Comprehensive Plan for HIV Prevention in Alabama

2009 – 2013

Revised 09/09

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

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Introduction

The ***Comprehensive Plan for HIV Prevention in Alabama*** demonstrates the collaboration between the Alabama HIV Prevention Council (AHPC) and the Alabama Department of Public Health's Division of HIV/AIDS Prevention and Control. In light of the new ***Advancing HIV Prevention Strategy*** promoted by the CDC, the AHPC is the sole Alabama HIV Prevention Community Planning Group. This transition process began in the summer of 2003. The Plan is the result of the commitment and efforts of Alabamians from diverse backgrounds and with varied interests who are dedicated to preventing the spread of HIV infection.

The Plan prioritizes risk populations based on the trends of the epidemic and the needs of the most affected populations. The Division uses this Plan to guide programs and resource allocations for HIV prevention in the State.

Because HIV Prevention Planning is an ongoing process, the Plan continues to evolve. The national program's shift to HIV positive persons and their partners and other high-risk individuals will increase planning efforts to link prevention and care. The new strategy will further encourage improved service delivery among all providers. Despite less emphasis on primary prevention, the Division will continue to provide capacity-building assistance for specialized programs demonstrating the potential for the greatest impact on individuals, groups, institutional systems, or communities.

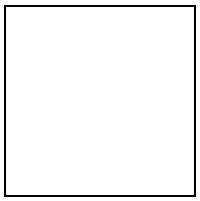
Section I

Background Information

The epidemiology profile (epi-profile) is the foundation piece of the HIV Prevention Comprehensive Plan. The Community Planning Group Epi-profile Committee worked persistently with surveillance staff to identify and analyze data to prioritize the top three populations at risk. Numerous conference calls and meetings were held to effectively prioritize at-risk groups. Prioritization discussions were based on review of other state processes before deciding on the best approach for Alabama. Consequently, a weighted ranking process yielded the results cited in Section II, page 31.

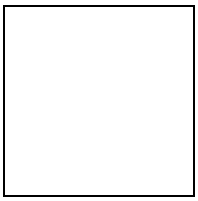
A. Background Information, HIV/AIDS in Alabama

From January 1 – December 31, 2007, 890 HIV/AIDS cases were reported to the HIV/AIDS Surveillance Branch (Figure 1), the second highest annual total of HIV/AIDS cases ever reported in Alabama. The highest total was 934 cases, diagnosed in 2006.

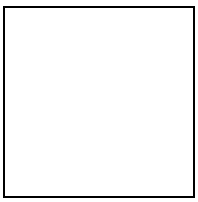


With the development of HAART, persons infected with HIV/AIDS are living longer and, in many cases, more productive lives than those diagnosed in the beginning of the HIV/AIDS epidemic. This has placed significant burdens on Alabama's health care infrastructure and limited HIV Direct Care budget. Figure 2 demonstrates the

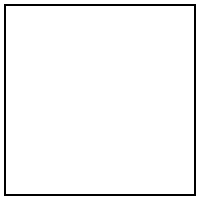
increasing number of persons living with HIV/AIDS who are potentially eligible for Direct Care Services in Alabama.



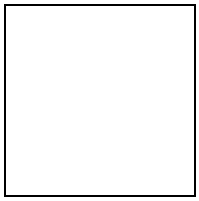
Although the 2007 death ascertainment for HIV/AIDS is incomplete, the annual number of deaths among HIV/AIDS cases has continued to decrease for the past seven years (Figure 3). As of January 2008, 149 HIV-infected Alabama residents are known to have died during 2007. This represents a 39% decrease from the number of deaths reported among HIV/AIDS-infected persons in 2006. Blacks accounted for over 75% of the deaths reported among HIV/AIDS cases in 2006 and 2007. The death rate among Blacks in 2007 (9.7 per 100,000) was nearly ten times greater than that of Whites (1.0 per 100,000).



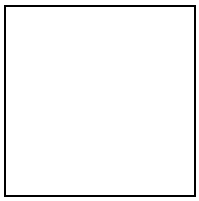
For twenty-five years, after the first Alabama resident was diagnosed with HIV/AIDS in 1982, the number of persons diagnosed with AIDS remained greater than those diagnosed with HIV. The number of persons diagnosed with HIV (non-AIDS) continued to increase, with the percentage rising by 153% between 1993 and the end of 2007 (Figure 4). Now, for the second consecutive year in Alabama, the number of persons diagnosed with HIV (non-AIDS) has surpassed the number of persons diagnosed with AIDS. The number of HIV (non-AIDS) cases diagnosed during the years 2003-2005 increased by 42%, while the number of AIDS cases decreased by nearly 16%.



The 2006 U.S. Census estimates Alabama's population to be 4,447,100. Seventy-two percent of Alabama's population is White, followed by Black (26%) and Hispanic (2%) (Figure 5).



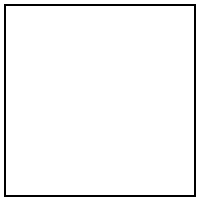
Alabama's HIV/AIDS epidemic began within the White population, but by 1987, it became clear that Alabama's Black community would bear the brunt of the disease (Figure 6). By 1988, more Blacks were infected with HIV/AIDS than Whites, and this trend continues. In 2007, Blacks represented 69% of the HIV/AIDS cases diagnosed among Alabama residents.



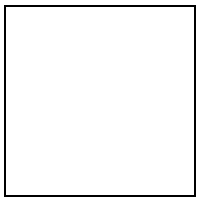
The rate of HIV/AIDS diagnoses continues to be highest among Blacks, followed by Hispanics, and then Whites (Figure 7). The rate among Blacks in 2007 was seven times greater than among whites. Since 1998, the rate of HIV/AIDS diagnoses in Hispanics has exceeded that of Whites, and the numbers have quadrupled since that time. A significant problem is the disparity of HIV/AIDS infection in Alabama's Black

community, and the fact that HIV Prevention plans have not been effective in reducing new infections in this population.

If new HIV Prevention programs are not developed to target both traditional and nontraditonal at-risk populations, the epidemic will continue to decimate Alabama's Black population. There is a critical need to bring together community advocacy organizations, community leaders, care providers, and local and state government agencies, to effectively reduce the burden of new HIV infections within the Black population.



Males have comprised the majority of Alabama's HIV/AIDS cases since 1982 (Figure 8). In 2007, males represented 69% of the HIV/AIDS cases reported, compared to 31% for females. The number of HIV/AIDS cases diagnosed among males and females increased by nearly 9% and 12%, respectively, between 2003 and 2007.



Of the 616 HIV/AIDS cases diagnosed among males in 2007, Blacks accounted for 67% of those cases, followed by Whites at 28% and Hispanics at 3% (Table 1). Among males, the rate of HIV/AIDS diagnoses was highest among Black males (77 per 100,000). The rate among Hispanic males (42 per 100,000) exceeded that of White males (11 per 100,000).

Among females, Blacks represented 74% of the 2007 HIV/AIDS cases reported, followed by Whites (19%). Black females had the highest rate of HIV/AIDS diagnoses

(33 per 100,000), followed by Hispanic females (37 per 100,000) and White females (3 per 100,000).

Table 1. HIV/AIDS Cases by Race/Ethnicity and Gender, Alabama

January 1 – December 31, 2007

	Female			Male			Total		
Race/Ethnicity	No.	%[a]	Rate[b]	No.	%[a]	Rate[b]	No.	%[a]	Rate[b]
White	52	19	3	173	28	11	225	25	7
Black	202	74	33	413	67	77	615	69	53
Hispanic	12	4	37	18	3	42	30	3	40
Other/Unknown	8	3	-	12	2	-	20	2	-
Total[c]	274		12	616		29	890		20

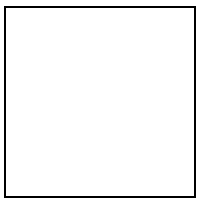
Note. Dash indicates the rate was not calculated because of small numbers.

[a]Calculated as the percentage of all cases during this period. Percentages do not add up to 100 due to rounding.

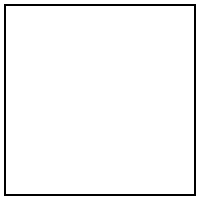
[b]Rates per 100,000 per year in racial/ethnic groups using 2006 U.S. Census estimates

[c] Totals include all cases during this period.

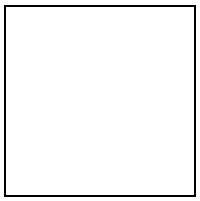
Persons aged 25-34 years, and 35-44 years, respectively represented 26% and 27% of the number of HIV/AIDS cases diagnosed in 2007 (Figure 9). The number of persons aged 50+ was similar to those in the 13-24 year group.



The number of Blacks diagnosed with HIV/AIDS was slightly higher among the 24-34 year old group than among those aged 35-44 (Figure 10). The number of Hispanics diagnosed with HIV/AIDS in 2007 was similar among the two groups that were aged 13-24 years and 50+ years.



Among males, the most HIV/AIDS cases were diagnosed in the 25-34 year group (Figure 11). Males and females, aged 13-24 years and 50+ years, had similar numbers of cases diagnosed that year.



By risk-exposure category, 324 persons (38%) were classified as being infected through male-to-male sex (MSM), 286 (34%) reported no risk factor, 168 (20%) listed heterosexual transmission, 44 (5%) were classified as injection drug users (IDU), and 16 (2%) were cited as IDU/MSM in 2007 (Table 2). Among males diagnosed with HIV/AIDS during this reporting period, the predominant exposure category was male-to-male sexual contact (48%), followed by heterosexual contact (8%), IDU (4%), and IDU/MSM (3%). For the 260 females with HIV/AIDS, heterosexual contact (46%) was the predominant exposure category.

Table 2. HIV/AIDS Cases by Exposure Category and Gender, Alabama

January 1 – December 31, 2007

	Female		Male		Total	
Race/Ethnicity	No.	%[a]	No.	%[a]	No.	%[a]
Male-to-Male Sexual Contact (MSM)	-	-	343	56	343	39
Injection Drug Use (IDU)	22	8	26	4	48	5
MSM/IDU	-	-	17	3	17	2
Heterosexual Contact	134	49	55	6	189	21
Other	2	<1	2	<1	4	<1
No Risk Factor Reported	116	43	173	28	289	33
Total[b]	274		616		890	

Note. Dash indicates the rate was not calculated because of small numbers.

[a]Calculated as the percentage of all cases during this period. Percentages do not add up to 100 due to rounding.

[b]Totals include all cases during this period.

cOther represents 2 in both the male and female columns to make totals.

The number of diagnosed female HIV/AIDS cases that were reported with No Risk Factor (43%) continues to indicate that females: 1) are engaging in high-risk sexual activity, and 2) are not discussing previous sexual activities with their partners. Currently the HIV/AIDS exposure categories are not adequate to determine high-risk sexual activity. In an attempt to ascertain exposure categories, we have revised our presumptive heterosexual category (PHC) to be defined as: An adult female who denies injection drug use and has sex with a male for whom HIV exposure category and HIV serostatus is unknown.

As a result of collaboration with the Division of STD Prevention and Control, the HIV/AIDS Surveillance Branch has reclassified all 117 cases reported among females with No Risk Factor, into the Presumed Heterosexual Category (Table 3).

Table 3. HIV/AIDS Cases by Exposure Category and Gender Utilizing PHC Criteria, Alabama, January 1 – December 31, 2007

	Female		Male		Total	
Race/Ethnicity	No.	%[a]	No.	%[a]	No.	%[a]
Male-to-Male Sexual Contact (MSM)	-	-	343	56	343	38
Injection Drug Use (IDU)	21	8	26	4	48	5
MSM/IDU	-	-	17	3	17	2
Heterosexual Contact/PHC	251	92	55	6	306	34
Other	2	<1	2	<1	4	<1
No Risk Factor Reported	-	-	173	28	173	19
Total[b]	274		616		890	

Note. Dash indicates the rate was not calculated because of small numbers.

[a]Calculated as the percentage of all cases during this period. Percentages do not add up to 100 due to rounding.

[b]Totals include all cases reported during this period.

cOther represents 2 in both the male and female columns to make totals.

Overall, Adult HIV Clinics, CTS (Counseling, Testing Services) and STD facilities and hospitals reported 54% of the HIV/AIDS cases diagnosed in 2007 (Table 4). The Department of Corrections reported 18 HIV/AIDS cases during this period. Drug

treatment facilities, life insurance companies, and blood banks/plasma centers accounted for similar percentages of HIV/AIDS cases.

Table 4. HIV/AIDS Cases by Facility of Diagnosis and Disease Category, Alabama, January 1 – December 31, 2007

	HIV		AIDS		Total	
Facility	No.	%[a]	No.	%[a]	No.	%[a]
Hospital	55	11	82	22	137	15
Private Physician	29	6	12	3	41	5
Adult HIV Clinic	64	13	109	29	173	19
CTS/STD	156	31	40	10	196	22
Correction	11	2	7	2	18	2
Drug Treatment	9	2	0	-	9	1
Life Insurance	8	2	0	-	8	<1
Blood Banks/Plasma Center	6	1	0	-	6	<1
OB/GYN Clinics	5	1	0	-	5	<1
Total[b]	509		381		890	

Note. Dash indicates the rate was not calculated because of small numbers.

[a]Calculated as the percentage of all cases during this period. Percentages do not add up to 100 due to rounding.

[b]Totals include all cases during this period.

Summary

Overall, the data shows that Alabama's reported HIV infection numbers are increasing, partly due to the expansion of rapid testing and Opt-out routine testing. The Black community bears the brunt of the disease, making up almost 70% of the State's HIV/AIDS cases. The MSM, Heterosexual, and No risk Factor exposure categories account for over 90% of our reported cases. After identifying MSM's (Men who have Sex with Men)**,** WSM's (Women who have Sex with Men)**,** and MSW's (Men who have Sex with Women) as our top three priority populations at greatest risk, the Needs Assessment Committee began to dialogue with them. Focus groups were utilized by the

CPG to elicit direct input to determine needed materials, programs, and services (See Attachment IV, page 50).

B. An Overview of Alabama's HIV Prevention and Control Program

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

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

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

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

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

Cross Program Issues

The HIV, STD, and TB Programs of the Alabama Department of Public Health (ADPH) began an organized effort in 1994 to work together cooperatively. Currently, the HIV/AIDS Division and the STD Division central office staff work together to assure continuity of services and achievement of goals and objectives for HIV/STD prevention and control. Representatives from all programs have been cross trained in HIV, STD, TB issues and screening methods. Quarterly meetings occur to review activities, discuss progress, and plan future collaborative efforts. Disease Intervention Specialists (DIS's) participate in the community planning process.

The Divisions share responsibility for the collection and analysis of HIV counseling and testing data. Counseling, Testing, Referral Partner Notification (CTRPN) services are performed by the STD Program for clients who test positive for HIV in both public and private health care settings. In addition, clients who test positive for HIV are referred for a tuberculin skin test. HIV/AIDS-related reports are forwarded from the STD Division to the HIV/AIDS Surveillance Branch for data entry and analysis.

HIV and STD prevention programs will continue to work closely to plan and implement strategies for HIV prevention through early detection and treatment of STDs. Proposed strategies include refinement of counseling and testing, data gathering techniques for HIV/STD risk assessment, and inclusion of community-based AIDS Service Organizations (ASO's) in cross- educational training.

Additionally, the HIV/AIDS, STD, and TB Programs work jointly with the Alabama Department of Mental Health and Mental Retardation (ADMH/MR), and Substance Abuse Treatment personnel to establish Qualified Service Organization Agreements (QSOA's) which allow the exchange of patient information between ADPH and MHMR, primarily related to persons in drug rehabilitation. A joint training session on QSOA's was conducted for supervisory personnel from ADMHMR and other Department divisions, such as ADPH HIV/AIDS, STD and TB.

Surveillance Activities

Data from the Surveillance Branch is shared on a regular basis with health department program components, those who have direct involvement with HIV/AIDS prevention: counseling and testing services, patient education/risk reduction activities, members of the State Prevention Council, and the Ryan White-funded HIV Care Consortium. Data interpretation and technical assistance from the HIV/AIDS Division staff are used for planning and evaluating prevention activities and targeting groups and geographic areas that are most in need. Staff of the Surveillance Branch prepares an extensive epidemiologic report for the State Prevention Council.

In November 1987, the Alabama Board of Health designated HIV as a reportable condition. Physicians are required to report diagnosed cases of AIDS. In order to retain a license, all laboratories performing HIV testing are required to report reactive tests, the providers, and patient identifiers. Until 1990, the ADPH had very limited participation in provision of direct care services to persons infected with HIV/AIDS. With the receipt of Ryan White funding in 1991, a Direct Care Services Branch was organized to assume responsibility for all direct patient services and drug reimbursement.

HIV Care Consortia were developed to provide direct care services, and home-based medical services were expanded for persons living with HIV disease.

Results of serosurveillance surveys and surveillance data were used as criteria for funding eight HIV Care Consortia. These consortia collaborate with existing HIV clinics, ASO's and local health departments to provide an accessible system of care and services for most people living with HIV in Alabama. Support services, including case-management, transportation, and access to service/treatment are funded in areas where the need is documented and supported by results of surveillance data.

The HIV/AIDS Surveillance Branch will continue to prepare an extensive epidemiologic report for the State Prevention Council. The Division supplies State and statistical data from numerous sources, including the STD Division, the Center for Health Statistics, and the Center for Demographic Data and Cultural Research, Auburn University at Montgomery. To determine needs beyond the data in the epi-profile, regions will continue to use various methods, including resource inventories, surveys, key informant interviews, community forums, and focus groups. A state-level epidemiologist will develop the statewide epi-profile and work closely with the Alabama HIV/AIDS Prevention Council.

Collaboration of agencies and organizations involved in HIV/AIDS Prevention Services

Collaboration partnerships and community projects are established both internal and external of the Health Department. Services include fostering linkages throughout the State among prevention programs, direct care services, consumer advisory groups, non-traditional community based organizations, and AIDS Service Organizations. Other special services include:

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

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

Alabama Prison Initiative
The Alabama Prison Initiative aims to provide primary and secondary education services to HIV positive inmates identified in the Alabama Department of Corrections. The Initiative is a collaborative partnership between the Alabama Department of Public Health, HIV/AIDS Division, the Alabama Department of Corrections, NaphCare Pharmacy, statewide AIDS service organizations, and community-based organizations. ADPH has collaborated with NMAC and ADC to provide agencies with HIV services trainings such as Prison Rape Elimination Act (PREA) and Discharge Planning. ASO's and CBO's also provide agency information regularly to inmates.

Funded Projects
The HIV/AIDS Division provides HIV prevention funding to support primary and secondary education and outreach activities. Since 1997, the Division has funded projects that responded to the Request for Proposals. Funded agencies were those who presented unique and innovative strategies for responding to the prioritized risk populations in the eleven Public Health Areas. Currently, there are 7 community-based organizations throughout the State that receive CDC federal funding through the Alabama Department of Public Health.

Enhanced Referral Tracking System
The Enhanced Referral Tracking System (ERTS) has eleven HIV Coordinators, divided by regions, who track and link newly-diagnosed HIV cases into care. ERTS has been fully implemented since January, 2005 and has been presented at several national conferences as a model for other states to imitate. For the past three consecutive years, Alabama has reported that over 60% of newly-diagnosed HIV cases have been linked into care, due to ERTS. The ERTS program will continue to follow up and verify that clients have entered care. In addition, the Quality Assurance component of the program continues to enhance the information reported by coordinators. With the continued increase in new HIV cases, the coordinators maintain their strong collaborations with DIS's, ASO's, and peer mentors.

The State of Alabama currently has 15 AIDS Service Organizations (ASO's). These organizations have multiple contracts that provide a comprehensive range of social and clinical services. Some of these services include medical and dental care, case management, housing assistance, post-test counseling, prevention education, screening, and community street outreach. Each of the ASO's has received funding from the Special Education Trust Fund, appropriated by the State legislature, to support prevention education activities in middle and high schools, detention centers, colleges and universities, nontraditonal academic settings, businesses, and group homes.

FOCUS Program
The FOCUS program engages school systems statewide to incorporate the program as a class credit course, a core youth auxiliary, or other mechanism to teach HIV prevention/ community planning/risk behavior subjects to students. To date, one hundred and two schools statewide are implementing this program. Both exceptional and marginal students are invited to participate in this peer learning/teaching model.

Technical Assistance for Collaborative Partnerships
Technical assistance is offered throughout the State to collaborative partners upon request. Services offered include grant writing, program monitoring and evaluation,

board/committee development, program development and implementation, primary and secondary prevention planning, community and street outreach, developing partnerships and nontraditonal organizations, and documentation and reporting.

The ADPH has an established network of public health social workers. Since April 1990, "Targeted Case Management" for HIV/AIDS has been available to Medicaid-eligible individuals through funding from the Health Care Financing Administration (HCFA). These case management activities are performed by licensed social workers who are certified by the Department to be case managers. In addition, the HIV/AIDS Division funds social workers to provide case management services to individuals who are not Medicaid-eligible in the following higher-prevalence areas: Public Health Areas 1 and 2, which are comprised of counties across northern Alabama; the southeastern counties of PHA's 8 and 10; PHA 11 (Mobile County); and PHA 4 (Jefferson County). In other areas, funding for case management services is available for Medicaid-eligible individuals. Services are provided for non-Medicaid-eligible people through Ryan White Part B funds. Advanced clinical services for management of HIV disease have been available in two areas of the state, Birmingham and Mobile. The Center for AIDS Research at the University of Alabama at Birmingham (UAB) works in conjunction with the 1917 AIDS Outpatient Clinic, AIDS Clinical Trials Unit, and AIDS Vaccine Evaluation Unit.

The Birmingham Veterans Administration Medical Center offers clinical HIV services to outpatient and inpatient veterans. The Children's Hospital in Birmingham and the University of South Alabama Women's and Children's Hospital in Mobile are the sites for pediatric AIDS demonstration projects and have provided care for the majority of HIV-infected children in the State. Education and counseling for family members of these children are also provided at both sites. Cooper Green Hospital serves indigent patients in Jefferson County through its operation of St. George's HIV Clinic. Mobile County Health Department and Franklin Primary Health Center provide clinical HIV services funded by Ryan White Part C. Also, clinical HIV expertise is provided through a contract with the University of South Alabama Medical Center's Infectious Disease Department which provides services at multiple sites in Mobile.

Update: The CDC Advancing HIV Prevention Initiative has a tremendous impact on the funding mechanism for the State. The current cycle of projects places considerably more emphasis on secondary prevention relative to identified priority populations as determined by the AHPC (statewide CPG). The Division, in partnership through the CPG process, recognizes the importance of funding ASO's to provide secondary prevention activities to HIV-positive clients and MSM's. This trend will continue by approving similar projects and by offering capacity-building assistance to nontraditonal groups seeking to provide prevention and care services. Individuals who are high-risk positives and high-risk negatives and their partners, will serve as the principal targeted audiences. Each primary prevention proposal submitted will require a testing component. The State also works with nontraditonal community based organizations that assist with ancillary services provided to persons who are infected with HIV. Some of these nontraditonal settings include substance abuse rehabilitation centers, mental health facilities, domestic violence and homeless shelters, and local county jails.

Communications/Public Information Activities

Public information and education continue to serve as effective preventive tools against HIV infection and against fear and resultant discrimination directed toward people who are infected. A public information campaign was one of the first tactics initiated by the ADPH in the early days of the epidemic. Thousands of Alabamians are reached through mass media, health fairs, printed materials/videos, music CDs, and other events throughout the year. Educational/informational efforts encourage individual risk assessment, testing, behavior modification, and early intervention through medical treatment. Education and training activities are especially designed for health care workers, care givers, emergency medical service workers, educators, social workers, correctional facility staffs, law enforcement personnel and others working with HIV/AIDS.

The Alabama AIDS Hotline, established by ADPH in 1988, provides information and referrals to callers who access the toll-free number. The one-to-one interactions between callers and trained hotline counselors provide opportunities for specific and personal exchange of information/education and referrals. The toll-free line also serves as a tool for CNG's, ASO's, and CBO's to receive technical assistance from central office staff.

The HIV/AIDS Resource Directory for the State of Alabama was updated and published through 2007 by ADPH, and listed national, state, and local HIV/AIDS services. Over the past ten years, more than 50,000 copies were distributed. Beginning in 2009, the Directory was replaced with the HIV Prevention Reference and Referral Poster and will be updated annually and distributed statewide through community networks and the AIDS Division web-based HIV resource ordering system. The Communications Branch coordinates a web page for the Division that provides current information about AIDS, HIV, and related issues and activities in Alabama. Additionally, thousands of culturally sensitive brochures promoting HIV Prevention have been distributed.

Collaboration with Other HIV Prevention Communities

Alabama has 15 community-based ASO's, which provide direct care and prevention services. Representatives of the organizations and a representative of the HIV/AIDS Division meet quarterly as a statewide network, the AIDS Service Organization Network of Alabama (ASONA). The meetings serve as a means of sharing information and techniques, giving support, and receiving technical assistance. The Division director serves as liaison for the organization and individual groups.

The Division coordinates the distribution of HIV Prevention funding to support education and outreach. Beginning in 1997, the Division has funded projects from those who responded to a Request for Proposals (RFP) and a review process. These projects implement programs based on priorities established through the CPG process. Currently, there are 7 organizations across the State that receive CDC federal funding through the ADPH. In addition, some State monies are used to provide funding for prevention efforts by other CBO's.

Collaboration with HIV/AIDS-specific organizations

Representatives of the organizations and the HIV/AIDS Division meet quarterly as a statewide network, the AIDS Service Organization Network of Alabama (ASONA). Travel reimbursement is provided by ADPH. Meetings serve as a forum for sharing

information, providing support, and receiving technical assistance. AIDS Alabama (AA) serves as fiscal agent for the network, subcontracting with the other organizations to provide prevention services, post-test education, case-management, and housing, funded by State and Federal grants. This includes funding for prevention education directly from the State legislature through the Alabama Special Education Trust Fund.

Since 1990, ADPH has used State funds to contract with the community-based ASO's through AA to provide post-test education sessions for individuals infected with HIV. Health department clinics, private physicians, and other testing sites may refer individuals, who have received initial post-test counseling, to local ASO's for additional post-test education and support. ADPH will reimburse for four sessions per individual during a two-year follow-up period.

Direct Care and Support Services

The Alabama AIDS Drug Assistance Program accepts referrals from physicians, university-associated clinics, hospitals, and medical facilities. The project operates on a first-come, first-serve basis.

The ADPH has an established network of public health social workers. Since April 1990, Targeted Case Management for HIV/AIDS has been available to Medicaid-eligible individuals via funding from the Health Care Financing Administration (HCFA). These activities are performed by certified case managers. In addition, the HIV/AIDS Division provides State funds for one social worker to provide case management services to individuals who are not Medicaid-eligible. Funding sources for health department case management services include Medicaid for those individuals who are Medicaid-eligible and Ryan White Part B for those individuals who are not covered by Medicaid.

Until 1990, the ADPH had very limited participation in provision of direct care services to persons infected with HIV/AIDS. Under Ryan White funding in 1991, a Direct Care Services Branch was organized to assume responsibility for all direct patient services, including a drug reimbursement program and the development and implementation of HIV Care Consortia.

Alabama epidemiological and surveillance data are used as criteria for funding service providers. Funding is awarded by a formula based on the number of persons living with HIV/AIDS in a defined service area, the geographic area to be served, and the number of clients served by that provider.

Significant Occurrences

- Alabama's 2007 Ryan White grant award increased over the 2006 allocation, in excess of 7 million dollars.

- The cap for Alabama's ADAP enrollment was increased from 1100 to 1200, which helped to eliminate the need to reinstate the waiting list in 2007.

- Increased funding allowed for the expansion of the ADAP formulary to include a limited number of physician-requested medications.

- Increased funding allowed for additional ADAP staff to accept applications electronically, and to assess client eligibility for the program at the ADAP central office.

- Funding made available to HIV care and service agencies doubled in 2007, thus allowing for improved care and case management services statewide.

- The ADPH Central Laboratory continued to provide CD4 and viral load testing. With increased funding in 2007, the central laboratory agreed to offer resistance testing at no cost to clients or providers.

Alabama AIDS Drug Assistance Program (ADAP) Key Improvements

- *Strengthened ADAP eligibility verification process, recertified 100% of ADAP clients semi-annually, and eliminated ADAP waiting list*

Alabama's ADAP waiting list was eliminated for the first time in over ten years on June 6, 2006. Implementation of HRSA's 2005 semi-annual (twice per year) ADAP client recertification funding requirement, continued to have a positive impact on Alabama's ADAP in 2006, and was a very important factor in helping to eliminate one of the nation's longest state waiting lists. Semi-annual recertification strengthened Alabama's ADAP client eligibility verification process which resulted in opening up close to 300 slots which enabled clients to move off the ADAP waiting list and onto active participation. Alabama's ADAP has maintained a 100% client recertification rate since beginning semi-annual recertification in 2005. Enrollment of ADAP clients in Medicare Part D insurance plans played a major role, as well, in eliminating Alabama's ADAP waiting list. Four hundred and twenty-five ADAP clients with Medicare qualified for full or partial low income subsidy assistance, and were successfully transitioned onto Medicare Part D insurance plans to supply their HIV medications, beginning in May 2006.

A future goal for the Direct Care Branch is to establish a statewide body to plan and strategize care issues for Alabama. This state body will work parallel to the CPG's prevention roles.

Alabama's AIDS Service Organizations, Clinics, and Laboratories

An Alabama Public Health Area Map is provided on page 27 which identifies the Public Health Areas and counties.

AIDS Action Coalition (AAC) is a 501 (c) (3) AIDS Service Organization that operates both the Davis Clinic in Huntsville and the Hames (satellite) Clinic in Florence. The Davis Clinic provides comprehensive HIV and primary medical care, education, social services, and emergency financial assistance to individuals infected with or affected by HIV/AIDS in Public Health Areas 1 and 2. The AAC service area encompasses approximately 8,300 square miles in northern Alabama, including Colbert, Franklin, Lauderdale, Marion, Winston, Limestone, Madison, Marshall, Morgan, Cullman, Jackson, and Lawrence counties. The clinics currently serve 550 active clients.

AIDS Alabama supportive services include availability of multiple apartment complexes which house applicable individuals living with HIV, case management, and transportation to medical and social service appointments. The house units consist of single ones for individuals, permanent subsidized housing for homeless families, a care facility designed for those with a serious mental illness plus HIV/AIDS, and a facility licensed by the Alabama Department of Mental Health/Mental Retardation as a Residential Care Home/Rehabilitation Day Program. AIDS Alabama also has a Rectory Substance Abuse Treatment Program (transitional housing) that has the availability of eleven beds to HIV positive, homeless persons seeking substance abuse treatment. Transportation services are provided for residents, in all housing programs, to medical appointments, social service appointments, and planned activities. Comprehensive case management is provided by case managers and social workers to help infected individuals assess their strengths, needs, and goals, and to be linked to the resources and services they need to meet those goals. The needed resources are many and varied, such as housing, Medicaid, SSI/SSDI, Mental Health/Medical/Substance Abuse Treatments, and other agency services.

The Alabama Department of Public Health Clinical Laboratories central lab in Montgomery continues to perform in excess of 100,000 HIV tests for all clinics in its public health system. Additionally CD4 lymphocyte testing is offered and performed free of charge for private providers and outpatient HIV clinics throughout the State.

Alabama Reference Laboratory in Montgomery serves a broad geographic area, providing HIV-antibody testing and CD4 lymphocyte counts for private physicians and medical clinics throughout the southern region of the State.

AIDS Outreach of East Alabama Medical Center (EAMC) is a full-service HIV/AIDS-specific agency serving Lee, Macon, Russell, Chamber, and Tallapoosa counties in Public Health Areas 8 and 6. Services include case management, medical care three times a month (in conjunction with MAO/Copeland Clinic), ADAP, transitional housing, permanent supportive housing, education, and testing.

Birmingham AIDS Outreach (BAO) has a full-time staff of nine, providing client services and prevention education programs in the greater Birmingham and surrounding areas. BAO offers several programs and services with Ryan White funds: Since 2006, the food bank has prepared and distributed 3,400 boxes, each containing approximately 60 lbs. of food. They have provided financial assistance in 526 cases, to help with co-payments and to purchase medicines, medical supplies, nutritional supplements, and clothing. BAO provided 2,840 instances of transportation assistance in 2003 and provided 1,253 instances of personal hygiene products. There were 797 unduplicated sessions of counseling that served 98 individuals, and a total of 2,421 hours of case management work. BAO offers several HIV Support Groups and has an ADPH-funded intervention program called the Birmingham Mpowerment Project which targets young African-American MSM's, aged 18-40.

The Birmingham VA Medical Center, located in the State's largest city, serves as the primary medical provider for the HIV- infected veteran population for the Southeast. The clinic's multidisciplinary team approach combines the efforts of attending physicians, fellows, physician assistants, nurse coordinators, mental health providers, social workers, team associates, and support staff. This hospital and clinic generally report more than 10

HIV/AIDS cases quarterly in Alabama. The clinic also has an effective collaborative relationship with Jefferson County Department of Health's disease intervention staff for new patients who need in-care services. They presently serve 350 active patients, of whom 60% are African-American and 10% are women. Dr. John Baddley is the chief of infectious diseases, and his clinic collaborates extensively with UAB's 1917 Clinic.

Cooper Green Hospital/St. George's Clinic in Birmingham is funded by Ryan White Parts B & C grants, and serves as the primary medical provider for the indigent HIV-infected population for Jefferson County (Public Health Area 4). This hospital and clinic generally report more than 36 HIV/AIDS cases quarterly in Alabama. The clinic has an effective collaborative relationship with Jefferson County Department of Health's disease intervention staff for new patients who need in-care services. They presently serve 750 active patients, of whom 80% are African-American and 33% are women. Dr. Jane Mobley is the medical director, and her clinic collaborates extensively with UAB Family Clinic at Children's Hospital, which is the largest HIV clinic for follow-up of prenatally-exposed children and their families.

Franklin Memorial Primary Care Center in Mobile is a primary care facility that receives Ryan White, Part C, Early Intervention funds from HRSA and is also funded by the state health department for prevention/education activities. A full range of services is available to persons with HIV.

Health Services Center, Inc. (HSC) is a Community Based Organization and medical clinic that provides HIV medical care, substance abuse treatment, housing assistance, case management, education, and support to a fourteen-county area (Public Health Areas 5 and 6) of East Alabama that includes Blount, Calhoun, Chambers, Cherokee, Clay, Cleburne, Coosa, Dekalb, Etowah, Randolph, St. Clair, Shelby, Talladega, and Tallapoosa counties. The Center has been funded by Ryan White and other sources since 1991. HSC has five satellite clinics which are spread throughout the coverage area, and they are located in the counties of Dekalb, Etowah, Talladega, Tallapoosa, and Chambers. HSC serves approximately 375 HIV clients in their medical clinics and many others through additional programs.

Jefferson County AIDS in Minorities, Inc. (AIM) is a (501) (c) (3) Community Based Organization. AIM's services include HIV antibody testing, counseling and education, syphilis testing, counseling and referral services, HIV/AIDS School and Community Outreach Services, Prison HIV/AIDS education, 3MV intervention, and MSM-based projects. Recent program additions are GED preparation and Narcotics Anonymous (12 step meetings).

Maude Whatley Health Services is a family medical facility which houses the Hope Clinic, a non-profit ASO that is medically-based for HIV positive clients. Whatley Health Services provides family medicine at different sites, with one site having a dental clinic. Their offices are located in the counties of Lamar, Walker, Bibb, Hale (includes dental), Greene, and Sumter. Hope Clinic is based in Tuscaloosa and has satellite offices in Walker and Sumter counties. Hope Clinic staff consists of physicians, a nurse practitioner, a program director, a nursing director, an RN coordinator, a care coordinator, a program assistant, and outreach coordinator/workers.

Mobile's Early Intervention Clinic the second largest, research-oriented clinic in Mobile, is affiliated with the University of South Alabama School of Medicine and is

housed in the Mobile County Health Department. This facility is a Ryan White, Part C, Early Intervention Clinic grantee.

Montgomery AIDS Outreach (MAO)/Copeland Clinic is a Ryan White Titles B and C clinic, providing comprehensive HIV-specific services. Located in Montgomery and Dothan, it also operates satellite clinics in five other counties (towns of Selma, Clayton, Auburn, Greenville, and Troy). The catchment area covers 22 counties, located in Public Health Areas 7, 8, 10, and 11, and currently serves 1120 active patients.

Providing Ultimate Life-sustaining Strategies through Education (PULSE) is a non-profit organization formed in February 2007 and has recently obtained its 501 (c) 3 status. The main objective of PULSE is to provide educational services and to create awareness about HIV/AIDS and its effects. PULSE also provides outreach services for those infected and affected by the disease.

Selma AIDS Information and Referral (Selma AIR) is a Ryan White Part B clinic, providing services to individuals affected by HIV/AIDS. It is located in Selma, Alabama, home of the Civil Rights Movement. Selma AIR extends services to all eight counties that comprise Public Health Area 7 (Choctaw, Dallas, Hale, Lowndes, Marengo, Perry, Sumter, and Wilcox counties). The clinic currently serves 60 active clients.

UAB's 1917 Clinic, an academically-based clinic, is the largest HIV health care unit in Alabama and serves more than 1,500 patients annually. For more than 20 years the UAB 1917 Clinic has primarily provided comprehensive core medical and social services to adult HIV-infected patients. Medical specialty, dental, and mental health services are available onsite through referral. In 2008, the 1917 Clinic received Ryan White Parts C & D funding. The Director is James Raper, DSN, CRNP, JD, FAANP and J. Michael Kilby, MD, serves as Medical Director. Since 1994 the Alabama HIV/AIDS Clinical Trials Unit (HCTU), has been nested within the 1917 Clinic, under the direction of its Principal Investigator, Michael S. Saag, MD, who is responsible for HIV/AIDS prevention, vaccine, and treatment research. During 2007 the clinic enrolled 61 participants, and they are presently in trial phases I & II. The Clinical Trials Unit is funded by the National Institute of Allergy and Infectious Diseases (NIAID).

UAB Family Clinic, Children's Hospital, Birmingham, is directed by Dr. Marsha Sturdevant and funded by Ryan White Part D. The clinic provides medical and supportive services to an estimated 95% of the known-infected children, adolescents, young adults, pregnant women/adult women in Alabama. The clinic is a statewide referral source for infected and affected children and their families.

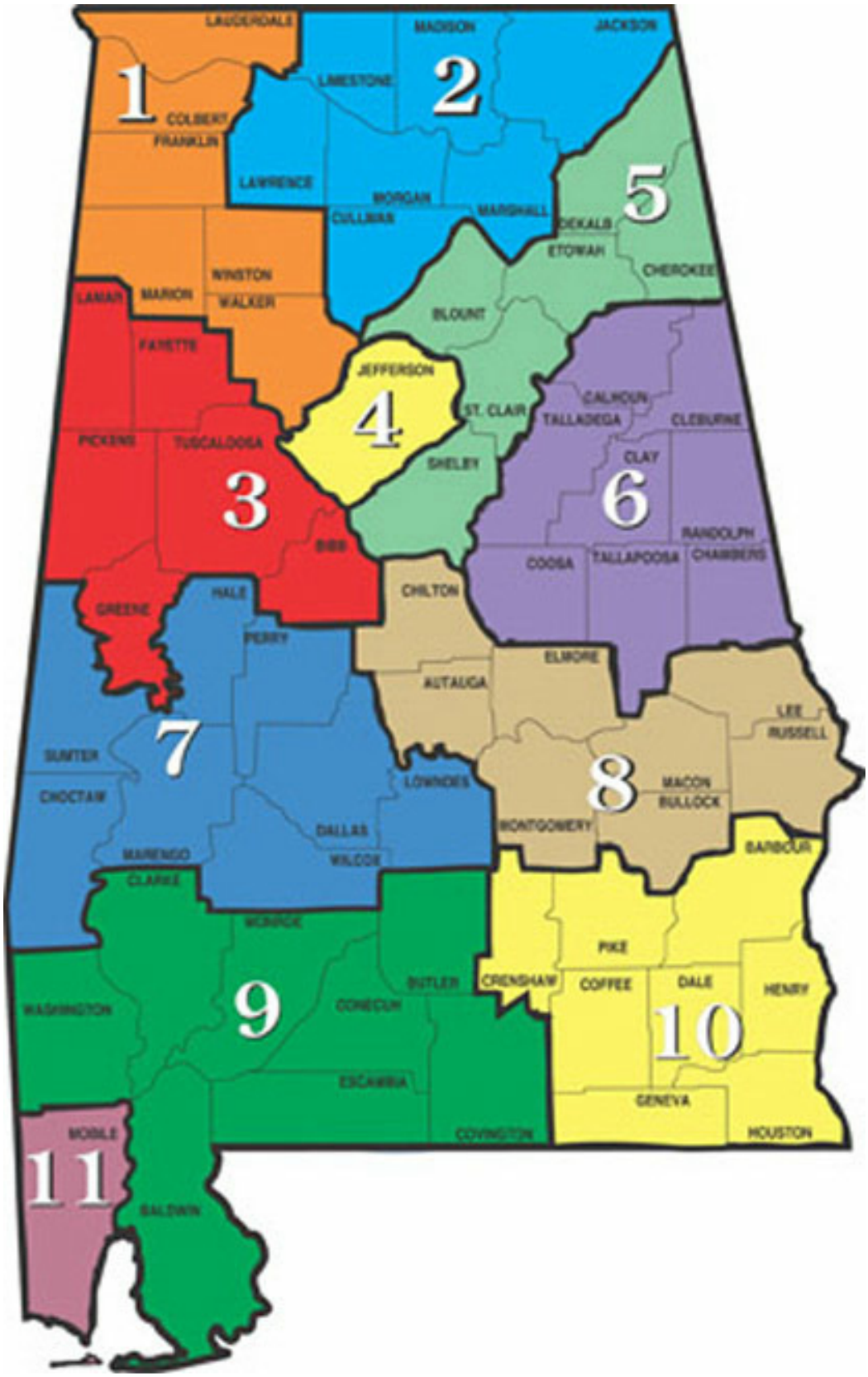
UAB Immunology Laboratory in Birmingham provides HIV and CD4 testing for University Hospital and many other clinical providers in the Birmingham area.

UAB Montgomery Family Clinic, located in Montgomery, is a Ryan White Part D clinic, providing services to infected children and adolescents, along with their families. The catchment area is all counties in PHA's 7-11, the southern half of Alabama.

West Alabama AIDS Outreach (WAAO) is a non-profit ASO that is social-services-based. WAAO operates their main office in Tuscaloosa. They are open Monday through Friday from 8 A.M. to 5 P.M, and they serve clients in the following 9 counties:

Tuscaloosa, Bibb, Pickens, Lamar, Greene, Hale, Perry, Sumter, and Walker (in Public Health Areas 1, 3, and 7). WAAO has eleven staff members.

Public Health Area map



Section II

Update of the Community Planning Process in Alabama

A. Update on the HIV Prevention Community Planning Process in Alabama
The Division of HIV/AIDS Prevention and Control is strongly committed to the process of community planning for HIV prevention. In the early days of the AIDS epidemic in the State, ADPH emphasized the importance of community participation and initiated the Alabama AIDS Network to promote prevention and care, provide education, and maximize resources. The structure of the network defined state, area, and local levels of organization and linked governmental and non-governmental agencies, organizations and institutions involved in HIV prevention and care services.

Background
Regional community planning groups for HIV prevention were the natural direction for HIV prevention initiatives in Alabama. Multiple groups, based on the existing ADPH organizational structure and staffing, were essential to ensure local participation in defining community needs and actualizing the purpose of community planning. Each regional CPG was facilitated by an Area HIV Coordinator who served as health department co-chair and an elected community co-chair, along with other community representatives who served as members-at-large. All former regional CPG's operated with an "open door" policy, and recruitment of members was an on-going and open process. Each CPG was responsible for developing regional prevention plans. Working collaboratively throughout the year; members would compile various sources of information. The epi-profile was presented in the spring, followed by prioritization exercises, intervention strategies, and gap analysis.

Each CPG conducted and compiled results of the evaluation tools for regional plans. The regional plans were then incorporated into the state comprehensive plan before being submitted to the CDC. In 1997, the statewide Alabama HIV Prevention Council (AHPC), was formally adopted, consisting of health department and community co-chairs and two members-at-large from each regional CPG. The AHPC met four times a year and served as a statewide guiding body for prevention activities. Upon receipt of regional plans, the copies were distributed for peer review by AHPC members and staff of the HIV/AIDS division. During the June meeting, the prioritization process was finalized with members in agreement on the upcoming years' prevention program focus. The four work teams of the AHPC, 1) membership, 2) epi-profile, 3) needs assessment and 4) evaluation/technical assistance. These work teams were responsible for a set of tasks that included the following: reviewing and summarizing the area plans, establishing statewide objectives, and recommendations for the statewide plan. The interventions were then prioritized on explicit considerations of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values. Individual CPG's then reviewed and discussed the overall plan, made recommendations, and wrote letters of concurrence.

Changing Structure
The Alabama HIV Prevention Community Planning Group faced new challenges in changing the structure from eleven multi-regional CPG's to one statewide CPG, which began September 2003. This change was necessitated, due to strong encouragement by CDC, to have just one statewide CPG. The new Alabama HIV Prevention Council (AHPC) met quarterly and consisted of twenty-seven members representing all public health areas. This transitional period continued through FY 2004. The work teams consisted of the following: 1)HERR, 2)Linkages/Public Information,

3)CTR/PCR/Perinatal, 4)Epi Profile, and 5)Infected Persons. These work teams were created to reflect the CDC's *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. The current AHPC membership, consisting of twenty-two community members and eleven Health Department Coordinators, facilitated the transition process by nominating and selecting new members and establishing new by-laws. Pre-planning began in June 2003 and continued through September 2003, when three ad hoc committees were formed. The Nominating and Selection committees met in January 2004 and created criteria and application forms for the process. Membership applications were distributed statewide. During the April 2004 meeting, the applications received were reviewed for representation, in order to reflect the diversity of the epidemic in Alabama. During the June 2004 meeting, the Selection Committee presented the AHPC with the prospective slate of new members for approval. The By-laws Committee met as needed and presented the new by-laws for approval in June. The final by-laws were formally adopted April 21, 2005. During the June meeting, the AHPC collaborated and coordinated the revision of the Comprehensive Plan for HIV Prevention in Alabama. The existing AHPC membership provided guidance, technical assistance and orientation training to the newly-formed statewide CPG. During the 2005 fiscal year, the existing regional CPG's were transformed into **HIV Prevention Network Subcommittees.** Each HIV Prevention Network meets monthly or bi-monthly. The Network continued to coordinate prevention activities within specified regions, with emphasis on community participation, identifying priority HIV prevention needs, targeted HIV testing/risk reduction, and collaboration with community partners. Each Network continues to conduct needs assessment activities (i.e. focus groups, surveys). Staff roles and responsibilities of the HIV Coordinators are ever-changing to better support efforts of the new initiative.

1. Elements of Community Planning in Alabama

The AHPC is the statewide guiding body for prevention activities. Work teams of the AHPC have assisted in developing standardized processes, procedures, forms and strategies to facilitate consistent plan development and appropriate prevention, as well as direct care related program activities. Goals and objectives for 2009-2013 are as follows:

Goal One: Community planning supports broad-based community participation in HIV prevention planning.

Objective 1: Continue an open recruitment process (outreach, nominations, and selection) for CPG membership. The regional Prevention Networks will continue to meet monthly or bi-monthly and welcome anyone who wishes to participate. The regional HIV Prevention Network will promote AHPC as an agenda item at each meeting to promote interest and recruitment for the Statewide body. In addition, the Networks will conduct focus groups, surveys and community forums, which will serve as sources of local input from marginalized communities who may not be able to participate fully in the community planning process. There will be additional emphasis placed on collaboration and coordination of activities with the State Direct Care Division.

Objective 2: Ensure that the CPG membership is representative of the diversity of populations most at risk for HIV infection and of the characteristics in the jurisdiction. The CPG membership should include key professional expertise and representation from key governmental and non-governmental agencies**.** The AHPC is committed to finding

ways to elicit input from populations most at risk. The new membership will be solicited and recruited statewide by the Nominating Committee, with emphasis on representation that reflects the diversity of the epidemic in Alabama. The Selections Committee will ensure that all regions of the state are represented among the membership. In addition, the selection committee process will insure that appropriate individuals from the public and private sector with HIV/AIDS knowledge, experiences and/or expertise in planning, behavioral sciences, evaluation and community development are represented.

Objective 3: Foster a community planning process that encourages inclusion and parity among community planning members. Orientation methods and training will be used by AHPC to encourage inclusion. The former AHPC members will be recruited to serve as mentors and to offer technical assistance to the group. To enhance parity, the members will be provided opportunities to participate in capacity-building workshops. The workshops, which includes skills-building, will be designed to increase the ability of the members to equally participate and carry-out planning tasks or duties in the community planning process.

Goal Two: Community Planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

Objective 1: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction. The Epidemiology Committee ranked all risk populations by the total of newly diagnosed HIV cases by risk populations from 2001-2005. The MSM, Heterosexual, and No Risk exposure categories account for over 90% of our reported HIV/AIDS cases.

Objective 2: Ensure that prioritized target populations are based on an epidemiologic profile. The Epi Committee ranked risk populations and redefined "heterosexual" and "no identified risk" categories to include the total number of HIV infections. The HIV data was provided directly from the epi-profile which is generated by the ADPH HIV/AIDS Division Surveillance Branch.

The risk populations are: Men who have Sex with Men, Women who have Sex with Men, Men who have Sex with Women, Male Injection Drug Users, Female Injection Drug Users, Men who have Sex with Men and Inject Drugs.

1. **MSM**
2. **WSM**
3. **MSW**
4. **MIDU**
5. **FIDU**
6. **MSM/IDU**

The AHPC places heavy emphasis on our top 3 priority populations by encouraging agencies applying for funding to submit proposals for interventions which will target and impact these populations.

Objective 3: Ensure prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness and/or have been adequately tested with intended target populations for cultural appropriateness, relevance and acceptability.

In the requirements for agency proposals, one of the criteria is for an agency to propose the use of a DEBI/EBI and to identify which behavioral or social science theory model is utilized. In 2007, ADPH was able to fund 6 agencies to implement 8 interventions.

Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the Comprehensive HIV Prevention Plan.

Objective 1: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for Federal HIV prevention funding. The AHPC and its' work teams are responsible for sets of tasks toward development of the Alabama Comprehensive Plan. A request for proposals is issued by the health department to agencies, organizations and/or institutions to address HIV interventions. The interventions must target prioritized populations identified by the AHPC, which fosters strong linkages between the community planning process and the application for federal HIV prevention funding.

Objective 2: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions. In 2007, the HIV/AIDS Division funded several approved contracts in response to requested proposals for prevention intervention programs targeting populations prioritized through community planning. These contracts are for the cycle of 2007-2009 for a total of $540,000 a year, which were awarded to 8 approved projects.

2. Obstacles to the community planning process

Geographical Issues: The predominantly rural nature of the State means that members in many of the public health areas must travel long distances to attend meetings or other community planning activities. Both distance and the time factors related to travel may inhibit the recruitment and active involvement of members from rural areas. As the transition takes place to only one CPG for the State, this may create an even greater barrier for some representatives.

Retention of Members: Retaining active members on a long-term basis initially presented problems for the AHPC. Some members were unable to participate due to personal reasons, health conditions, employment constraints, and for some, prevention "fatigue". Prior to the issuance of the new initiative by CDC, many members were lost because they felt that the process had become stagnant due to continual emphasis on planning. Selection and terms of office for the reorganized CPG has improved participation.

Knowledge and Experience: Progress is sometimes delayed by the lack of a clear understanding of the CPG member roles when new members begin their term.

National Prevention Summit and other National Meetings: The application guidance states that ADPH Prevention staff are required to attend national meetings/conferences.This often presents a challenge due to administrative restrictions placed on the number of staff allowed to attend.

3. Technical Assistance

Guidance will be provided through the Division staff, the state CPG (AHPC), area HIV Prevention Networks, funded projects, and the project officer.

Areas of need identified by previous CPG's, which still impact the state CPG planning process, continue to be:

a. Effective recruitment and member retention, especially in traditionally difficult to reach populations
b. Implementing quality programs at low cost, due to the economy
c. Staff/program retention and maintaining trained staff
d. Increasing testing effectiveness in high-risk environments
e. Reaching high-risk partners and strengthening risk reduction
f. Improving standards of testing, counseling and prevention case management
g. Making rapid tests more available

Evaluation

Currently, quarterly reports are submitted by funded agencies and the HIV Coordinators to document progress.

A comprehensive evaluation model will be developed and implemented for the funded prevention projects throughout the duration of the project cycle. The evaluation component will be developed to measure process and the impact of individual project intervention strategies. The evaluation component for the secondary prevention initiative will include, but is not limited to, the following measurements:

a. Successful completion of initial evaluation training-The purpose of this training will be to provide an overview of monitoring and evaluation of project outcomes, project goals and objectives, conducting internal agency evaluations, and state reporting guidelines.

b. Content of quarterly reports-This will include the process indicators for meeting goals and objectives, significant occurrences specific to behavioral modification, risk reduction, community collaborations, and knowledge assessments.

c. Project site visits -Twice annually to monitor the implementation and progress of project activities, and to review documentation and program materials that support quarterly reports.

d. Submission of project intervention data into PEMS (Program Evaluation Monitoring System).

e. Individual project reports provided at the quarterly Prevention Council meetings and monthly Community Networking Group meetings.

4. Specific impact of the planning process, including proposed shifts in or confirmation of:

a) Program budget priorities or expenditures

The community planning process has created a tremendous change in prevention program priorities and expenditures. Prior to 1994, there was very little input from local communities or regions in determining budgetary or allocation issues. The development, growth and maturity of the planning process have influenced the direction of expenditures and budget planning.

The new CDC initiative has impacted the funding process for new prevention projects. Secondary prevention continues to be the major emphasis for organizations seeking prevention funding. Increased funding awards will be directed to fewer organizations to strengthen the quality of programs offered. During the previous funding cycles, 10-14 organizations were funded. Currently, ADPH funds 6 organizations with strong and effective programs.

Funding goes directly to HIV prevention projects for prioritized populations. The involvement of community stakeholders fosters strong linkages between the community planning process and the application for funding.

Representatives of the CPG and funded CBO's are financially supported to attend capacity-building meetings/trainings such as the SISTA, VOICES, NMAC-Prison Discharge, Orasure/Oraquick, NMAC Direct Care and Prevention Strategic Planning, initiated or sanctioned by the Division. This is an incentive to those who demonstrate long-term commitment to prevention planning and program development.

Funds are used for support materials, resources, training sites, trainers, travel, and lodging expenses. Stipends also are paid to focus group participants and facilitators. Additional funds are used to promote HIV prevention messages and special programs, and to purchase condoms, brochures, and videos, including culturally relevant and specific materials designed for African-Americans, MSM, persons with HIV, youth and women. Such tools are used to enhance targeted programs and to promote community and individual awareness.

Division and area staff, funded by federal prevention monies, utilize substantial portions of their total time on prevention activities and community planning. Surveillance staff spends a considerable time providing epidemiologic data and analysis for assessment of disease trends critical to HIV prevention planning.

The Alabama State legislature potential shortfall of general funds in May 2009, heavily impacts the programs of the Alabama Department of Public Health, Division of HIV Prevention and Control and CBO's that provide HIV services statewide. Funding cuts may be severe which could result in employee lay-off's, employees' functioning in multiple roles, and services being eliminated or reduced. If the Division receives level funding, cuts will be made in prevention, direct care, and program support due to salary adjustments and other expenses. Maintaining linkages between the community planning process, prevention priorities and the application for funding is needed more than ever.

b) Allocation, assignment, or function of staff

With the new initiative, staffing has adjusted responsibilities to meet the expanded requirements. Community planning will continue to be the foundation to build sound prevention program activities. Staff of the HIV/AIDS Division, STD Division and the public health area staff whose positions are funded through federal prevention monies will spend a substantial proportion of their total time on activities related to prevention for positives, their partners, and other high-risk populations.

c) Characteristics of clients targeted or served

As mandated by the CDC, our state program will continue to intensify its efforts begun in 1998 to reach HIV positives, their high risk partners and other high risk negatives. **PLWA's** living in rural Alabama may have limited access to prevention and care services. Transportation, loss of income, lack of insurance and insecurities regarding confidentiality further complicate secondary prevention care. The Alabama Drug Assistance Program currently serves 1,400+ individuals with HIV disease, with no cap on enrollment. Clients are accessed and referred through public and private health care facilities.

The Alabama HIV Prevention Council believes its prioritization process further complements the current focus, resulting in the following prioritized populations for 2009-2013.

1. **Men Who Have Sex with Men**
2. **Women Who Have Sex with Men**
3. **Men Who Have Sex with Women**

Interventions were identified for each population. Interventions included strategies to prevent HIV infection and to provide education, support and resources to those already infected.

Finally, all prevention activities affiliated with the Alabama Department of Public Health encourage abstinence, postponing sexual activity, and reducing risks of exposure to HIV.

d) Requests for proposals to be issued by the grantee.

Monies received from the CDC will be used to fund statewide HIV primary and secondary activities, targeting the identified prioritized population.

Funding is allocated based on the specific needs of the community and innovative strategies proposed to implement project interventions with high-risk groups. The prioritized populations are based on information provided by the community planning groups and HIV/AIDS surveillance data. Contracts for funded agencies are renewed annually based on funding availability and overall evaluation of project implementation and compliance from the previous year.

Request for proposals will be issued throughout the State to AIDS Service Organizations, Community Based Organizations, non-traditional organizations that provide ancillary

services to persons who are infected or at high risk for HIV infection. Specific marketing efforts will be implemented to encourage submission of RFP's from medical providers and agencies that provide mobile clinical care and targeted street outreach to HIV infected persons who frequent non-traditional venues.

B. 2009 Community Planning Goals and Objectives

The following vision and mission statements were adopted and updated by the AHPC Bylaws Committee.

> **Council Vision:** The Alabama HIV Prevention Council embraces the "HIV Prevention Community Planning" concept, to create an environment free from risk of HIV infection in every community through active grassroots participation
>
> **Council Mission:** The mission of the Alabama HIV Prevention Council is to develop a Comprehensive HIV Prevention Plan for the State of Alabama.

In 2009, HIV Prevention Council meetings will be held quarterly. These meetings enhance the planning process using peer-led work teams to foster participation and collaboration in the community planning process.

Goal One: Community planning supports broad-based community participation in HIV prevention planning.

Objective 1: Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.

Activities:

1. During the September AHPC meeting, a new community co-chair is elected by the Council.

2. Each HIV Coordinator will be pre-selected to serve a 2 year term as AHPC Co-chair.

3. During January through May of each year, the current AHPC members will solicit and recruit, potential members for the statewide CPG.

4. By each June, the Nominating Committee will provide application forms for AHPC membership to local network prevention members.

5. By each September, the Selection Committee of AHPC will select 11 new community members and present the slate to the membership for approval in January.

Objective 2: Ensure that the CPG membership is representative of the diverse populations most at risk for HIV infection and characteristics in the jurisdiction and includes key professional expertise and representation from key governmental and non-governmental agencies.

Activities:

1. By each September, the regional Prevention Networks will contact local universities and/or other agencies (public and private) to identify resource people and potential members.

2. By each September, the Nomination and Selections committees of the AHPC will solicit and recruit members with emphasis on representation to reflect the diversity of the epidemic in Alabama and to ensure that all regions of the State are represented among the membership.

Objective 3: Foster a community planning process that encourages parity, inclusion and representation among community planning members.

Activities:

1. In January, orientation training for the new members begins. The current AHPC members will serve as mentors and provide technical assistance.

2. Annually members will be provided opportunities to participate in capacity-building workshops.

Goal Two: Community Planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

Objective 1: Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.

Activities:

1. Quarterly, the HIV/AIDS Surveillance Branch prepares extensive epidemiologic data for the State, in addition to regional profiles.

2. Annually, the HIV Prevention Networks will continue to update the State HIV Prevention Reference and Referral Poster.

3. Quarterly, a state-level epidemiologist will provide technical assistance for development and analysis of Area and State profiles.

Objective 2: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.

Activities:

1. By December 2009, the HIV Prevention Reference and Referral Poster will be updated. Community service providers are contacted for current information. Statewide distribution of most recent directory continues during the updating process.

2. By April 2009, the Needs Assessment Committee will submit results of community services assessment (resource inventory, needs assessment) to the rest

of the AHPC for input and feedback. The Epi-Committee refined the Decision Matrix, the population prioritization tool, from the regional use to that of states.

3. During 2009, work with the Surveillance Branch to maintain the change in the risk exposure category "risk not reported" to "men who have sex with women" and "women who have sex with men".

Objective 3: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and /or have been adequately tested with intended target populations for cultural appropriateness, relevance and acceptability.

Activities:

1. By April 2010, identify individuals from the governmental and non-governmental agencies with HIV/AIDS knowledge, experiences and/or expertise in planning, behavioral sciences, evaluations and community development to serve as AHPC members.

2. By April 2013, identify and prioritize characteristics of interventions by populations.

3. By April 2010, research and complete literature reviews for effective activities and interventions, including the document CDC's Compendium of HIV Prevention Interventions with Evidence of Effectiveness, revised August 2001.

4. By April 2010, identify interventions having cultural appropriateness, relevance and acceptability, based on behavioral and social science.

5. By June 2009, list interventions for specified populations.

Goal Three: Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the Comprehensive HIV Prevention Plan.

Objective 1: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for Federal HIV prevention funding.

Activities:

1. During 2009, the Division and the AHPC established a prevention planning and program development schedule.

2. During January through June 2009, the AHPC work teams collaborated with the Division staff in updating the Comprehensive HIV Prevention Plan and making recommendations.

3. By September 2009, the AHPC will submit a letter of concurrence.

4. By September 2009, the comprehensive plan/application will be routed through the ADPH for approval.

5. By September 2009, documents will be submitted to CDC.

Objective 2: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

Activities:

1. By November 2009, proposals will be solicited by competitive RFP for projects to be funded for FY 2010. The proposals must address HIV interventions in populations designated by the CDC new prevention initiative and those listed as priority populations in the Comprehensive HIV Prevention Plan.

2. By February 2010, funding awards (FY10) will be announced.

Section III

Statewide Comprehensive HIV Prevention Plan Action Steps

A. Long-Range Goals and Objectives

Overall programmatic goals for 2009 through 2013 include:

1. Reduce the incidence of new HIV infections in Alabama

2. Improve public understanding of, involvement in, and support for HIV prevention

3. Prevent/reduce behaviors that transmit HIV

4. Increase individual knowledge of serostatus and improve referral to appropriate prevention and treatment services

5. Develop partnerships for HIV prevention

B. HIV Prevention Program Specific Plans – FY 2009

1. Counseling, Testing, Referral and Partner Notification and Referral Services

Goal One: Increase the number of persons seeking HIV Counseling, Testing and Referral Services (CTR). At the end of fiscal year 2005, CTR services were provided to approximately 110,000 persons. In 2007 the number increased to 120,000. By the end of fiscal year 2010, CTR services will have likely increased by 10% more.

By the end of FY 2013:

Objective 1: By the end of fiscal year 2012, provide financial support to nontraditonal testing sites, contingent upon available funding.

Provide support through additional training, i.e. Pre/Post Test Counseling, safety and confidentiality, Oral HIV testing, cultural sensitivity and competency. To provide funding and technical support to organizations currently providing testing services, i.e. community based organizations, mobile medical testing units, street outreach programs, gay, lesbian and transgender organizations.

Objective 2: Collaborate with the State Community Planning Group, persons with HIV and community partners to establish new testing venues.

Objective 3: Apply recommendations from the Alabama State Board of Health for training, written information and meetings for hospital and medical personnel to encourage HIV testing with an opt-out option as a routine practice.

Objective 4: Offer support services, test kits, brochures, condoms, advertising, Hotline number and referral services to organizations that already offering testing in an effort to expand services to more people. Include entities such as corrections (adult and juvenile), homeless populations, mental health and substance abuse facilities.

Goal Two: Increase the number of persons who receive Post Test Counseling and Referral services to 60%.

Objective 1: Provide a condensed version of HIV Pre/Post Test Counseling.

Objective 2: Provide on site preliminary test results as allowed by Alabama Law. Conduct confirmatory tests, when appropriate, offered on site following a preliminary positive test.

Objective 3: Seek informed consent from clients who are not under the influence of a substance that may alter their judgement and behavior.

Objective 4: Provide referrals and support services on site and when possible provide on site assistance to the next service provider.

Objective 5: Provisions for maximum privacy will be made for nontraditonal site testing, i.e. separate rooms and/or partitions.

Objective 6: Test results will be given on site or near the testing site.

Objective 7: Explore the possibility of offering incentives according to what is permitted by departmental policies and procedures.

Objective 8: Strongly recommend non-funded, private testing sites to report test numbers.

Objective 9: Require sites, using test kits purchased by the State, to report test results and adhere to program audits. Conduct direct observation of testing.

Objective 10: Track test results of newly identified HIV positive clients through the state HIV/AIDS Surveillance Branch.

Objective 11: Identify new HIV positives that have been linked to care through the ERTS and Peer Mentor programs.

Partner Counseling Referral Service (PCRS)

Goal One: By 2012, the Alabama Department of Public Health will strengthen the quality of PCRS services offered in order to identify high risk HIV positive clients and their partners.

Beginning in 2009:

Objective 1: Update guidelines on the provision of PCRS to promote consistency in the delivery of service.

Objective 2: Improve program operations conducive to effective PCRS, as determined by guidelines.

Goal Two: By 2009, the Alabama Department of Public Health will strengthen early referral, testing, counseling and follow-up services of high-risk partners.

By the end of FY 2009:

Objective 1: During the report period, at least 90 percent of sex and/or needle sharing partners of infected persons will be identified. At least 70% will be counseled and tested within seven – fourteen days of DIS notification at the health department or agreed upon site.

Objective 2: During the report period, at least 70% of sexual and/or needle sharing partners with negative results will be post-test counseled.

Goal Three: By 2010, improve linkages between health departments, physicians, ASO's, and other providers for early PCRS, in accordance with recommended guidelines.

By the end of FY 2010:

Objective 1: Monthly, health department staff (HIV Coordinators, DIS's, nurses, social workers) will collaborate with providers through organized screenings at non-clinical high risk locations.

Objective 2: Distribute PCRS guidelines to physicians and other providers, as needed.

2. Health Education/Risk Reduction (HE/RR)

Goal One: Implement secondary prevention programs and create partnerships designed to increase awareness of risk reduction choices and services for persons with HIV and for persons engaging in high risk behaviors.

By the end of FY 2010:

Objective 1: Offer train the trainer sessions that provide risk reduction behavioral interventions for persons with HIV.

Objective 2: Purchase, develop and distribute printed/audio/visual materials with educational messages that emphasize secondary prevention, managing an HIV positive health status, risk reduction and related issues.

Objective 3: Provide information and referral resources through the toll-free Alabama HIV/AIDS Hotline, staffed by HIV/AIDS Division personnel.

Objective 4: Provide a statewide HIV/AIDS conference or training to include topics that include the following: HIV testing, primary and secondary prevention information for health care and community based providers, mental health professionals, persons with HIV and their families, substance abuse professionals, volunteers, and others who provide behavior modification techniques that promote healthy life style choices.

Objective 5: Distribution of the OraSure and/or OraQuick Test Kits to organizations or institutions providing HIV testing services.

Objective 6: Conduct Quality Assurance Audits for agencies/organizations receiving Ora Quick tests.

Objective 7: Provide trained personnel for community testing initiatives.

Objective 8: Provide follow up services on all Partner Counseling and Referrals through the State STD Division.

Objective 9: Provide free male and female condoms through county health departments, community based organizations, community outreach programs and other organizations and facilities that serve infected and/or at-risk individuals.

Objective 10: HIV Coordinators will coordinate HIV Prevention screening programs in collaboration with the STD Division field staff and other community providers.

Objective 11: Provide educational sessions in health departments across the State via satellite conferences and webinars to disseminate updated treatment and prevention information.

Objective 12: Prevention programs will be conducted, targeting high risk young adults in alternative schools, court mandated and/or juvenile detention settings.

Objective 13: Quarterly, HIV Coordinator staff will conduct at least fifteen outreach encounters with consortia, CBO's, support groups, medical providers and other high risk sites to promote early diagnosis and treatment.

Goal Two: To implement secondary risk reduction and behavior modification intervention activities with persons already infected with HIV/AIDS, especially those representing the prioritized populations, men who have sex with men and at-risk heterosexuals, as identified by the State Community Planning Group's epidemiological profile and needs assessment.

Objective 1: Purchase, develop and distribute educational materials providing information on HIV transmission and prevention.

Objective 2: Provide on-going educational opportunities in health departments across the state via satellite, audio and/or webcast and disseminating updated treatment, testing, risk reduction and prevention information.

Objective 3: Provide free condoms through county health departments, AIDS service organizations, and community based outreach programs.

Objective 4: Expand group level interventions to incorporate social and health related topics that affect persons who have HIV.

Objective 5: Provide intense individual level interventions that emphasize risk reduction techniques, behavior modification skills, self-empowerment and assessment tools for implementing new and healthy behaviors.

Goal Three: Continue to promote the Focus Program through partnership with the Alabama School System.

Objective 1: Provide a contract person who coordinates Focus activities statewide.

Objective 2: Two subcontractors will coordinate FOCUS activities and prepare documentation and reports under the guidance of the contractor.

Objective 3: HIV Coordinators will assist with coordinated training in schools, with the Central Office providing support for the program.

3. Public Information

Goal One: Improve public understanding of, involvement in and support for HIV testing and screening and for primary and secondary HIV prevention services.

By the end of FY 2009:

Objective 1: Following review by the Literary Review Panel**, t**he HIV/AIDS Communication Branch will purchase, develop and distribute educational materials and will provide updated information regarding training and workshops.

Objective 2: Provide information and referral resources through the toll-free Alabama AIDS Hotline, which is staffed by HIV/AIDS Division staff.

Objective 3: Continue 18-wheeler side panel haul ads promoting HIV testing for all ages and ethnicities.

Objective 4: Monitor and update the website which offers current statistics and contains meeting and training announcements, HIV related information and related links.

Objective 5: Provide media interviews and press releases.

Objective 6: Provide technical assistance, funding and referral information to organizations and community groups involved in HIV testing, treatment and prevention activities.

Objective 7: Continue to update and publish the Alabama HIV/AIDS Prevention Reference and Referral Poster, as well as the HIV Prevention Brochure.

4. Evaluation

Goal One: Monitor and evaluate the progress of new and ongoing testing initiatives.

By the end of 2009:

Objective 1: Continue to require funded sites to report numbers of clients who receive Counseling, Testing and Referral services.

Objective 2: Initiate quality assurance reviews of CDC funded CTRN/PCRS sites.

Goal Two: To collect, monitor and evaluate data specific to program activities submitted through PEMS, as outlined by the CDC compatibility guidelines, when PEMS becomes fully operational.

By the end of 2009:

Objective 1: Collect and enter prioritized client level data and prevention activities.

Objective 2: Report at least the minimum data requirements for counseling, testing and referral, and financial reporting.

Objective 3: Implement statewide counseling, testing and referral reporting, financial reporting and community planning data compatibility with CDC program indicators on the annual Progress Report.

Objective 4: Collect and enter data on the prevention of perinatal transmission on the annual Progress Report.

Goal Three: To collect and report data on community prevention activities and project interventions implemented by the funded projects.

By the end of 2010:

Objective 1: Evaluate the effectiveness of community planning activities with the membership survey and/or other tools to monitor the planning process.

Objective 2: Collect and evaluate information on budget reviews for directly funded prevention projects.

Objective 3: Monitor and evaluate project interventions of client level data including, but not limited to, individual and group level interventions, prevention case management, counseling/testing/referral, partner counseling referral services and recruitment.

Goal Four: To implement a standardized protocol for process monitoring of statewide project interventions and activities.

By the end of 2010:

Objective 1: Obtain and ensure quality content of narrative quarterly reports.

Objective 2: Participate in project site visits annually to monitor the implementation and progress of project activities.

Objective 3: Require the submission of project intervention data into PEMS (Program Evaluation Monitoring System).

Objective 4: Require funded project reports to be provided at the quarterly Prevention Council meetings and monthly Community Networking Group meetings.

Objective 5: Participate in and attend at least two statewide project activities annually.

Goal Five: By 2012, the Alabama Department of Public Health will establish the Enhanced Referral Tracking System (ERTS) to monitor the linkages of new HIV positives into care.

Beginning in FY 2005:

Objective 1: By 2006, a computer based program will collect ERTS data. .

Objective 2: Regional HIV Coordinators will receive routine listings of ERTS cases to ascertain care status.

Objective 3: HIV Coordinators will establish relationships with ASO's, STD staff, traditional and University- based hospitals, and other institutions to support the ERTS program.

Objective 4: Annually, at least 4-6 ERTS cases will be linked into care, referred to as Coordinator Linked Into Care (CLIC).

Objective 5: Annually, Division staff will conduct an ERTS program audit.

5. HIV Prevention Capacity Building

Goal One: Develop new partnerships for HIV Prevention, while supporting the continued growth of long term partnerships.

During the 2009-2013 HIV Prevention Plan, the following objectives will be met:

Objective 1: Conduct one combined capacity-building training for HIV, TB, Hepatitis C, and STD division staff to support integration of activities.

Objective 2: Promote capacity-building by conducting combined training for community partners (including PLWH) and State entities listed in Objective 1.

Objective 3: Offer capacity-building training, meetings, and workshops to the medical community to encourage routine HIV testing and participation with PCRS.

Objective 4: Collaborate with the Peer Mentors and the Alabama Consumer Advisory Board to elicit and address their training needs.

Objective 5: Continue regular- and rapid-test training, protocol development, and technical support for agencies that need/request it.

Objective 6: Provide cross-training for personnel listed in Objective 1.

Objective 7: Respond to any follow-up requests from physicians regarding the disseminated perinatal resource kits.

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

Objective 9: Utilize CDC's CRIS system (Capacity-building Request Information System) for requesting prevention training and support.

Objective 10: Identify other consultants through the national capacity-building network and key organizations to provide technical assistance to support prevention planning.

Objective 11: Provide quality orientation, ongoing training, and mentoring for members of the Community Planning Group.

Objective 12: Utilize evidence-based (DEBI and EBI) modules when providing specialized intervention training.

Objective 13: Elicit collaboration with non-traditional community partners in order to expand outreach to more high risk people.

1. HIV Consumer Services

Goal One: The Division Consumer Services Liaison will establish a program which centralizes HIV Consumer Issues.

By the end of 2010:

Objective 1: Identify qualified HIV positive persons to promote the Peer Mentor program.

Objective 2: Quarterly, Peer Mentors will meet with Division staff.

Objective 3: Peer Mentors will attend Area Prevention Network meetings and other meetings/events supported by the Division.

Objective 4: Peer Mentors will submit bi-weekly documentation of activities and services provided.

Objective 5: Consumer Service Liaison will provide technical assistance and advisory support to the CAB.

Objective 6: Consumer Service Liaison will collaborate with the Prison Discharge Program in conjunction with the Alabama Department of Corrections.

Objective 7: Consumer Service Liaison will develop new and innovative approaches to improve communication, collaboration and capacity-building needs of HIV positive persons.