:			_____

Exposure Categories: The three exposure categories most impacted in your community are:

Exposure Categories	%	Nominee Score	Points
Men who have sex with Men	44%	If the nominee self identifies as falling within this exposure category, he receives	3
Heterosexual Contact	41%	If the nominee self identifies as falling within this exposure category, he/she receives	2
Injecting Drug User	11%	If the nominee self identifies as falling within this exposure category, he/she receives	1
If the nominee is in another exposure category, he/she does not receive any points			
NOMINEE'S SCORE:			_____

Disease Status

Disease Status	Nominee Score	Points
HIV Positive	If the nominee self identifies as HIV positive, he/she receives	2
HIV Negative/Affected	If the nominee self identifies as HIV negative, he/she receives	1

NOMINEE'S SCORE: _____

Partnership Experience

Partnership Experience	Nominee Score	Points
Greater than Three (3) years	If the nominee has been involved with any Florida HIV Prevention Community Planning Partnership for a time greater than 3 years, he/she receives	3
One (1) to Three (3) years	If the nominee has been involved with any Florida HIV Prevention Community Planning Partnership for one (1) to three (3) years, he/she receives	2
Less than One (1) Year	If the nominee has been involved with any Florida HIV Prevention Community Planning Partnership for less than one (1) year, he/she receives	1

NOMINEE'S SCORE: _____

Guidance Expertise: The Centers for Disease Control and Prevention Supplemental Guidance on Community Planning identifies the following areas of expertise that must be included within every state's Community Planning Process. (Maximum of one point allowed)

Guidance Expertise	Nominee Score	Points
Epidemiology	If the nominee is an expert in this field as indicated by a graduate level degree and work experience, he/she receives	1
Behavioral and Social Sciences	If the nominee is an expert in this field as indicated by a graduate level degree and work experience, he/she receives	1
Program Evaluation	If the nominee is an expert in this field as indicated by a graduate level degree and work experience, he/she receives	1
Health Planning	If the nominee is an expert in this field as indicated by a graduate level degree and work experience, he/she receives	1

NOMINEE'S SCORE: _____

NOTE: The highest scored that may be earned is 20

NOMINEE'S TOTAL SCORE: _____

**Florida HIV/AIDS Comprehensive Planning Network
Member/Professional Information Disclosure Form**

All nominees must complete the Nominee/Member Disclosure Form. The purpose of this form is to provide the State Health Office with information about planning group members. The information is used to ensure compliance with the guidelines of parity, inclusion, and representation as defined and required by the Centers for Disease Control and Prevention (CDC).

NAME: _____

TITLE: _____

AGE: _____ **SEX:** _____ **RACE/ETHNICITY:** _____

HOME ADDRESS: _____ **BUSINESS ADDRESS:** _____

TELEPHONE (HOME) _____ **E-Mail Address:** _____
(BUSINESS) _____ **(FAX)** _____
(SUNCOM) _____ **(SUNCOM FAX)** _____

Please list any HIV/AIDS Professional Associations/Organizations that you are affiliated with.

Issues/Groups Represented: (Please check all that apply)

- | | |
|---------------------------------|------------------------------|
| Substance Abuse _____ | Bisexual _____ |
| HIV+/PWA _____ | Youth _____ |
| Partners of HIV+/PWA _____ | People Who Barter Sex _____ |
| Men Who Have Sex with Men _____ | Prisoners/Inmates _____ |
| Lesbian _____ | Other (Please specify) _____ |

AFFILIATIONS: (Check all that apply)	FOR DEPARTMENT USE ONLY:
Partnership _____	Community _____
Consortium(tia) _____	Ryan White _____
CBO/ASO _____	Public Health _____
	At-Large (area of representation) _____

Disclosure of information contained on this form is prohibited unless authorized by the nominee in writing. Please indicate by signing below your approval for the department and/or the Florida HIV/AIDS Comprehensive Planning Network to disclose this information as needed for issues directly related to community planning. This information will only be used in aggregate forms and will not be linked to FCPN members by individual identifiers.

Signature _____ Date _____

