Jurisdictional HIV Prevention Plan Update 2009-2013 State of Georgia

Introduction

Dedication

This document is dedicated to all those who have lost the fight against AIDS or have been infected, affected, or are dedicated to bringing an end to this objectionable epidemic.

Acknowledgements

- Current and former members of the Georgia HIV Planning Group
- Members of the 2012 HIV/AIDS Jurisdictional Plan writing team (Lyto Marcius, Jeselyn Rhodes, Lerissa Smith, Sean Webb and Brandi Williams)
- Georgia Department of Public Health (DPH) Staff
- County Health Department Staff
- AIDS Service Organizations (ASOs) and Community Based Organizations (CBOs) staff throughout the State
- Volunteers throughout the state
- The thousands of Georgians who have provided input to the community planning process
- All persons who work tirelessly to bring about positive change in the arena of HIV/AIDS

Preface

This update to the 2009-2013 Georgia State HIV Prevention Plan was designed to provide a benchmark for the current HIV epidemic and available services here in the state. Additionally this plan will serve as a roadmap for future HIV Prevention services throughout Georgia. As to abide by the recommendations set forth by the Centers for Disease Control and Prevention (CDC), the Georgia Department of Public Health has worked closely with the Georgia HIV Planning Group (HPG) towards the recruitment of community members who are most profoundly impacted by HIV/AIDS; these identified individuals have assisted and provided input towards the completion of the Jurisdictional HIV Prevention Plan.

Letter of Concurrence

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Overview of CPG

Background

In accordance with the CDC mandate requiring all state, local, and territorial health departments' to actively support and integrate a participatory HIV planning process, the Georgia HIV Planning Group or HPG (formerly the Georgia Community Planning Group) was formed in 1994. CDC defines HIV community planning as *"an ongoing, comprehensive planning process that is intended to improve the effectiveness of state, local and territorial health departments' HIV prevention programs by strengthening the scientific basis, community relevance, and population or risk based focus of prevention interventions*". The HPG operates as a single statewide body that plans for HIV prevention needs across the entire state. The HPG is part of an ongoing process whereby grantees share responsibilities for developing a Jurisdictional HIV Prevention Plan (formerly known as the Comprehensive HIV Prevention Plan) with other state/local agencies, non-governmental organizations, and representatives of the community including groups that are infected or affected by HIV. Together, representatives of affected populations, medical providers, epidemiologists, behavioral and social scientists, HIV/AIDS prevention service providers, health department staff, and others analyze the course of the epidemic in their jurisdiction, assess and prioritize HIV prevention needs, identify HIV prevention interventions to meet those needs, and develop comprehensive HIV prevention plans that are directly responsive to the epidemics in their specific jurisdictions.

Composition

According to the HPG bylaws there can be a maximum of 53 members (including Co-chairs) on the group at any given time.

- 45 Community members
    - 33 community voting members
    - 12 community alternate members

- 8 Agency Representatives (with voting privileges)
    - Agency representatives are identified by the state

- 2 Community Co-chairs

- Metro Atlanta (Urban)
- Non-Metro Atlanta (Rural)

- 1 State Health Department Appointed Co-chair

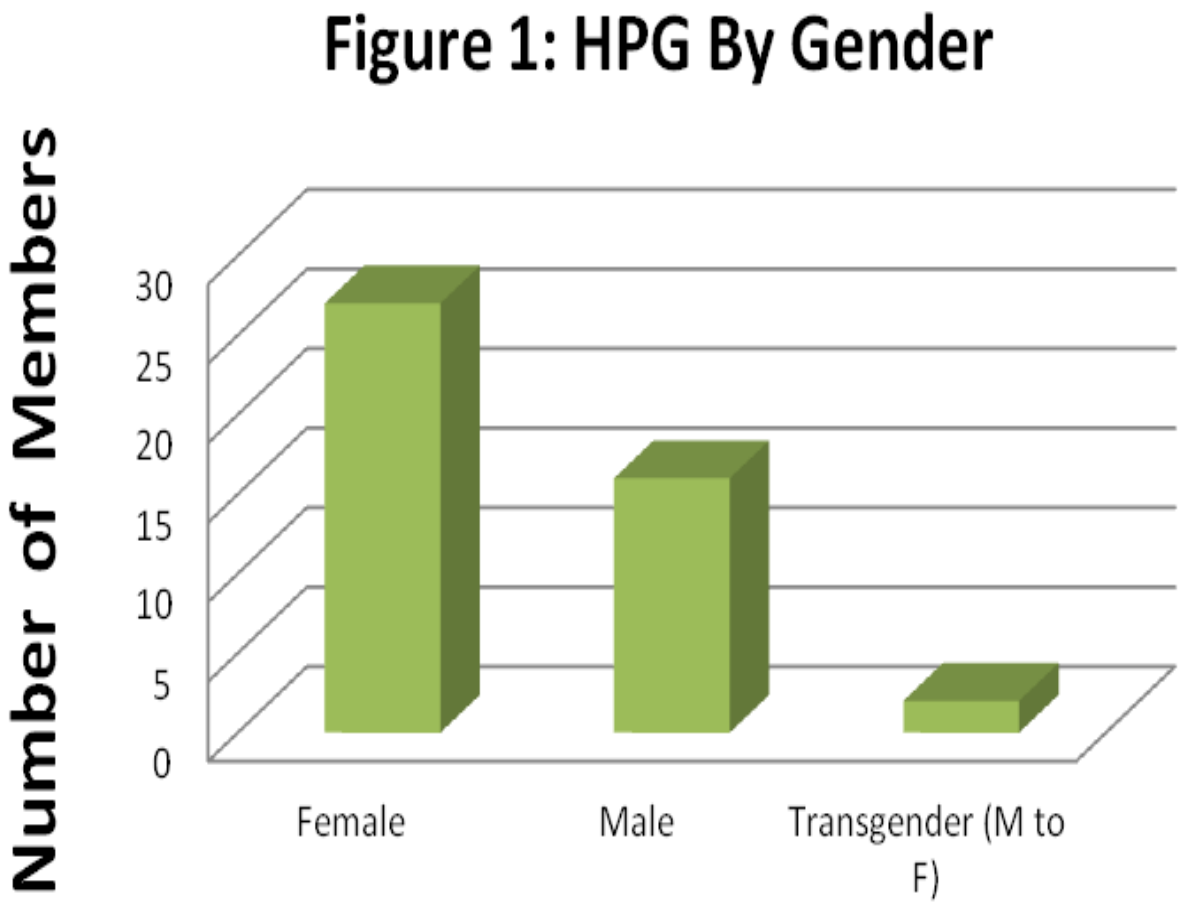


Figure 2: HPG By Area

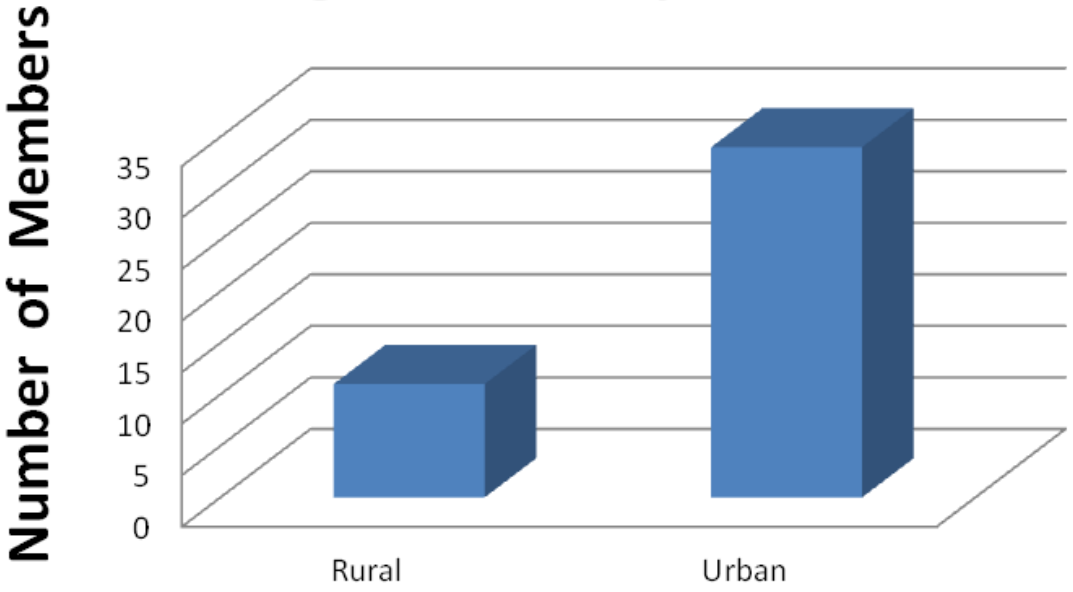
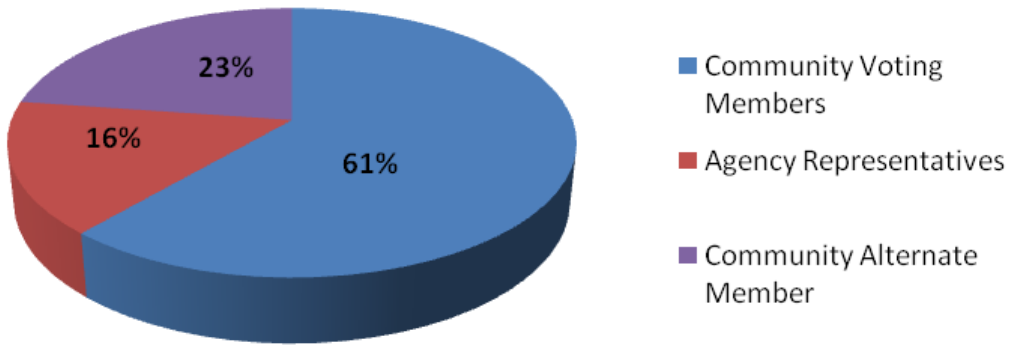


Figure 3: HPG Members by Voting Status



Committees

The standing committees for the HPG are as follows:

- ✓ Executive Committee
- ✓ Membership Committee
- ✓ Populations Committee
- ✓ Publicity Committee
- ✓ Bylaws Committee
- ✓ Intervention Committee
- ✓ Community Services Assessment (CSA) Committee
- ✓ Data Integrity

The Executive Committee appoints HPG members to standing committees and all members are required to serve on at least one committee. Each committee then selects a chairperson to oversee committee activities and a secretary who is responsible for providing a written report of the proceedings of each meeting. Additionally the Executive Committee is responsible for the development and coordination of the annual orientation(s), meeting agendas, making decisions on behalf of the HPG (where time is of the essence), and developing interim policies, when necessary, until permanent policies can be established. The Executive Committee is also responsible for making recommendations to the HPG for its vote on the annual calendar to include locations, dates, and tasks. At the end of the year, each committee is responsible for providing a written summary of the year's activities to the Executive Committee. At the end of each planning year a final report summarizing all committee activities is distributed to the HPG for review and comment, and a copy is retained for public record. The executive committee is composed of all 3 co-chairs and the chairs from each standing committee.

The Membership Committee reviews current recruitment and selection processes and makes recommendations for improvements when necessary. To standardize the membership selection process, the current membership application (see Appendix B) was designed to score and weight each potential applicant's responses. Every year, one third of the members of the planning group rotate and new members are selected based on either personal or professional representation. As these openings occur, the Membership Committee reviews the applications, makes the selection of new members, and presents a slate of new members to the HPG for discussion and vote. The selection of new members is based on the most current epidemiological profile of the state, geographic considerations, and gaps in representation on the HPG board. The Membership Committee plays an active role in the recruitment of members so that the HPG maintains parity,

inclusion, and representation (PIR). Review and revision of the membership application occurs periodically to ensure that the HPG membership is inclusive and represents the state of Georgia.

Figures 1 and 2 provide information on demographic characteristics of the HPG members. The data is obtained via self-report measures and members are not required to answer all questions. Current figures indicate that the majority of members are female (n=27) composing 60% or Black (n=30) whom account for 66.7% of members. Of members who reported HIV Status 45% (n=29) self-report as persons living with HIV/AIDS (PLWHA). Of persons who reported sexual orientation 35% (n=9) self-report as men who have sex with men (MSM). The members of the HPG reflect the diversity found within the state and mirror the demographic characteristics of the populations that are impacted by the HIV epidemic. However, the HPG recognizes that gaps in membership do exist.

The Populations Committee reviews the current priority-setting process and makes recommendations for updating as needed. Both qualitative and quantitative data are used to select and rank priority populations. Selection and ranking of populations (in terms of HIV prevention priority) are revised annually as indicated by data, recognized trends and research findings.

The Publicity Committee is responsible for raising community awareness of the Georgia HPG. This includes general awareness of the HPG's mission, goals, objectives, products, activities, and recruitment processes. By and large the goal for this group is to promote community participation in the Georgia HPG.

The Bylaws Committee reviews and updates HPG Bylaws used to govern HPG business. The bylaws committee serves as the content experts on the Bylaws and ensures that the HPG is not in violation of the Bylaws as members are appointed, officials elected, committees formed, meetings held, and HPG recommendations for HIV prevention intervention programs are put forth. Additionally the bylaws committee also addresses the removal of HPG members, conflict resolution, and parliamentary procedure. The Bylaws Committee is responsible for working in conjunction with other standing committees to ensure that needed amendments to the Bylaws are addressed in a timely fashion. Amendments to the bylaws are considered twice a year, in May and November.

The Intervention Committee is responsible for identifying a set of interventions proven to reduce the spread of HIV infection within prioritized populations. Members of the Interventions Committee

work together to update HPG members on intervention strategies and risk reduction models, appropriate for identified high-risk target populations, which will most effectively prevent the greatest number of new infections. The Interventions committee has identified the following interventions:

The Data Integrity Committee utilizes research, statistical analysis, and data collection analysis methods to address the data collection, reporting, and analysis issues associated with HIV transmission risk defined as no identified risks (NIR) and/or no reported risk (NRR).

Table 7. Individual Level EBI and Priority Populations

Name of EBI	Priority	Brief Overview	Targeted Changes
Partnership for Health	HIV Positive Men and Women	Partnership for Health (PfH) uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention. Implementation of PfH includes development of clinic and staff "buy-in" and training.	No Changes
RESPECT	HIV Positive Men and Women	RESPECT is the first individual level intervention to be added to the Diffusion of Effective Behavioral Interventions (DEBI). The RESPECT intervention utilizes a client-focused, interactive HIV risk reduction counseling model based on Project RESPECT. The RESPECT intervention is designed to support risk reduction behaviors by increasing the client's perception of his/her personal risks and by emphasizing incremental risk-reduction strategies.	Modify for at-risk individual counseling
Comprehensive Risk Counseling and Services	HIV Positive Men and Women	Comprehensive Risk Counseling and Services (CRCS), formerly Prevention Case Management (PCM), is a client-centered HIV prevention activity. Originally, CRCS was conceived as a combination of HIV risk-reduction counseling and conventional case management for persons at high risk of transmitting or acquiring HIV. As such, CRCS typically provided intensive, ongoing, individualized prevention counseling, support, and service brokerage. However, information from CRCS demonstration projects indicates that a more successful model for CRCS for HIV-infected persons clearly defines the CRCS prevention counselor's primary role as working closely with existing case management systems to provide other services to clients.	No Changes
Safety Counts (Individual and Group Level)	HIV Positive men and Women Injection Drug Users (IDU)/IDU Mental Health, MA	Safety Counts is an HIV prevention intervention for out-of-treatment active injection and non-injection drug users aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings.	No Changes

Table 8. Group Level EBI and Priority Population

Name of EBI	Priority	Brief Overview	Targeted Changes
Healthy Relationships (HR)	HIV Positive Men and Women	Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills.	No Changes
Holistic Health Recovery Program (HHRP)	HIV Positive and Negative Substance Abusers/ IDU	The Holistic Health Recovery Program (HHRP) is a 12-session, manual-guided, group-level program for HIV-positive and HIV negative injection drug users.	No Changes
Many, Men Many, Voices 3MV	African American Men who have Sex with Men, Men who have Sex with Men	3MV is a seven-session, group-level HIV and STD prevention intervention for black gay men. The intervention addresses factors that influence the behavior of black men who have sex with men, including cultural, social, and religious norms; interactions between HIV and other sexually transmitted diseases; sexual relationship dynamics; and the social and psychological influences that racism and homophobia have on HIV risk behaviors. 3MV is designed to be delivered by two culturally competent facilitators in groups of up to 12 clients.	Can by modified for other Races/Ethnicities
Sistering, Informing, Healing, Living, and Empowering (SiHLE)	AA Adolescent Females	A group level intervention, SIHLE is a peer-led, social-skills training intervention aimed at reducing HIV sexual risk behavior among sexually active, African American teenage females, ages 14-18. An adaptation of the SISTA intervention, SIHLE emphasizes ethnic and gender pride, and enhances awareness of HIV risk reduction strategies such as abstaining from sex, using condoms consistently, and having fewer sex partners. It consists of four 3-hour sessions, delivered by two peer facilitators (ages 18-21) and one adult facilitator in a community-based setting.	Can by modified for other Races/Ethnicities
ARTAS Linkage to Care Management (ALCM)	HIV Positive Men and Women	Anti-Retroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention to link individuals who have been recently diagnosed with HIV to medical care. ARTAS is based on the Strengths-Based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (especially the concept of Self-Efficacy) and Humanistic Psychology.	No Changes

Name of EBI	Priority	Brief Overview	Targeted Changes
Personalized Cognitive Counseling (PCC)	HIV Negative Men who have Sex with Men	An individual-level, single session counseling intervention designed to reduce unprotected anal intercourse (UAI) among men who have sex with men (MSM) who are repeat testers for HIV. PCC focuses on the person's self-justification (thoughts, attitudes and beliefs) he uses when deciding whether or not to engage in high risk sexual behavior. PCC is a five step process. The counselor assists the client to: (1) recall a memorable episode of UAI; (2) complete the PCC Questionnaire – list of self-justifications torationalize risky behavior; (3) discuss the episode and his thoughts/feelings; (4) identify the self-justifications that facilitated the episode; and (5) discuss what he will do in the future.	No Changes
WILLOW	HIV positive Heterosexual women ages 18-50	This program helps young people living with HIV identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve quality of life. It emphasizes how contextual factors influence ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals.	No Changes
Choosing Life: Empowerment! Action! Results! (CLEAR)	HIV positive/ high risk Men and women ages 16 and older	CLEAR is a client-centered program delivered one-on-one using cognitive behavioral techniques to change behavior. The intervention provides clients with the skills necessary to be able to make healthy choices for their lives. Unprotected sex is the risk behavior addressed in CLEAR. The risk and contextual factors associated with unprotected sex for this target population are: increased sexual activity among youth living with HIV/AIDS (YLWH/A), substance and alcohol use, confronting disclosure and stigma of living with HIV, treatment adherence, health care and self-care.	No Changes
VOICES (Video Opportunities for Innovative Condom Education and Safer Sex)	African-American and Latino men and women	VOICES is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills. The program is based on the theory of reasoned action, which explains how behaviors are guided by attitudes, beliefs, experiences, and expectations of other persons' reactions.	No Changes
SISTA (Sisters Informing Sisters about Topics on AIDS)	African American women	SISRA is a peer-led, skill-building intervention project to prevent HIV infection. It is delivered in 5 sessions and includes discussions of self-esteem, relationships, and sexual health.	No Changes

Community Services Assessment (CSA) Committee uses data-collection methods that help identify needs, resources, and gaps in prevention and care services across the state for people at risk, affected by, or living with HIV. This Committee reviews current CSAs and provides recommendations for conducting future CSAs, including specific geographic areas, services, and populations to study.

Overview of the HIV/AIDS epidemic in Georgia

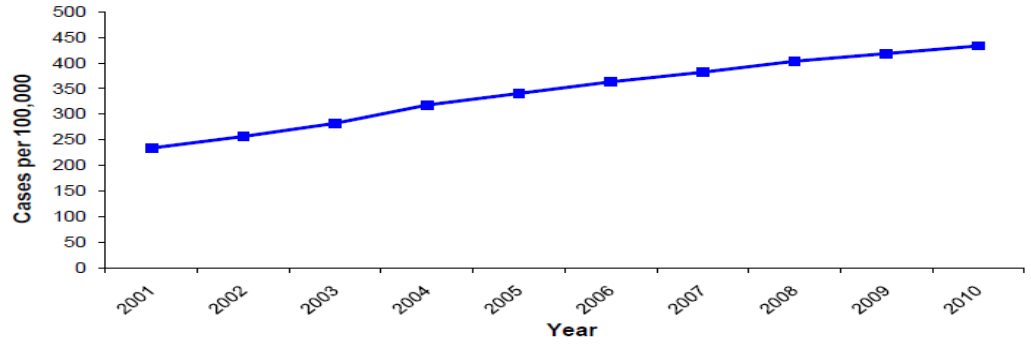
HIV/AIDS remains an important public health problem in Georgia. While all of Georgia's residents have the potential to be impacted by HIV/AIDS, certain populations continue to bear a disproportionate burden of the HIV epidemic within the state. The purpose of this section is to provide an overview of the epidemiology of HIV in Georgia. Most data for this section was collected by the HIV/AIDS Epidemiology Section (HAES) at the DPH. Many of the tables and figures can be found in other reports.

Persons living with HIV/AIDS

As of year-end 2009, Georgia had one of the highest rates of persons living with a diagnosis of HIV infection in the United States, estimated at 442.6 cases per 100,000 people [1]. As of December 31, 2010, DPH reports that 41,986 individuals were living with HIV/AIDS in Georgia, 23,451 of which were living AIDS cases, and 18,535 of which were HIV non-AIDS cases. Of Georgia's 159 counties, the 28 counties of the Atlanta-Sandy Springs Metropolitan Statistical Area (MSA) comprised approximately 50% of the state's population in 2010 and 66% of persons living with HIV/AIDS in the state [2].

From 2001 to 2010, the rates of persons living with HIV/AIDS in Georgia have increased each year. This change mirrors the national trend of increasing numbers of persons with HIV living longer lives. At year-end 2010, the largest proportions of persons living with HIV/AIDS in Georgia were male (74%), Black (70%), and 40 to 59 years of age (60%). Approximately 1% of Georgia's Black residents were living with HIV – evidence of a generalized epidemic among this population.

Figure 4: Rates of Persons Living with HIV/AIDS[2], Georgia, 2001 - 2010

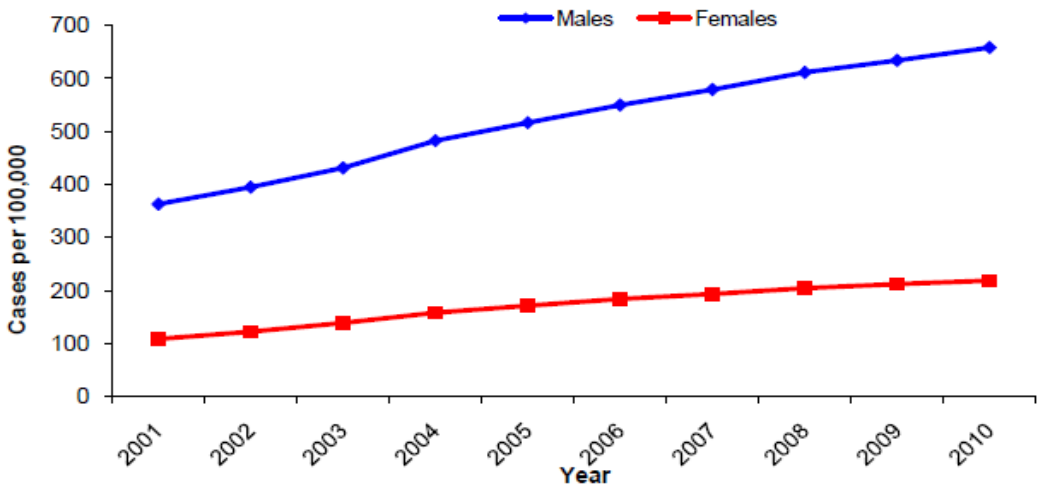


[2] Persons Living with HIV/AIDS are defined as individuals living with HIV-NA + individuals living with AIDS

Source: DPH HIV/AIDS Epidemiology Section, Integrated Epidemiologic Profile, Georgia 2011

At year-end 2010, the rate of people living with HIV/AIDS was 658.6 per 100,000 among men and 218.6 per 100,000 among women. In general, the number of people living with HIV/AIDS increased slightly, at approximately 4% among both men (4.1%) and women (4.2%). Rate of persons living with HIV/AIDS among Blacks (1,012.4 cases per 100,000 people) was nearly 6 times higher than the rate for Whites (181.4 cases per 100,000) and 5 times higher than the rate for Hispanics (221.3 cases per 100,000). From 2009 to 2010, the number of Blacks living with HIV/AIDS increased 5% and for Whites, there was an increase of 2%.

Figure 5: Rates of Persons Living with HIV/AIDS by Gender, Georgia: 2001 - 2010



Source: DPH HIV/AIDS Epidemiology Section, Integrated Epidemiologic Profile, Georgia 2011

People between the ages of 40-49 (36%) made up the largest group of living cases of HIV/AIDS, while people between the ages of 20-29 accounted for 10%, and 50-59 year olds accounted for 24%. Among the youngest age groups of persons living with HIV/AIDS, those between 0-12 accounted for less than 1% as did those between the ages of 13-19. Thirty-six percent (36.8%) of people living with HIV/AIDS cases either had no risk identified or reported, which makes interpretation of risk categories limited. Among cases for which risk was known (n = 26,506), the largest risk group was men who have sex with men (62%), followed by those with heterosexual contact (18%), and then injection drug users (12%).

Table 1: Persons Living with HIV (not AIDS) and AIDS by Gender, Age and Race/Ethnicity, Georgia, 2010

	HIV (not AIDS)[1]		AIDS[2]		Total	
Gender	Count[3]	Percent[4]	Count	Percent	Count	Percent
Male	13,138	77	18,007	77	31,145	74
Female	5,397	23	5,444	23	10,841	26
Age as of December 31, 2010 (years)[5]						
<13	147	<1	22	<1	169	<1
13-19	250	1	95	<1	345	<1
20-24	1,161	6	312	1	1,473	4
25-29	2,026	11	814	3	2,840	7
30-39	4,636	25	3,830	16	8,466	20
40-49	5,823	31	9,185	39	15,008	36
50-59	3,355	18	6,661	28	10,016	24
60+	1,136	6	2,532	11	3,668	9
Race/Ethnicity						
White, Non-Hispanic	4,143	22	5,676	24	9,819	23
Black, Non-Hispanic	13,253	72	16,217	69	29,470	70
Hispanic/Latino, Any Race	779	4	1,110	5	1,889	4
American Indian/Alaskan Native, Non-Hispanic	28	<1	26	<1	54	<1
Asian/ Hawaiian/Pacific Islander, Non-Hispanic	82	<1	78	<1	160	<1
Multiracial/Unknown/Others, Non-Hispanic	250	1	344	1	594	1
Total	**18,535**		**23,451**		**41,986**	

[1] "Persons living with HIV (not AIDS)" refers to persons who, as of December 31, 2010, were living with HIV (not AIDS) and residing in Georgia, regardless of their state of residence at the time of HIV (not AIDS) diagnosis. Persons are assumed to be alive unless otherwise documented or reported.

[2] "Persons living with AIDS" refers to persons who, as of December 31, 2010, were living with AIDS and residing in Georgia, regardless of their state of residence at the time of AIDS diagnosis.

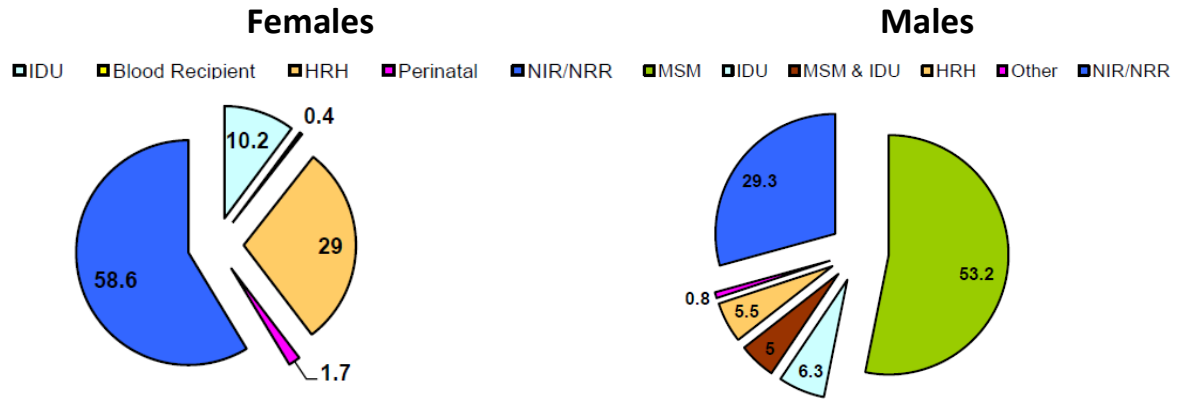
[3] Numbers are based on data entered through June 30, 2011, and are not adjusted for reporting delays. Persons are assumed to be alive unless otherwise documented or reported.

[4] Total percentages may not add up to 100% due to rounding and represent the percentage of the total.

[5] Excludes 1 person with incomplete birth date information.

Source: DPH HIV/AIDS Epidemiology Section, HIV/AIDS Surveillance Summary, Georgia, 2010

Figure 6: Percent Living with HIV/AIDS by Gender and Transmission Category as of December 31, 2010, Georgia



Source: DPH HIV/AIDS Epidemiology Section, Integrated Epidemiologic Profile, Georgia 2011

Table 2: Persons Living with HIV (not AIDS) and AIDS by Current Public Health District of Residence, Georgia, 2010

		HIV (not AIDS)		AIDS		Total	
	Public Health District	Count	Rate[4]	Count	Rate	Count	Rate
1-1	Northwest (Rome)	317	49.6	382	59.7	699	109.3
1-2	North Georgia (Dalton)	254	58	303	69.2	557	127.2
2	North (Gainesville)	235	38	289	46.8	324	52.5
3-1	Cobb-Douglas	1,087	132.5	1,312	160	2,399	292.4
3-2	Fulton	4,387	476.5	7,353	798.7	11,740	1275.3
3-3	Clayton (Jonesboro)	949	365.8	1,003	386.6	1,952	752.4
3-4	East Metro (Lawrenceville)	939	94.8	1,082	109.2	2,021	204
3-5	DeKalb	3,530	510.2	4,104	593.2	7,634	1103.3

4	La Grange	659	82.3	738	92.2	1,397	174.6
5-1	South Central (Dublin)	360	233.1	268	173.5	628	406.5
5-2	North Central (Macon)	953	183	872	167.4	1,825	350.4
6	East Central (Augusta)	918	198.9	1,124	243.6	2,042	442.5
7	West Central (Columbus)	693	186.8	695	187.4	1,388	374.2
8-1	South (Valdosta)	481	190.6	469	185.69	950	376.5
8-2	Southwest (Albany)	678	190.2	764	214.3	1,442	404.6
9-1	Coastal (Savannah)	970	170.2	1,271	223	2,241	393.2
9-2	Southeast (Waycross)	418	115.3	546	150.6	964	265.8
10	Northeast (Athens)	301	65.4	417	90.6	718	156
Unknown Health District		406		459		865	
Total		**18,535**	**191.3**	**23,451**	**242.1**	**41,986**	**433.4**

Note: Case counts include incarcerated persons and may inflate rates in certain geographic regions where there are large concentrations of HIV-positive inmates.

[4] Rates are calculated as the number of cases per 100,000 population and are based on Georgia 2010 population estimates obtained from the 2010 U.S. Census.

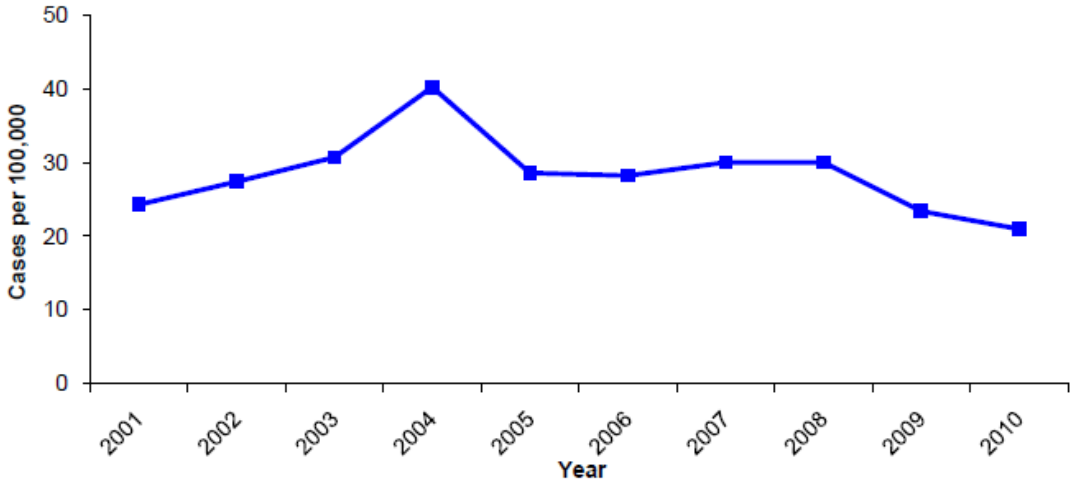
Source: DPH HIV/AIDS Epidemiology Section, HIV/AIDS Surveillance Summary, Georgia, 2010

Newly diagnosed with HIV/AIDS

The CDC 2010 HIV Surveillance Report reports that in Georgia there were an estimated 2,581 persons newly diagnosed with HIV/AIDS for a rate of 26.3 per 100,000 people [1]. As of December 31, 2010, DPH reports that 2,037 individuals were diagnosed and reported with HIV/AIDS in Georgia, 1,294 of which were HIV non-AIDS cases, and 743 of which were AIDS cases. Of Georgia's 18 public health districts, residents of 5 health districts accounted for 56% (n = 1,148) of newly diagnosed cases; the districts were DeKalb (60.0 cases per 100,000), Clayton (57.8 cases per 100,000), Fulton (45.3 cases per 100,000), West Central-Columbus (27.8 cases per 100,000) and South – Valdosta (22.7 cases per 100,000).

The overall rate of persons newly diagnosed with HIV/AIDS in Georgia has declined since 2008. At year-end 2010, there were 2,037 newly diagnosed cases reported in Georgia with the largest proportion of total cases being among men (75%), Blacks (78%), and persons 20 to 39 years of age (58%).

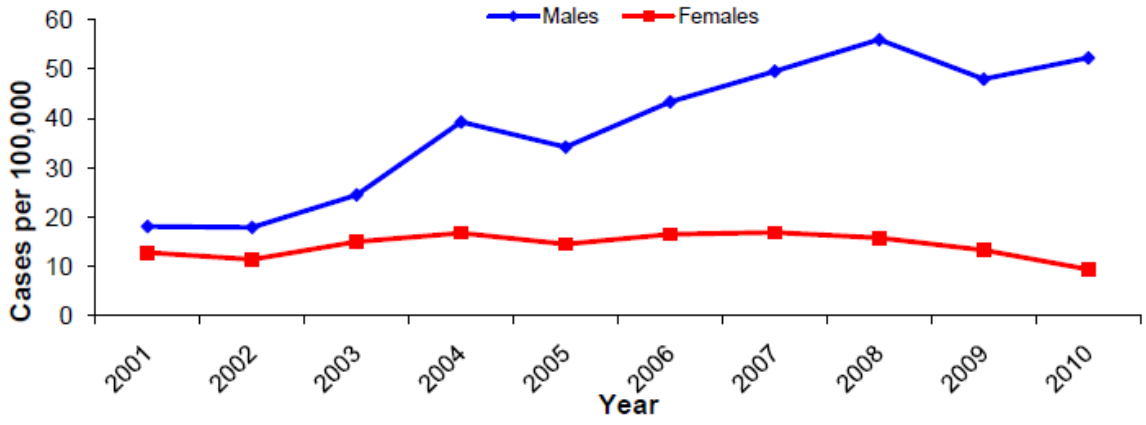
Figure 7: Rates of Newly Diagnosed HIV/AIDS Cases, Georgia, 2001 - 2010



Source: DPH HIV/AIDS Epidemiology Section, Integrated Epidemiologic Profile, Georgia 2011

At year-end 2010, the rate of persons newly diagnosed with HIV/AIDS was 32.3 cases per 100,000 among men and 10.3 cases per 100,000 among women. In general, the number of people newly diagnosed with HIV/AIDS decreased approximately 10% in 2010 from 2009; cases among men decreased 9.6% and 8.7% among women. Rate of persons newly diagnosed with HIV/AIDS among Blacks (54.5 cases per 100,000 people) was nearly 9 times higher than the rate for Whites (6.0 cases per 100,000) and almost 5 times higher than the rate for Hispanics (11.6 cases per 100,000). From 2009 to 2010, the number of Blacks newly diagnosed with HIV/AIDS decreased 5% (1,674 in 2009 to 1,586 in 2010) and for Whites, there was a decrease of 23% (423 in 2009 to 325 in 2010).

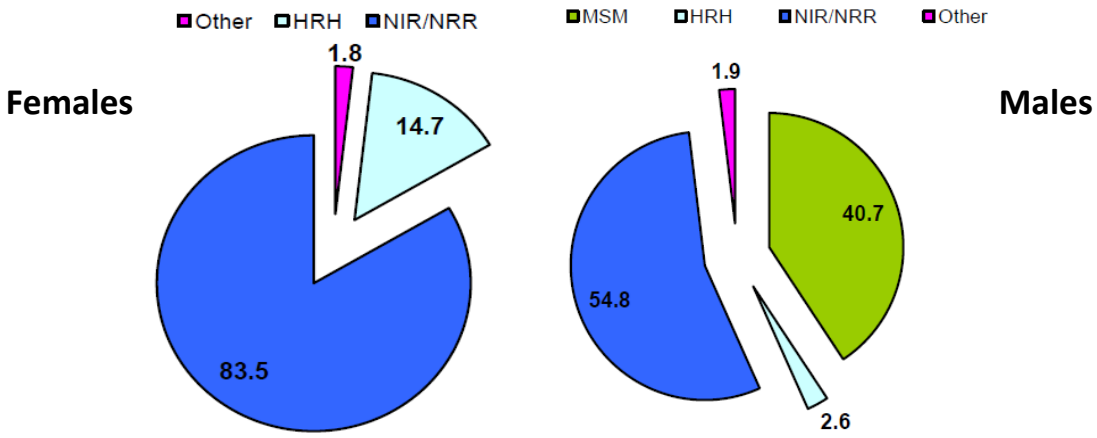
Figure 8: Rates of Newly Diagnosed HIV/AIDS Cases among 15-24 Year Olds by Gender, Georgia, 2001 - 2010



Source: DPH HIV/AIDS Epidemiology Section, Integrated Epidemiologic Profile, Georgia 2011

People between the ages of 30-39 (25%) made up the largest group of newly diagnosed HIV/AIDS cases, while people between the ages of 40-49 accounted for 23%, and 20-24 year olds accounted for 17%. Among the younger age groups, those between the ages of 13-19 years of age accounted for approximately 5% of the total number of people living with HIV/AIDS. Sixty-two percent (62%) of people newly diagnosed HIV/AIDS cases either had no risk identified or reported, which makes interpretation of risk categories limited and not specific to all newly diagnosed cases. However, among cases for which risk was known (n = 774), the largest risk group was men who have sex with men (80%), followed by those with heterosexual contact (14%), and then injection drug users (3%).

Figure 9: Percent of Newly Diagnosed HIV/AIDS Cases by Gender and Transmission Category, Georgia, 2010



Source: DPH HIV/AIDS Epidemiology Section, Integrated Epidemiologic Profile, Georgia 2011

Table 3: Newly Diagnosed HIV (not AIDS) and AIDS by Public Health District of Residence at Diagnosis, Georgia, 2010

		HIV (not AIDS)		AIDS		Total	
	Public Health District	Count	Rate	Count	Rate	Count	Rate
1-1	Northwest (Rome)	19	2.9	10	1.6	31	4.8
1-2	North Georgia (Dalton)	14	3.2	12	2.7	27	6.2
2	North (Gainesville)	16	2.6	14	2.3	31	4.9
3-1	Cobb-Douglas	75	9.1	40	4.9	117	14.3
3-2	Fulton	260	28.2	164	17.8	417	45.3
3-3	Clayton (Jonesboro)	90	34.7	64	24.7	150	57.8
3-4	East Metro (Lawrenceville)	42	4.2	43	4.3	84	8.5
3-5	DeKalb	258	37.3	160	23.1	415	60
4	LaGrange	61	7.6	32	4	92	11.6
5-1	South Central (Dublin)	17	11	15	9.7	33	20.7
5-2	North Central (Macon)	60	11.5	16	3.1	77	14.6
6	East Central (Augusta)	57	12.4	20	4.3	77	16.7
7	West Central (Columbus)	71	19.1	28	7.5	99	26.7
8-1	South (Valdosta)	38	15	22	8.7	63	25
8-2	Southwest (Albany)	63	17.7	19	5.3	80	22.4
9-1	Coastal (Savannah)	89	15.6	47	8.2	135	23.7
9-2	Southeast (Waycross)	25	6.9	10	2.8	38	10.5
10	Northeast (Athens)	26	5.6	17	3.7	41	9.3
Unknown Health District		13		10		30	
Total		**1,294**	**13.2**	**743**	**7.7**	**2,037**	**20.7**

Note: Case counts include incarcerated persons and may inflate rates in certain geographic regions where there are large concentrations of HIV-positive inmates.

Table 4: Newly Diagnosed HIV (not AIDS) and AIDS by Gender, Age and Race/Ethnicity, Georgia, 2010

	HIV (not AIDS)[1]		AIDS[2]		Total	
Gender	Count[3]	Percent[4]	Count	Percent	Count	Percent
Male	962	74	565	76	1,527	75
Female	332	26	178	24	510	25
Age at Diagnosis (yr)	Count	Percent	Count	Percent	Count	Percent
<13	4	<1	0	0	4	<1
13-19	85	7	9	1	94	5
20-24	273	21	68	9	341	17
25-29	223	17	104	14	327	16
30-39	291	22	209	28	500	25
40-49	236	18	226	30	462	23
50-59	141	11	99	13	240	12
60+	41	3	28	4	45	2
Race/Ethnicity	Count	Percent	Count	Percent	Count	Percent
White, Non-Hispanic	218	17	107	14	325	16
Black, Non-Hispanic	1,008	78	578	78	1,586	78
Hispanic/Latino, Any Race	52	4	47	6	99	5
American Indian/Alaskan Native, Non-Hispanic	1	<1	0	0	1	<1
Asian/ Hawaiian/Pacific Islander, Non-Hispanic	9	<1	8	1	17	<1
Multiracial/Unknown/Others, Non-Hispanic	6	<1	3	<1	9	<1
Total	**1,294**		**743**		**2,037**	

[1] Persons "Newly Diagnosed with HIV infection (not AIDS)" refers to reported cases that meet the CDC surveillance case definition from HIV (not AIDS) and were diagnosed in Georgia in 2010.

[2] Persons "Newly Diagnosed with AIDS" refers to reported cases that meet the CDC surveillance case definition for AIDS and were diagnosed in Georgia in 2010.

[3] Numbers are based on data reported through June 30, 2011, and are not adjusted for reporting delays.

[4] Total percentages may not add up to 100% due to rounding and represent the percentage of the total.

Indicators of risk for HIV in Georgia

Sexually Transmitted Infections

The association between HIV and sexually transmitted infections (STI) has been well documented [3]. Studies have shown that persons infected with a STI, such as gonorrhea or syphilis, may be two to five times more likely to acquire HIV if they are exposed through sexual contact [4]. Gonorrhea and syphilis infections have been cited as biological markers for high risk sexual behaviors. In Georgia, gonorrhea and primary and secondary (P&S) syphilis continue to constitute a major public health challenge. Georgia has consistently had one of the nation's highest rates of P&S syphilis. According to national estimates from CDC, in 2010, Georgia had the 7th highest rate of gonorrhea and the 2nd highest rate of P&S syphilis in the nation [5].

In recent years, the proportion of incident STI cases among persons with HIV (concurrently or previously diagnosed) has increased. DPH HAES reports that in 2010, a history of STI (chlamydia, gonorrhea, and syphilis) co-infections occurred overwhelmingly among males (82%) living with HIV [2]. Screening for and treatment of STI is accessible in a variety of public and private health care settings in Georgia. Studies have found that STI treatment may help reduce community viral load, however recent research suggests that STI is under-diagnosed by HIV care practitioners. Baffi et al. examined STI screening in a Southeastern U.S. HIV clinic and found that among HIV infected persons with incident syphilis, only 1 in 4 received further testing for gonorrhea and Chlamydia [6]. To curtail the risk of HIV transmission and the impact of biological markers such as syphilis and gonorrhea for persons with HIV, facilitating increases in STI testing as a part of HIV care is a viable strategy to reduce new HIV infections and improve the health of persons living with HIV in the state of Georgia.

Poverty

The burden of HIV/AIDS in Georgia and the Southeastern U.S. disproportionately impacts communities of color [7]. A recent study that sought to identify factors important in explaining the effects of HIV on Black MSM compared to other MSM found that structural factors such as poverty/employment, stigma, and stricter criminal justice policies, not sexual risk behavior nor drug and alcohol use, were more likely drivers of the health inequity [8]. Studies have shown that poverty is a socio-economic characteristic that individually, and in interaction with other factors, are associated with HIV prevalence [9]. According to results from the U.S. Census Bureau American Community Survey, in 2010, 18% of Georgia's populations had an income below poverty level,

compared to 15% nationally; within the state, county-level poverty rates range from 7% to 38% [10]. Poverty rates in Georgia where highest among Hispanics (31.2%) and Blacks (26%) but females, independent of race, were more likely to be in poverty. In Georgia, the geographic distribution of counties with higher rates of poverty mirrors that of the distribution of counties with higher rates of persons living with HIV. In an examination of county level HIV rates and social determinants of health, Gant and colleagues found that as income inequality increased, so did rates of HIV diagnoses [11]. In light of evidence for the compounding effect of poverty and other socio-economic factors, Millett et al. suggest that HIV prevention strategies must consider these structural factors as key impediments to accessing and remaining in HIV care. While it is important to address contextual factors such as poverty on an individual level, community-level HIV intervention strategies may be more beneficial in areas of the state of Georgia with high rates of poverty.

Education

Educational attainment has been cited as a factor in the complex interactions of structural and policy factors that facilitate behaviors that promote adverse HIV health outcomes [12]. For example, in a study to understand Anti-Retroviral Therapy (ART) non-adherence among PLWHA in the American Deep South, researchers found that persons whose educational attainment was high school level or below tended to report more reasons for having missed a dose then those who pursued education beyond high school[13]. Based on data from the American Community Survey, nearly 16% of Georgia's population ages 25 and over had less than a high school education (12th grade)[14]. When examined by race/ethnicity, Blacks (19%) and Hispanics (43%) had the highest proportion of persons with lower educational attainment, when compared to their White (12%) counterparts. In order to maximize the effectiveness of HIV prevention strategies that address ART adherence, efforts in Georgia, particularly in rural areas of the state, should include novel approaches such as skills-building to assist patients in developing reminder strategies.

Drug Use

According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, National Survey on Drug Use and Health, an estimated 8.11% of individuals who live in Georgia engage in some form of illicit drug use. Engaging in high risk behavior as a result of illicit drug use is a strong co-factor for HIV transmission and acquisition. The 8.11% of individuals encompasses all illicit drug use including marijuana; however, it is worthy to

note that 3.36% of individuals use illicit drugs exclusive of marijuana. While alcohol consumption is not illicit, there is significant concern related to the use of alcohol and the role it plays in individuals engaging in high risk behaviors that could potentially lead to HIV transmission.

In 2010, 10, 290 HIV test events (approximately 9% of the total test events for the year) in the state of Georgia listed intoxication from drugs and/or alcohol as a risk factor for HIV transmission. While there is no "actual data" that quantifies how many persons may have been infected with HIV with alcohol use as a contributing fact, however, it is widely accepted that the co-factor of intoxication is a contributing risk factor for HIV.

Clinical and Behavioral risk

The Medical Monitoring Project (MMP) is a population-based surveillance system designed to assess clinical outcomes and behaviors of persons receiving care for HIV. Analysis of Georgia's 2008 MMP data found that 15% of sampled HIV-infected adults in care self-reported not currently taking antiretroviral medications. Whereas 24% reported that the time between receiving a HIV diagnosis and entry into HIV care was 3 months or more. Additionally, 63% of MSM sampled reported having two or more sexual partners within the last 12 months and 36% reported unprotected sex with at least one partner in the last 12 months [15].

The National HIV Behavioral Surveillance (NHBS) system is a population-based data collection activity that employs various sampling methodologies (i.e., respondent driven, venue-based) to assess and monitor trends in populations at highest risk for HIV. Data collection is performed in "cycles". Georgia's second-MSM cycle of 2008, conducted in the Atlanta MSA, found that 74% of MSM surveyed reported that their last MSM sex partner was a "main sex partner" compared to 23% reporting "casual sex". Among those who reported insertive sex, 45% did not use condoms and from those that did report using a condom, 22% did not use a condom the entire time [16]. Furthermore, results from the 2011 Atlanta Health Survey, a leg of the NHBS, found that among 506 sexually active MSM randomly selected and tested at various venues through the Atlanta MSA the prevalence of HIV infection was 26%. And among the HIV-positive MSM in the study, 38% were unaware of their status. Study researchers concluded that the findings support the need to promote at least annual HIV testing among MSM in the Atlanta MSA, since 66% of the newly diagnosed men reported having been tested at least once in the past 12 months [17].

National HIV/AIDS Strategy (NHAS)

On July 13, 2010, the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the nation's first-ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015.

The development of the NHAS is important because it is an effort to reflect on what is and is not working in order to increase the outcomes received for public and private investments. The Strategy is intended to refocus existing efforts and deliver better results to the American people within current funding levels, as well as make the case for new investments. It is also a new attempt to set clear priorities and provide leadership for all public and private stake-holders to align their efforts toward a common purpose.

In an effort to accomplish the Strategy's goals, there must be a more coordinated national response to the epidemic. This will require increasing the coordination of HIV programs across the Federal government and between Federal agencies and state, territorial, tribal, and local governments, as well as developing improved mechanisms to monitor and report on progress toward achieving national goals. Towards these ends, there have been several changes to the HIV Planning process that should lead to more comprehensive and effective prevention efforts.

According to the NHAS, the United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

Goals of the National HIV/AIDS Strategy

- **Reducing New HIV infections**
  - By 2015, lower the annual number of new infections by 25% (from 56,300 to 42,225)
  - Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30% (from 5 persons infected per 100 people with HIV to 3.5 persons infected per 100 people with HIV)
  - By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people)

- **Increasing Access to Care and Improving Health Outcomes for People Living with HIV**
  - By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85% (from 26,824 to 35,078 people).
  - By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80% (or 237,924 people in continuous care to 260,739 people in continuous care).
  - By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86% (from 434,000 to 455,800 people). (This serves as a measurable proxy of our efforts to expand access to HUD and other housing supports to all needy people living with HIV.)

- **Reducing HIV-Related Health Disparities**
  - Improve access to prevention and care services for all Americans
  - By 2015, increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%
  - By 2015, increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%
  - By 2015, increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%

<u>HIV Prevention Projects</u>

The CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) have allocated approximately $10.5 million dollars to support the HIV prevention efforts of Georgia's community-based organizations, AIDS service organizations, county health departments, and the Georgia Department of Public Health.

Below is a list of the HIV prevention grants by funding source:

- CDC
  - Comprehensive HIV Prevention Programs for Health Departments ($7.7 Million)

Through this funding opportunity the Georgia Department of Public Health (DPH), Office of HIV/AIDS (OHA), has developed a *"Comprehensive HIV Prevention Program,"* which aims to reduce the spread of HIV among Georgians by identifying newly diagnosed HIV positive clients and those that have been previously diagnosed and identified as "Lost to Care" and linking them to medical care and other supportive services (e.g., Partner Services, STD/TB screenings, mental health and substance abuse treatment/prevention). Based on the level of funding received, health districts are required to implement a *"Comprehensive HIV Prevention Program,"* that includes a minimum of three core strategies: Comprehensive Prevention for Positives, HIV Counseling, Testing, and Linkage, and Condom Distribution[1].

As part of the *"Comprehensive HIV Prevention Program,"* all newly diagnosed clients and those who have been "lost to care" will be linked to HIV care, treatment, and prevention services using the Antiretroviral Treatment Access Study (ARTAS) intervention and/or other medical adherence interventions as deemed appropriate by the service provider. Health districts will be encouraged to promote re-engagement in care for those persons currently living with HIV/AIDS, utilizing the ARTAS Linkage Case Management model. By addressing HIV positive persons, the Georgia DPH will reduce the number of new infections and increase access to care and improve health outcomes for people living with HIV.

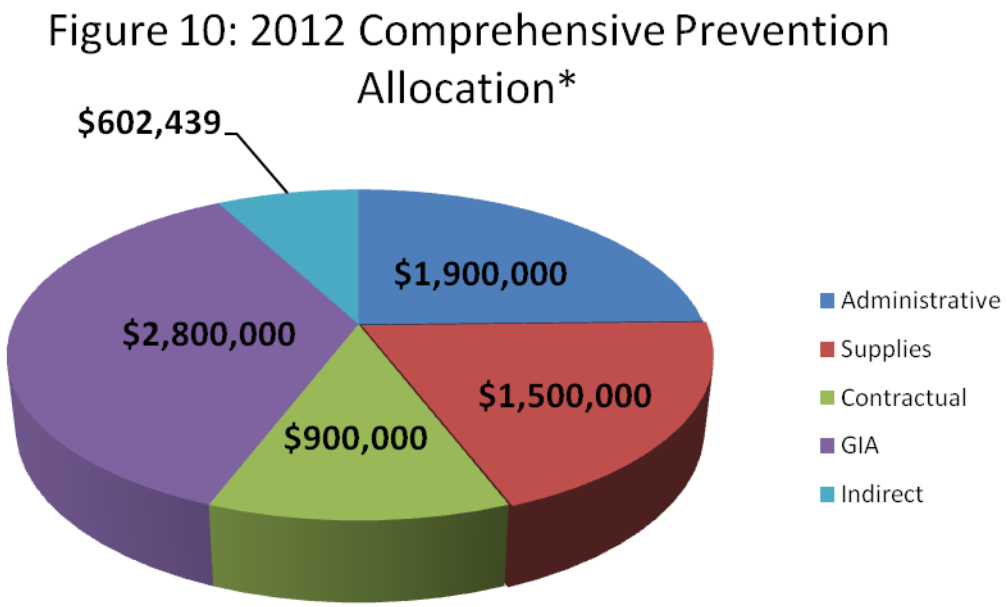
DPH OHA understands that HIV counseling, testing, and linkage services provide the foundation for an effective comprehensive prevention program. OHA will increase HIV testing opportunities for disproportionately affected populations by providing HIV testing in high prevalence areas and actively linking individuals to the appropriate clinical care and other supportive services as needed.

DPH will continue to make condom distribution a priority with the goal of increasing the number of condoms available at no cost throughout the state. Condom distribution enhances HIV prevention efforts in communities with high prevalence of HIV infection and those at greatest risk for acquiring and transmitting the virus. This goal also aligns with the NHAS by reducing new infections, reducing

[1] Funders receiving less than $50,000 were not required to implement prevention for positive strategies.

HIV related disparities and health inequities while achieving a more coordinated local, state, and national response to the HIV epidemic.

DPH will also implement "The Systems Linkage and Access to Care for Populations at High Risk for HIV Infection Initiative," or the Georgia "Test-Link-Care" Network in the Fulton, DeKalb, Cobb/Douglas, East Metro and Clayton public health districts. This model will identify and promptly link to care persons who are living with HIV but not receiving treatment (including those who are *unaware* of, as well as those who are *aware* of, their HIV-positive status) and improve patient retention in HIV primary care, through the use of trained Linkage Coordinators and systemic networking among HIV care providers, HIV testing providers and the health department.



*Administrative – Personnel, Travel, Capacity Building, CPG, etc; Supplies – Test kits, Condoms, Educational Supplies, etc; Contractual – CBOs, Social Marketing, and ECHPP Evaluation; GIA –Health Districts (Programmatic and Personnel), Office of STD, and Lab Processing; Indirect – GA DPH, Grant Administration Fees.

- Enhanced Comprehensive HIV Prevention Plan ($1.5 Million)

The Enhanced Comprehensive HIV Prevention Plan (ECHPP) is a three year demonstration project for the 12 municipalities with the highest number of people living with AIDS in the United States. As part of the response to the NHAS, the

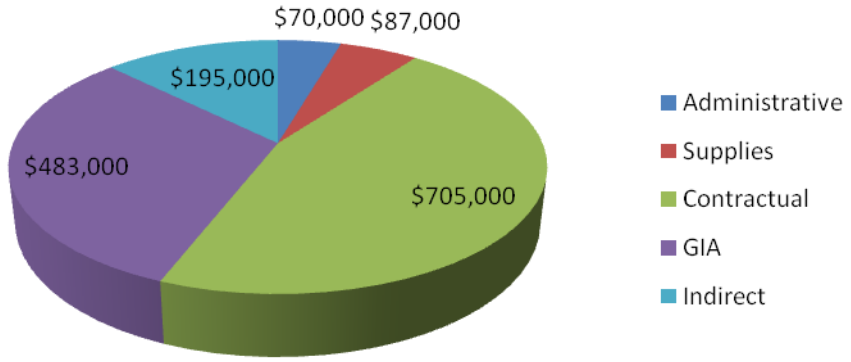
ECHPP project supports the 12 Cities Project which is directed by the Department of Health and Human Service (HHS).

The Atlanta metropolitan statistical area (MSA) comprises approximately two thirds of all newly diagnosed cases of HIV in Georgia. The counties of Fulton and DeKalb account for over 50% of newly infected cases. To this end, the Georgia DPH has been tasked with focusing ECHPP initiatives exclusively in the Atlanta MSA; the five counties that collectively account for 63% of the state's total HIV/AIDS morbidity; Fulton, DeKalb, Cobb-Douglas, Clayton, and Gwinnett counties respectively.

The Atlanta ECHPP focuses on developing and enhancing strategies to address HIV and AIDS in the Atlanta MSA. ECHPP incorporates a combination of initiatives related to scaling up certain activities including HIV testing in clinical and non-clinical settings, linking HIV positive persons to care and treatment services, medical and treatment adherence interventions for person who are HIV positive, partner services and condom distribution. ECHPP also includes activities that address individuals who are HIV negative and at high risk of infection.

This initiative allows the Georgia DPH to take advantage of best practices, including working with county health departments, Ryan White Part A, and community partners in the delivery of HIV prevention, care and treatment programs. The plan also provides Georgia DPH with a greater chance to refocus HIV prevention strategies and increase communication and coordination of activities between community partners, planning groups, and funded agencies. The goals of the Georgia ECHPP initiative align with the goals of the NHAS; to increase the number of people tested for HIV, increase the number of persons who are HIV positive and enrolled into primary care services, reduce the number of people who do not have access to care and treatment services, and improve the overall health outcomes for people with HIV.

Figure 11: 2011 - 2012 ECHPP Allocation*



*Administrative – Personnel; Supplies – Condoms, Test Kits and Office Supplies; Contractual – CBOs, Social Marketing, and ECHPP Evaluation; GIA –Health Districts (Programmatic and Personnel) and Office of STD; Indirect – GA DPH, Grant Administration Fees.

- SAMHSA

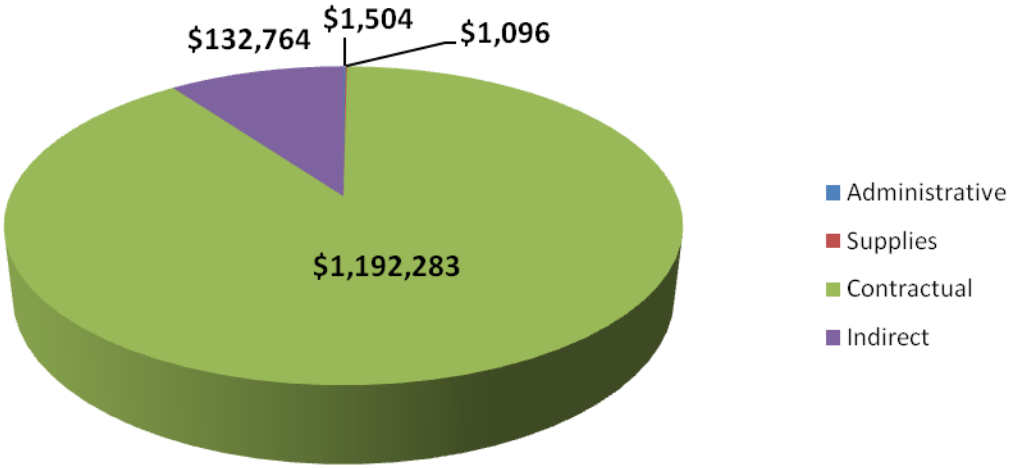
  - Minority AIDS Initiative (MAI) for Targeted Capacity Expansion (TCE) ($1.3 Million)

    The purpose of the MAI-TCE program is to facilitate the development and expansion of a culturally competent and effective integrated behavioral health and primary care network, which includes HIV services and medical treatment, within racial and ethnic minority communities. This project is also part of the response to the NHAS, and supports the 12 Cities Project which is directed by HHS.

    Through this grant, Georgia DPH created "Atlanta CHANGE." The vision of Atlanta CHANGE is to formalize existing relationships among HIV/AIDS provider agencies into a consortium of community based health and primary care programs. The goal of the consortium is to provide coordinated and integrated multidisciplinary services for individuals from underserved communities living with HIV/AIDS and a mental health and/or substance abuse disorder. The expected outcomes for the program include reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these areas. As the incidence of HIV/AIDS increases among racial and ethnic minority populations, the need for substance abuse and mental health services increases as well. This program aims to

ensure that individuals who are at high risk for or have a mental and/or substance use disorder and who are most at risk for or are living with HIV/AIDS have access to and receive appropriate behavioral health services (including prevention and treatment), HIV/AIDS care and medical treatment in integrated behavioral health and primary care settings (that may include infectious disease or other HIV specialty providers).

Figure 12: 2011 - 2012 SAMHSA Allocation



*Administrative – Travel; Supplies – Office Supplies; Contractual – Community Based Organizations; Indirect – GA DPH, Grant Administration Fees.

Through funds received, Georgia will continue to focus its HIV prevention efforts to match those of NHAS. In order to do this, the program aims to place a greater emphasize on cost-effective, and scalable interventions specifically targeting individuals at highest risk to become infected or to transmit HIV, with a strong emphasis on prevention for HIV positive individuals. This includes focusing HIV Prevention resources to geographic areas that are most impacted by the epidemic.

Table 7: Georgia DPH HIV Prevention Objectives

Georgia DPH HIV Prevention Objectives	Data Source
Reduce New HIV Infections	
By 2017, increase the provision of routine opt-out screening for HIV in public health clinical sites in Georgia where there are high concentrations of HIV infection.	EvaluationWeb
By 2017, increase the number of HIV tests conducted at public health supported non-clinical sites in areas with high concentrations of HIV in Georgia.	EvaluationWeb
By 2017, DPH will distribute 100,000 condoms in clinical sites to reach HIV-positive persons.	Condom distribution report
By 2017, DPH will distribute 100,000 condoms in non-clinical sites to reach persons at high risk of acquiring HIV infection.	Condom distribution report
Increase Access to Care and Improving Health Outcomes for people living with HIV	
By 2017, DPH will increase the provision of linkage to care, treatment, and prevention services for HIV-diagnosed individuals in Georgia.	CareWare
By 2017, DPH will increase the number of HIV-positive individuals in Georgia's public health districts who are linked to other HIV-related medical and social services (e.g. mental health counseling, substance abuse counseling, and housing services).	CareWare
By 2017, DPH will increase the capacity of public health supported entities to refer all newly diagnosed persons to partner services (PS).	Number of clients referred
By 2017, DPH OHA will coordinate with the Office of STD to strengthen the capacity of Ryan Clinics to offer ongoing PS.	Number of clients receiving PS
Reduce HIV-Related Health Disparities	
By 2017, DPH will fund a statewide social marketing campaign with tailored messages aimed at reducing HIV infection rates among gay and bisexual men.	Contract execution Number of media placements/events
By 2017, DPH will re-launch the Georgia Taking Control initiative to increase HIV testing and linkage to care for gay and bi-sexual men.	Contract execution EvaluationWeb
By 2017, DPH will fund a statewide social marketing campaign with tailored messages aimed at reducing HIV infection rates among black heterosexuals.	Contract execution Number of media placements/events

Community Services Assessment

Introduction

The Community Services Assessment committee worked in collaboration with DPH and its contractor Kennesaw AIDS Research and Evaluation Network Team (KAREnet) in conducting the State of Georgia HIV/AIDS 2010 Resource Inventory (Resource Inventory). The purpose of the Resource Inventory is to help identify needs, resources and gaps in HIV prevention and care in the state of Georgia. The Resource Inventory was developed using data from a survey of HIV/AIDS prevention and care service providers, findings from focus groups, and interviews conducted with specific high-risk populations and key HIV stakeholders. Based on these sources, the following HIV prevention service needs were identified.

Table 8: 2009 Provider Surveys of HIV/AIDS Prevention and Care Services Response Rate by Health District

Public Health District		N	Response Rate %
1-1	Rome	4	4.6
1-2	Dalton	2	2.3
2	Gainesville	3	3.4
3-1	Cobb/Douglass	4	4.6
3-2	Fulton	19	21.8
3-3	Clayton	1	1.1
3-4	Gwinnett	3	3.4
3-5	DeKalb	12	13.8
4	LaGrange	2	2.3
5-1	Dublin	2	2.3
5-2	Macon	6	6.9
6	Augusta	7	8.0
7	Columbus	3	3.4
8-1	Valdosta	2	2.3
8-2	Albany	5	5.7
9-1	Savannah	4	4.6
9-2	Waycross	4	4.6
10	Athens	4	4.6
Total		87	100

Figure 13: Percentage of Prevention Clients Served by Gender

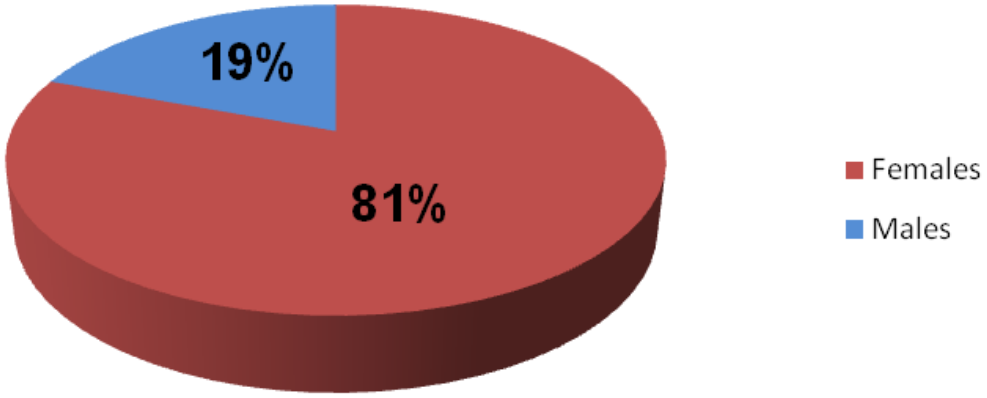


Figure 14: Percentage of Care Clients Served by Gender

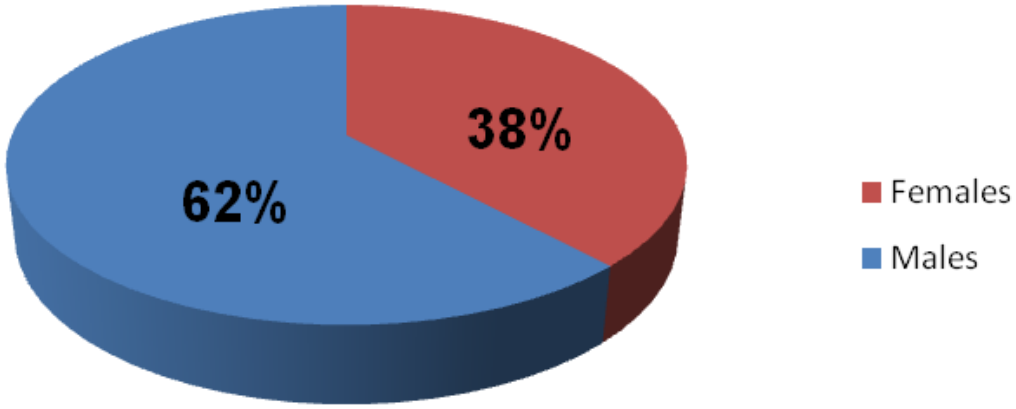


Figure 15: Percentage of Prevention Clients Served by Race

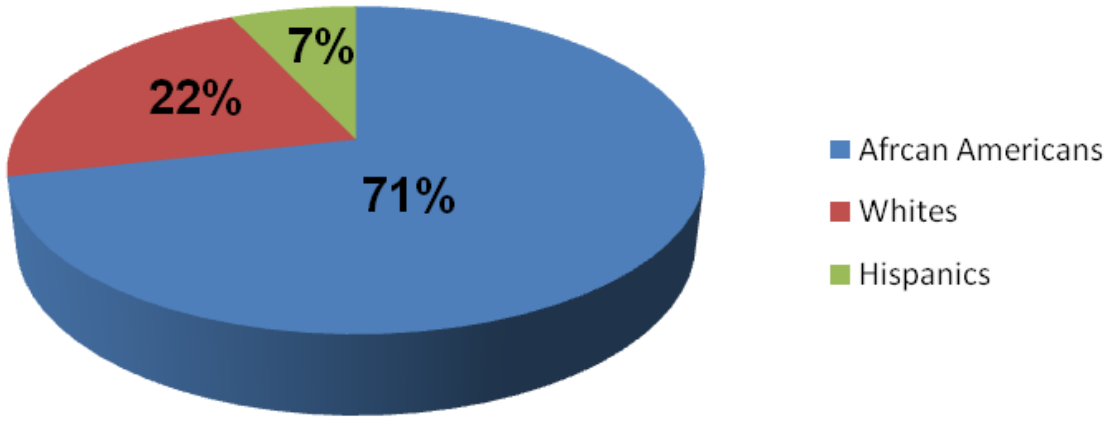


Figure 16: Percentage of Care Clients Served by Race

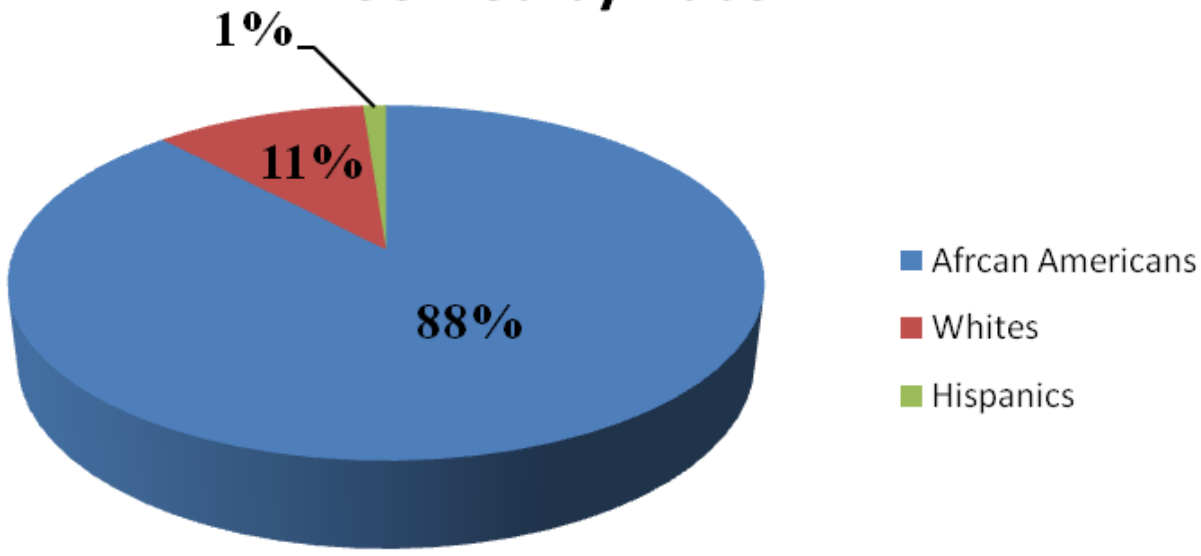


Figure 17: Prevention Clients served by Mode of Transmission

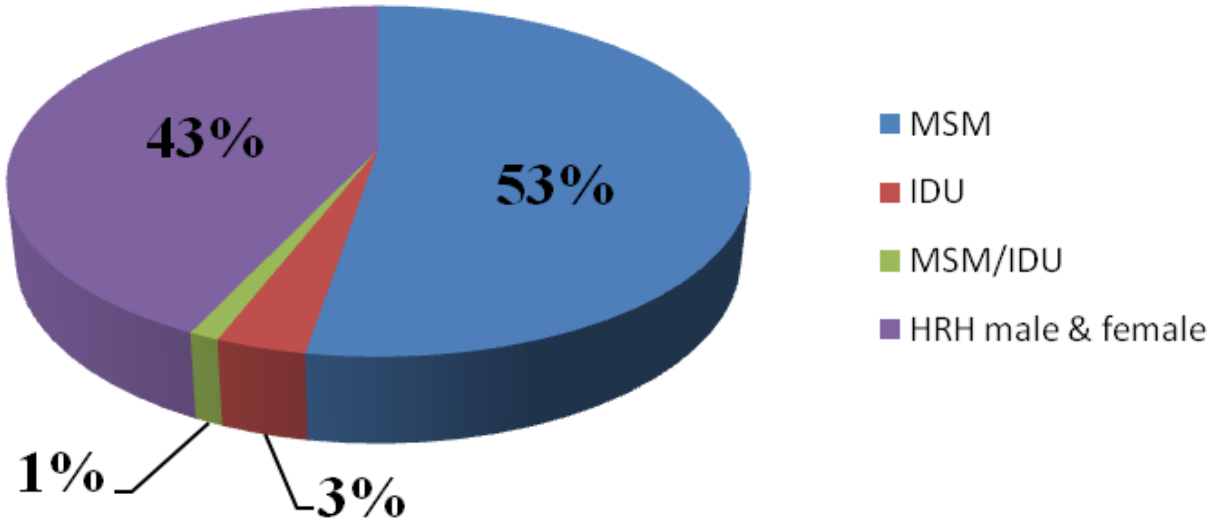
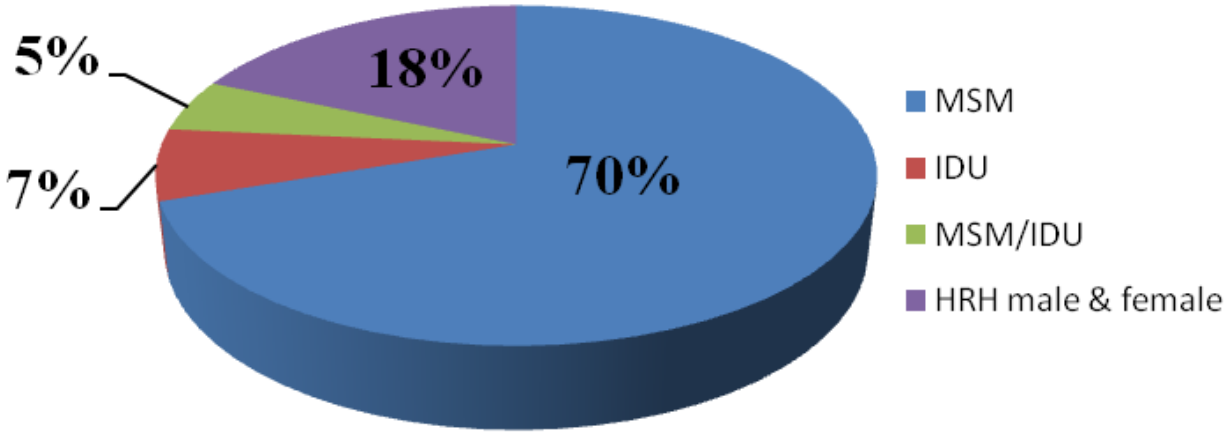


Figure 18: Care Clients served by Mode of Transmission



Barriers to Service

Results were derived based on a qualitative content analysis which coded the question, "What are the challenges you encounter in providing HIV related services" into four barrier categories including: (1) Health System Barriers, (2) Personal Barriers, (3) Resources Barriers, and (4) Cultural and Behavioral Barriers.

1. Health system barriers, which account for 53.7% of all assessed barriers, refers to inhibitors of patient care that stem from deficiencies within the healthcare structure. Inadequate funding and under staffing were the most commonly reported barriers in this category.
    - In an effort to address the need to provide optimum services with reduced funding, new and innovative tactics must be employed. CDC's division of HIV Prevention recommends a High-Impact Prevention approach to reducing new HIV infections. By using combinations of scientifically proven, cost-effective, and scalable interventions targeted to the right populations in the right geographic areas, this approach promises to increase the impact of every HIV prevention dollar spent.

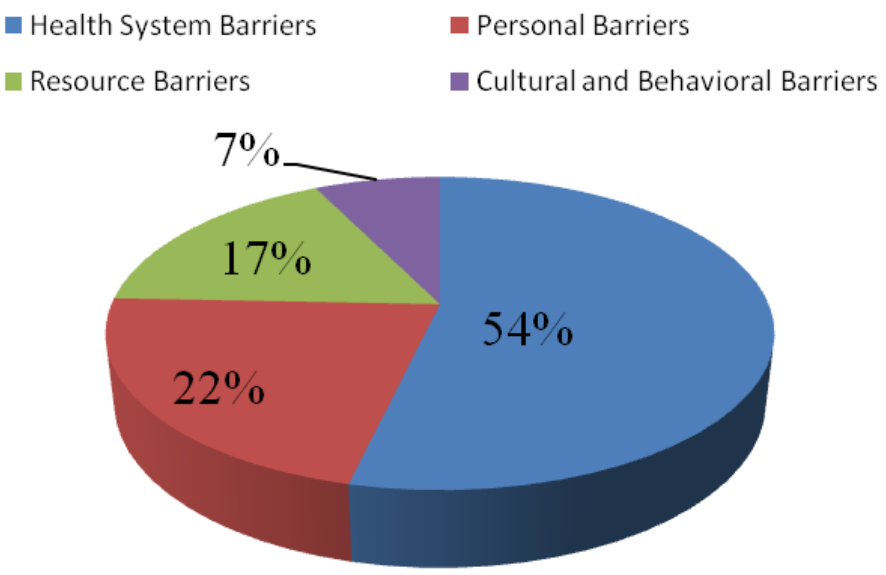
2. Personal Barriers, which account for 22% of all assessed barriers, refers to individual-based inhibitors that impede HIV prevention efforts. Lack of medication adherence and negative stigmas associated with HIV were the most common barriers in this category.
    - Targeted educational campaigns centered on the importance of consistent medication adherence need to be employed. Additionally, social marketing efforts should be utilized to help reduce the stigma associated with HIV/AIDS.

3. Resource Barriers, which account for 17.1% of all assessed barriers, refers to a lack of available personal resources. Competing financial priorities and lack of time were the most common barriers reported in this category.
    - Improved awareness/access to supplemental services for PLWHA (i.e. HOPWA) are needed. By eliminating competing priorities, financial and otherwise, PLWHA are likely to have more time and resources to focus on HIV prevention and care efforts.

4. Cultural and Behavioral Barriers which account for, 7.3% of all assessed barriers, refer to cultural customs and general behaviors that inhibit HIV prevention efforts. Lack of language skill, denial, and high risk behaviors all equally contributed to this barrier category

- Increased access to evidence based, culturally specific, risk reduction interventions are needed throughout the State. Additionally increased linkage to care is needed to help newly identified positives come to term with their diagnosis in a safe and productive manor.

Figure 19: 2009 Provider Survey of HIV/AIDS Prevention and Care Services- Barriers to Service



<u>2009 Provider Survey of HIV/AIDS Prevention and Care Services - Perceived Gaps</u>

Results were derived based on qualitative content analysis which coded the question "What do you perceive to be the gaps/needs related to HIV/AIDS services in your service-delivery area" into five areas of need including: (1) Supplemental Services, (2) Lack of Funding, (3) Continuity of Care, (4) Intervention Diversity and Community Outreach, and (5) Transportation.

1. Gaps in supplemental services, which account for 38.9% of all assessed gaps, refers to a lack of indirect HIV prevention services (i.e. substance abuse and/or mental health services). Lack of housing assistance and dental care were the most common perceived gap in this category.

2. Gaps in funding, which account for 19.4% of all assessed gaps, refers to a lack of sufficient HIV prevention funds. Lack of staffing due to reduced funding was the most common perceived gap in this category.

3. Continuity of Care gaps, which accounts for 13.9% of all assessed gaps, refers to the lack of cohesive, all encompassing prevention measures. The need for bilingual staff trained in multiple areas of prevention was the most commonly perceived gap in this category.

4. The need for an array of interventions and increased community outreach was identified. This category accounts for 13.9% of all assessed gaps. The need for heterosexual interventions and increased community outreach efforts were the most commonly perceived gap in this category.

5. Gaps in transportation services, which accounts for 13.9% of all assessed gaps, refers to the lack of available transport to and from rural communities.

CPG Identified HIV Population Prioritization in Rank Order

Historically the Populations Committee has been tasked with identifying and compiling a prioritized list of populations. However, moving forward the actual task of ranking has been shifted to the State. That said the expectation is that the populations committee will still be heavily involved with the priority ranking process though, in a slightly different capacity. As this is an update to the existing plan, we have retained the original priority populations identified by the CPG however; we have included the State's rankings and ranking methodology as appendix A.

1. HIV Positive Persons
2. African American MSM (15 – 24 years old and >24 years)
3. African American Heterosexual Women (15 – 24 years old and >24 years)
4. White MSM
5. African American Heterosexual Males
6. Injection Drug Use
7. Hispanic MSM
8. White Heterosexual Females
9. Hispanic Heterosexual Females
10. Transgenders and Asian/Pacific Islanders

Abbreviations used in this report:

AIDS	Acquired Immunodeficiency Syndrome
ALCM	ARTAS Linkage Case Management
ART	Antiretroviral Therapy
ARTAS	Antiretroviral Treatment Access Study
ASO	AIDS Service Organization
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CLEAR	Choosing Life: Empowerment! Action! Results!
CSA	Community Services Assessment
DPH	Georgia Department of Public Health
EBI	Evidence-based Behavioral Interventions
ECHPP	Enhance Comprehensive HIV Prevention Plan
EMA	Eligible Metropolitan Area
HAES	HIV/AIDS Epidemiology Section
HHRP	Holistic Health Recovery Program
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HPG	HIV Planning Group
HRH	High Risk Heterosexual
IDU	Injection Drug Use
KAREnet	Kennesaw AIDS Research & Evaluation Network
MAI	Minority AIDS Initiative
MMP	Medical Monitoring Project
MSA	Metropolitan Statistical Area
MSM	Men who have sex with men
NHBS	National HIV Behavioral Survey
NIR/NRR	No Identified Risk/No Risk Reported
OASIS	Online Analytical Statistical Information System
OHA	Office of HIV/AIDS
PCC	Personalized Cognitive Counseling
PIR	Parity, Inclusion, and Representation
PLWHA	People Living with HIV/AIDS
PROMISE	Peers Reaching Out and Modeling Intervention Strategies
SAMHSA	Substance Abuse and Mental Health Services Administration
SHIELD	Self-Help in Eliminating Life-threatening Diseases
STI/STD	Sexually Transmitted Infections/Sexually Transmitted Diseases
TB	*Mycobacterium tuberculosis*
TCE	Targeted Capacity Expansion
TLC	Together Learning Choices
WILLOW	Women Involved in Life Learning from Other Women

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Appendix A

State Identified HIV Population Prioritization

Determining priorities for reaching target populations with HIV prevention services is crucial given the limited resources available. However, the process of determining how certain populations should be prioritized can be controversial, and may be based strongly on personal experience. To mitigate subjective designations, a systematic review of (1) the current epidemiology of HIV in the state, (2) a review of relevant literature informing the relationship between HIV and social determinants of health, and (3) benchmarking of several methods were used to guide the prioritization decision making process. DPH used a prioritization tool developed by a local jurisdiction (Michigan) presented at a CDC HIV surveillance workshop (July 2011, Atlanta, GA) by epidemiologist Benjamin Laffoon. The tool is intended to provide an objective method for prioritizing populations using the best available data.

The purpose of this section is to document the process used by DPH to prioritize 2012 populations for HIV prevention targets. This work builds upon the efforts of the 2010-2011 HPG Populations Committee towards identifying priority-setting processes that select and rank populations at greatest risk for HIV transmission and acquisition in Georgia. The results of provisional data analysis using the tool were presented to the HPG in November 2011; the group expressed uncertainty with the validity of the order in which populations were prioritized. However, limitations on the variety of data sources used as inputs into the tool, not the tool itself, was deemed the reason for the disagreement. To this end, the current analysis includes data inputs on 11 of the 12 recommended outputs.

Description of the Tool

Based on guidance from the CDC, HIV-positive persons should be prioritized as the number one target population, this tool is meant to continue the prioritization process for all other populations based on demographic and behavioral risk information using a two-step process. This multi-stage process approach allows for the incorporation of a greater number of data sources.

Population prioritization tool terminology

Population

Population reflects the groups of interest to prioritize to receive targeted HIV prevention services. In the first step of the methodology, populations are based on sex and race/ethnicity only. The populations include White, Black, and Hispanic males and females. Populations based on behavioral risk are not included in Step 1 because data for the factors under consideration are not available for behavioral risk populations. The populations in Step 2 are based on the populations chosen in the first step with the addition of the three primary behavioral risk categories (MSM, IDU, and high risk heterosexual [HRH]).

Factors

Factors are the pieces of information that are considered when determining priorities. What follows is a description of the factors included in the tool and how the data were derived for each factor.

1. Population Size: Measures the size of the general population and therefore reflects the scope of potential prevention activities. Estimates were derived from data collected by the U.S. Census Bureau obtained by the DPH HIV Unit. U.S. Census population data are available by sex, race/ethnicity, and age but not by behavioral risk group.
2. Percent of the Population Living Below Federal Poverty Level: Research has shown that many communicable diseases disproportionately impact persons in poverty. This measure represents the impact of poverty in each population under consideration. Estimates were derived from data collected by the U.S. Census Bureau through the American Community Survey (ACS) and are available by sex, race/ethnicity, and age but not by behavioral risk group.
3. Rate of Living HIV Cases per 100,000 Population: Examines how HIV proportionately impacts each population under consideration. Information on the number of living cases was made available from surveillance data collected by the DPH HIV/AIDS Epidemiology Section (HAES). Population denominators were based on information from the U.S. Census Bureau.
4. Gonorrhea (GC) Rate per 100,000 Population: Risk behaviors associated with an STD diagnosis are also associated with risk for becoming infected with HIV. Research has shown that persons with an STD diagnosis are at greater risk for receiving an HIV diagnosis. The rate of reported gonorrhea cases represents the proportionate impact of this disease in each population under consideration. Information on the number of reported gonorrhea cases is available from the DPH public health data repository (OASIS).

5. Chlamydia (CT) Rate per 100,000 Population: Risk behaviors associated with an STD diagnosis are also associated with risk for becoming infected with HIV. Research has shown that persons with an STD diagnosis are at greater risk for receiving an HIV diagnosis. The rate of reported chlamydia cases represents the proportionate impact of this disease in each population under consideration. Information on the number of reported gonorrhea cases is available from the DPH public health data repository (OASIS).
6. Primary and Secondary (P&S) Syphilis Rate per 100,000 Population: Risk behaviors associated with an STD diagnosis are also associated with risk for becoming infected with HIV. Research has shown that persons with an STD diagnosis are at greater risk for receiving an HIV diagnosis. The rate of reported p&s syphilis cases represents the proportionate impact of this disease in each population under consideration. Information on the number of reported gonorrhea cases is available from the DPH public health data repository (OASIS).
7. Percent Change in living HIV cases over Five Years: Captures changes in the trends of which populations are being impacted by HIV disease. Information on the number of living cases for 2006 and 2010 was made available from surveillance data collected by the DPH HAES. Since a large number of cases are initially reported with missing risk factor information, and over time risk information is ascertained, the trends may be unfairly skewed if this measure is examined for populations based on behavioral risk. Therefore, the best available data regarding trends in new infection are available by sex, race/ethnicity, and age.
8. New HIV Diagnoses: Measures the impact of recent diagnoses on the populations under consideration. Data were produced from surveillance data collected by the HAES. Data are available by sex, race/ethnicity, age, and behavioral risk.
9. Living HIV Cases: Measures the current disease burden in the population under consideration. Data were produced from surveillance data collected by the HAES. Data are available by sex, race/ethnicity, age, and behavioral risk.
10. Biologic Transmission Risk: Measures the relative risk of HIV transmission from an infected partner to an uninfected person when engaging in a specific risk behavior. The risk value was taken from the Vermont HIV Prevention Prioritization Tool in 2004. Their data was derived from published research on transmission risks. Data are available by behavioral risk only.
11. Seroprevalence from Counseling and Testing Data: Measures the percentage of persons that tested positive at HIV counseling and testing sites. Data were produced from counseling

and testing data collected by the HIV Prevention Office. Data are available by sex, race/ethnicity, age, and behavioral risk.

Methodology

Redistribution of No Identified and No Reported Risk (NIR/NRR)

To account for the substantial proportion of cases with missing information that identifies the category that summarizes a person's possible risk factors for HIV, we collaborated with the HAES to apply statistical methodology to redistribute the cases based on the cases with known distribution. The redistribution values were analyzed to produce estimates of the number of cases by risk category.

Weights

Weights represent the importance each factor plays in the decision making process. In the current tool, each factor is weighted on a scale of 1 to 5, with a weight of 5 representing a factor that is extremely relevant and important to the decision making process. The weight of 1 represents a factor that is of minimal relevance and importance to the decision making process. It also might reflect a factor for which there is not strong confidence in the available data. For example, the number of persons living with HIV disease should strongly influence where we direct our prevention activities as it is a direct measure of the burden of disease. Therefore, in the current tool the factor examining the number of persons living with HIV is given a weight of 5. In contrast, we know that persons living in poverty are disproportionately impacted by HIV. However poverty is not a direct measure of the burden of HIV. Therefore it should receive a lower weight than a factor that measures the burden of HIV directly. As a result, in the current tool the factor examining the percentage of persons living below the federal poverty level is given a weight of 2.

Scoring

In the tool, each factor is scored on a ten point scale. It is important that all factors are scored using the same scale. In this tool the score is based on the ratio of the value in the population under consideration in relation to the population with the highest value. For example, using the factor of population size estimated from 2010 census counts, white females represent the largest value (2,752,627 persons). Therefore, their ratio to the maximum value is 1 (2,752,627/2,752,627). Their score is derived by multiplying their ratio (1) by 10 (the maximum range of the score scale) and by the weight of the factor (3). Therefore the score for white females based on population size

is 30. Black males represent 1,361,662 persons in Georgia's population; their ratio compared to the largest population size group (i.e., white females) is 0.49 (1,361,662/2,752,627). The ratio is then multiplied by 10 (the maximum range of the score scale) and by the weight of the factor (3). Therefore the score for black males is 15.

The scores are calculated using the same methodology for all factors. A sub-total score is derived for Step 1 by summing the scores for all the factors under consideration in Step 1. A sub-total score is derived for Step 2 in the same fashion. Because the score from Step 1 is based solely on demographic information, we did not feel that it should be applied equally to all behavioral risk groups under the appropriate demographic category. If the sub-total score from Step 1 is applied equally to all behavioral risk groups, it tends to place too much emphasis on demographic factors and not enough emphasis on behavioral factors. As a result, in the current template the sub-total score from Step 1 is proportionally distributed to each risk group in the appropriate demographic category in the calculation of the total score used to rank the target populations. For example, white males had a sub-total score from Step 1 of 66. Of the sub-total scores from Step 2, white MSM represented 76% of the Step 2 score among white males (87/(87+18+10)). Therefore white MSM would receive 76% of the sub-total score from Step 1 (0.76 x 66=49.93) plus their score from Step 2 (66). The total score for white MSM would be 137 (87+49.93). The population with the highest total score is ranked first, with additional populations ranked based on descending value of their total score.

State generated 2012 Prioritization of Target Populations

Priority Rank	Population by Race/Ethnicity and Behavioral Risk
1	Persons living with HIV/AIDS (PLWHA) – all behavioral risk categories
2	Black men who have sex with men*
3	White men who have sex with men*
4	Hispanic men who have sex with men*
5	Black female heterosexual**
6	Black male IDU
7	Black female IDU
8	White female heterosexual**
8	Black male heterosexual**
10	White male heterosexual**

10	Hispanic female IDU

*Men who have sex with men are classified as male-to-male sexual contact including men who report sexual contact with other men and men who report sexual contact with both men and women.

**For the purposes of HIV planning, heterosexual refers contact to persons at increased risk. This group includes men, women, and youth who are (1) partners of people who are HIV+, (2) are partners of people who are injection drug users (3) are partners of men who have sex with men, or (4) are people of color (including people who are Black, Hispanic, Asian/Pacific Islander, American Indian/Alaska Native).

Appendix B

Appendix C