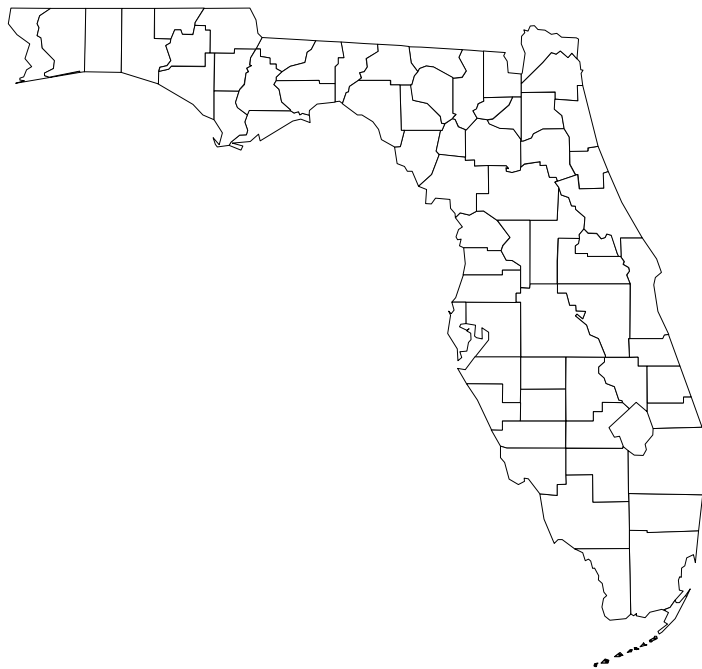


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Chapter One: Introduction



Dedication

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

Acknowledgements

- Members of the Prevention Planning Group (past and present)
- Members of the Community Planning Partnerships (past and present)
- Members of the 2010 HIV/AIDS Prevention Plan writing team (Dan Merkin, Yul Knighten, Maria Hobbs, Peter Bright, Dano Beck, and Sylvia Hubbard)
- Staff of the Florida Department of Health's Bureau of HIV/AIDS
- County Health Department staff
- AIDS Service Organization and Community-Based Organization staff throughout the state
- Volunteers throughout the state
- The thousands of Floridians who have provided input to the community planning process

PREFACE

The Florida Comprehensive Planning Network (FCPN)

The former Florida Community Planning Group (FCPG) met four times each year as opposed to the existing subsidiary planning groups of the FCPN meeting only three times each year for cost effective and efficient planning activities. The membership of the FCPN consists of representatives from across the state that are selected from local health departments, local HIV/AIDS community planning groups (CPGs) and local patient care consortia. The FCPN consists of three planning entities: prevention planning group/early intervention (PPG), the patient care planning group (PCPG) and the Florida Viral Hepatitis Council. At-large members are appointed to ensure representation of special populations, such as Religious /Faith Community (consumer or experience with program addressing the epidemic), Substance Abuse/Mental Health (consumer or specialized worker), Behavioral Science (professional or specialist), Haitian (consumer or specialized worker), Migrant/Farm worker (consumer if possible, or professional representative), PLWHA/consumer, Youth (consumer if possible, or representative of youth group involving youth aged 18-25) and Transgender.

The FCPN was known as the FCPG until December 2003, and met four times each year. The FCPN's subsidiary planning groups meet only three times each year for more cost effective and efficient planning activities. Members of the Prevention Planning Group (PPG) developed specific guidelines to assist local community planning partnerships in the development of their local prevention plans. The guidelines were developed during PPG and workgroup meetings held between the quarterly PPG meetings. Local partnerships were required to use the guidelines to develop their plans. Each local partnership updated their priority populations during August 2008. The local partnerships were instructed by the PPG to include the Advancing HIV Prevention (AHP) Initiative when developing their local plans.

The FCPN receives reports from the Patient Care Planning Group, The Viral Hepatitis Planning Council, the Black MSM Advisory Group, Latino MSM Advisory Group, White MSM Advisory Group, Black Leaders Group, Latinos Leaders Group, Faith Leaders Group, Consumer Advisory Group, and Black Women's Advisory Group.

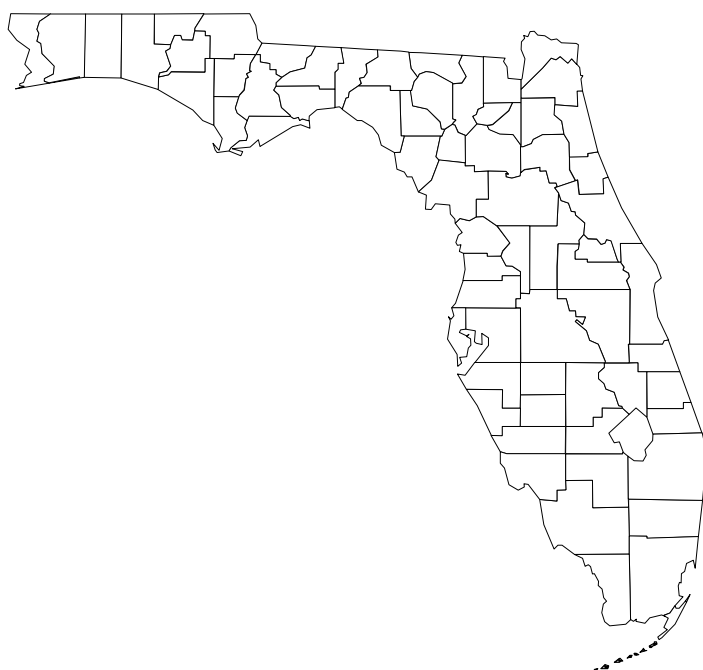
What are the Community Planning Partnerships?

The state is divided into seventeen distinct geographical areas. However, there are fourteen community planning partnerships because some areas conduct joint patient care and prevention planning. On January 1, 2006, funding for local planning groups was eliminated due to budget cuts. At that time, all fourteen planning partnerships stated that they intended to continue their prevention activities despite the loss of funding. All fourteen partnerships continue to conduct some prevention activities. The partnerships have continued to name representatives to the FCPN and to submit their priority populations. The member from the local partnership is not only responsible for representing the needs and concerns of the local partnership on the statewide body, but is also responsible for assuring the implementation of FCPN guidelines by the local area.

2010 State of Florida HIV Prevention Plan

In 2009, the Florida HIV/AIDS Prevention Planning Group, in collaboration with the Bureau of HIV/AIDS, determined that a one-year state prevention plan would be written rather than the usual three-year plan. This decision will allow PPG to gather accurate needs assessment data. An updated plan will be submitted in 2010 to cover a two-year period from 2011-2012.

Chapter Two: Epidemiologic Profile Summary



AIDS cases and rates per 100,000 population, and percent of total, by race/ethnicity, gender and age group at diagnosis and year of report. Rates are based on 2007 & 2008 Florida population estimates, by race/ethnicity, gender and age, respectively. DOC cases are excluded. **THESE PAGES ARE LINKED TO NEW CASES-DEATHS, DO NOT EDIT THIS PAGE**

2007							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	2,439	65.4%	26.6	0 - 12	8	0.2%	0.3
Female	1,293	34.6%	13.5	13 - 19	52	1.4%	3.1
Other/Unknown	0	0.0%	N/A	20 - 24	159	4.3%	13.2
Total	3,732	100.0%	19.9	25 - 29	320	8.6%	28.1
				30 - 39	989	26.5%	42.0
Race/Ethnicity	Cases	% Total	Rate	40 - 49	1,310	35.1%	48.5
White, Non-Hispanic	985	26.4%	8.6	50 - 59	663	17.8%	27.0
Black, Non-Hispanic	2,020	54.1%	68.9	60+	231	6.2%	5.4
Hispanic	653	17.5%	17.0	Total	3,732	100.0%	19.9
Asian/Pacific Islander	20	0.5%	N/A				
Amer. Indian/Alaskan	1	0.0%	N/A				
Other/Unknown	53	1.4%	N/A				
Total	3,732	100.0%	19.9				

2008							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	3,197	68.0%	34.5	0 - 12	13	0.3%	0.4
Female	1,504	32.0%	15.6	13 - 19	75	1.6%	4.4
Other/Unknown	0	0.0%	N/A	20 - 24	218	4.6%	17.9
Total	4,701	100.0%	24.9	25 - 29	367	7.8%	31.6
				30 - 39	1,179	25.1%	50.2
Race/Ethnicity	Cases	% Total	Rate	40 - 49	1,630	34.7%	60.8
White, Non-Hispanic	1,302	27.7%	11.4	50 - 59	891	19.0%	35.7
Black, Non-Hispanic	2,446	52.0%	82.2	60+	328	7.0%	7.6
Hispanic	867	18.4%	21.7	Total	4,701	100.0%	24.9
Asian/Pacific Islander	21	0.4%	N/A				
Amer. Indian/Alaskan	9	0.2%	N/A				
Other/Unknown	56	1.2%	N/A				
Total	4,701	100.0%	24.9				

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

HIV (regardless of AIDS) cases and rates per 100,000 population, and percent of total, by race/ethnicity, gender and age group at diagnosis and year of report. Rates are based on 2007 & 2008

Florida population estimates, by race/ethnicity, gender and age, respectively.

DOC cases are excluded.

THESE PAGES ARE LINKED TO NEW CASES-DEATHS, DO NOT EDIT THIS PAGE

2007							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	4,029	69.2%	43.9	0 - 12	162	2.8%	5.5
Female	1,795	30.8%	18.7	13 - 19	238	4.1%	14.1
Other/Unknown	0	0.0%	N/A	20 - 24	588	10.1%	48.7
Total	5,824	100.0%	31.0	25 - 29	726	12.5%	63.8
				30 - 39	1,537	26.4%	65.3
Race/Ethnicity	Cases	% Total	Rate	40 - 49	1,587	27.2%	58.7
White, Non-Hispanic	1,856	31.9%	16.1	50 - 59	724	12.4%	29.5
Black, Non-Hispanic	2,624	45.1%	89.5	60+	262	4.5%	6.2
Hispanic	1,262	21.7%	32.9	Total	5,824	100.0%	31.0
Asian/Pacific Islander	27	0.5%	N/A				
Amer. Indian/Alaskan	9	0.2%	N/A				
Other/Unknown	46	0.8%	N/A				
Total	5,824	100.0%	31.0				

2008							
Gender	Cases	% Total	Rate	Age Groups	Cases	% Total	Rate
Male	5,151	72.4%	55.7	0 - 12	90	1.3%	3.0
Female	1,960	27.6%	20.3	13 - 19	244	3.4%	14.4
Other/Unknown	0	0.0%	N/A	20 - 24	720	10.1%	59.0
Total	7,111	100.0%	37.6	25 - 29	806	11.3%	69.3
				30 - 39	1,730	24.3%	73.7
Race/Ethnicity	Cases	% Total	Rate	40 - 49	2,113	29.7%	78.8
White, Non-Hispanic	2,474	34.8%	21.6	50 - 59	1,061	14.9%	42.5
Black, Non-Hispanic	3,122	43.9%	104.9	60+	347	4.9%	8.0
Hispanic	1,422	20.0%	35.6	Total	7,111	100.0%	37.6
Asian/Pacific Islander	33	0.5%	N/A				
Amer. Indian/Alaskan	16	0.2%	N/A				
Other/Unknown	44	0.6%	N/A				
Total	7,111	100.0%	37.6				

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

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

2007							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	736	83.2%	8.0	0 - 12	0	0.0%	0.0
Female	147	16.6%	1.5	13 - 19	84	9.5%	5.0
Other/Unknown	2	0.2%	N/A	20 - 24	172	19.4%	14.3
Total	885	100.0%	4.7	25 - 29	138	15.6%	12.1
Race/Ethnicity				Race/Ethnicity			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	290	32.8%	2.5	30 - 39	213	24.1%	9.0
Black, Non-Hispanic	385	43.5%	13.1	40 - 49	203	22.9%	7.5
Hispanic	131	14.8%	3.4	50 - 59	56	6.3%	2.3
Asian/Pacific Islander	1	0.1%	N/A	60+	19	2.1%	0.4
Amer. Indian/Alaskan	1	0.1%	N/A	Other/Unknown	0	0.0%	N/A
Other/Unknown	77	8.7%	N/A	Total	885	100.0%	4.7
Total	885	100.0%	4.7				
2008							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	803	81.1%	8.7	0 - 12	0	0.0%	0.0
Female	187	18.9%	1.9	13 - 19	76	7.7%	4.5
Other/Unknown	0	0.0%	N/A	20 - 24	185	18.7%	15.2
Total	990	100.0%	5.2	25 - 29	145	14.6%	12.5
Race/Ethnicity				Race/Ethnicity			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	307	31.0%	2.7	30 - 39	247	24.9%	10.5
Black, Non-Hispanic	448	45.3%	15.1	40 - 49	241	24.3%	9.0
Hispanic	171	17.3%	4.3	50 - 59	77	7.8%	3.1
Asian/Pacific Islander	2	0.2%	N/A	60+	19	1.9%	0.4
Amer. Indian/Alaskan	1	0.1%	N/A	Other/Unknown	0	0.0%	N/A
Other/Unknown	61	6.2%	N/A	Total	990	100.0%	5.2
Total	990	100.0%	5.2				

2008 data provisional.

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

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

2007							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	11,653	49.8%	126.9	0 - 12	0	0.0%	0.0
Female	11,703	50.0%	122.2	13 - 19	6,468	27.6%	383.5
Other/Unknown	63	0.3%	N/A	20 - 24	7,626	32.6%	632.0
Total	23,419	100.0%	124.8	25 - 29	4,006	17.1%	351.9
				30 - 39	3,072	13.1%	130.4
Race/Ethnicity				40 - 49	1,582	6.8%	58.6
White, Non-Hispanic	4,168	17.8%	36.2	50 - 59	494	2.1%	20.1
Black, Non-Hispanic	14,792	63.2%	504.5	60+	171	0.7%	4.0
Hispanic	1,186	5.1%	30.9	Unknown	0	0.0%	N/A
Asian/Pacific Islander	75	0.3%	N/A	Total	23,419	100.0%	124.8
Amer. Indian/Alaskan	20	0.1%	N/A				
Other/Unknown	3,178	13.6%	N/A				
Total	23,419	100.0%	124.8				
2008							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	10,823	47.7%	116.9	0-12	0	0.0%	0.0
Female	11,824	52.1%	122.6	13 - 19	6,599	29.1%	390.4
Other/Unknown	51	0.2%	N/A	20 - 24	7,427	32.7%	608.8
Total	22,698	100.0%	120.1	25 - 29	3,827	16.9%	329.2
				30 - 39	2,952	13.0%	125.7
Race/Ethnicity				40 - 49	1,331	5.9%	49.7
White, Non-Hispanic	3,886	17.1%	34.0	50 - 59	425	1.9%	17.0
Black, Non-Hispanic	14,286	62.9%	479.9	60+	137	0.6%	3.2
Hispanic	1,262	5.6%	31.6	Unknown	0	0.0%	N/A
Asian/Pacific Islander	86	0.4%	N/A	Total	22,698	100.0%	120.1
Amer. Indian/Alaskan	28	0.1%	N/A				
Other/Unknown	3,150	13.9%	N/A				
Total	22,698	100.0%	120.1				

2008 data provisional.

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

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

2007							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	15,554	26.8%	169.3	0 - 12	0	0.0%	0.0
Female	42,215	72.9%	440.8	13 - 19	19,694	34.0%	1167.6
Other/Unknown	178	0.3%	N/A	20 - 24	22,002	38.0%	1823.4
Total	57,947	100.0%	308.9	25 - 29	9,109	15.7%	800.2
				30 - 39	5,212	9.0%	221.3
				40 - 49	1,349	2.3%	49.9
				50 - 59	311	0.5%	12.7
				60+	270	0.5%	6.4
				Unknown	0	0.0%	N/A
				Total	57,947	100.0%	308.9
Race/Ethnicity							
	Cases	% Total	Rate				
White, Non-Hispanic	13,955	24.1%	121.2				
Black, Non-Hispanic	27,575	47.6%	940.5				
Hispanic	5,890	10.2%	153.4				
Asian/Pacific Islander	383	0.7%	N/A				
Amer. Indian/Alaskan	71	0.1%	N/A				
Other/Unknown	10,073	17.4%	N/A				
Total	57,947	100.0%	308.9				
2008							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	18,293	26.5%	197.6	0-12	0	0.0%	0.0
Female	50,391	73.1%	522.7	13 - 19	23,242	33.7%	1375.1
Other/Unknown	217	0.3%	N/A	20 - 24	26,095	37.9%	2139.0
Total	68,901	100.0%	364.6	25 - 29	11,217	16.3%	965.0
				30 - 39	6,318	9.2%	269.1
				40 - 49	1,539	2.2%	57.4
				50 - 59	399	0.6%	16.0
				60+	91	0.1%	2.1
				Unknown	0	0.0%	N/A
				Total	68,901	100.0%	364.6
Race/Ethnicity							
	Cases	% Total	Rate				
White, Non-Hispanic	15,678	22.8%	137.0				
Black, Non-Hispanic	32,346	46.9%	1086.7				
Hispanic	7,174	10.4%	179.9				
Asian/Pacific Islander	478	0.7%	N/A				
Amer. Indian/Alaskan	82	0.1%	N/A				
Other/Unknown	13,143	19.1%	N/A				
Total	68,901	100.0%	364.6				

2008 data provisional.

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

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

2007							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	610	61.9%	6.6	0 - 12	0	0.0%	0.0
Female	376	38.1%	3.9	13 - 19	35	3.5%	1.2
Other/Unknown	0	0.0%	N/A	20 - 24	76	7.7%	2.6
Total	986	100.0%	5.3	25 - 29	97	9.8%	3.3
Race/Ethnicity				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	210	21.3%	1.8	30 - 39	140	14.2%	4.7
Black, Non-Hispanic	380	38.5%	13.0	40 - 49	206	20.9%	6.9
Hispanic	288	29.2%	7.5	50 - 59	173	17.5%	5.8
Asian/Pacific Islander	103	10.4%	N/A	60+	204	20.7%	6.9
Amer. Indian/Alaskan	2	0.2%	N/A	Unknown	55	5.6%	N/A
Unknown	3	0.3%	N/A	Total	986	100.0%	5.3
Total	986	100.0%	5.3				

2008							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	609	64.4%	6.6	0 - 12	46	4.9%	1.5
Female	337	35.6%	3.5	13 - 19	23	2.4%	1.4
Other/Unknown	0	0.0%	N/A	20 - 24	70	7.4%	5.7
Total	946	100.0%	5.0	25 - 29	69	7.3%	5.9
Race/Ethnicity				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	210	22.2%	1.8	30 - 39	137	14.5%	5.8
Black, Non-Hispanic	383	40.5%	12.9	40 - 49	195	20.6%	7.3
Hispanic	253	26.7%	6.3	50 - 59	179	18.9%	7.2
Asian/Pacific Islander	94	9.9%	N/A	60+	227	24.0%	5.3
Amer. Indian/Alaskan	1	0.1%	N/A	Unknown	0	0.0%	N/A
Unknown	5	0.5%	N/A	Total	946	100.0%	5.0
Total	946	100.0%	5.0				

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

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

2007							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	84	54.2%	0.9	0 - 12	0	0.0%	0.0
Female	71	45.8%	0.7	13 - 19	22	14.2%	1.3
Other/Unknown	0	0.0%	N/A	20 - 24	21	13.5%	1.7
Total	155	100.0%	0.8	25 - 29	13	8.4%	1.1
Race/Ethnicity				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	62	40.0%	0.5	30 - 39	23	14.8%	1.0
Black, Non-Hispanic	8	5.2%	0.3	40 - 49	12	7.7%	0.4
Hispanic	59	38.1%	1.5	50 - 59	13	8.4%	0.5
Asian/Pacific Islander	3	1.9%	N/A	60+	22	14.2%	0.5
Amer. Indian/Alaskan	0	0.0%	N/A	Unknown	29	18.7%	N/A
Other/Unknown	23	14.8%	N/A	Total	155	100.0%	0.8
Total	155	100.0%	0.8				

2008							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	84	56.0%	0.9	0 - 12	0	0.0%	0.0
Female	66	44.0%	0.7	13 - 19	9	6.0%	0.5
Other/Unknown	0	0.0%	N/A	20 - 24	6	4.0%	0.5
Total	150	100.0%	0.8	25 - 29	12	8.0%	1.0
Race/Ethnicity				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	66	44.0%	0.6	30 - 39	16	10.7%	0.7
Black, Non-Hispanic	11	7.3%	0.4	40 - 49	21	14.0%	0.8
Hispanic	57	38.0%	1.4	50 - 59	20	13.3%	0.8
Asian/Pacific Islander	2	1.3%	N/A	60+	32	21.3%	0.7
Amer. Indian/Alaskan	0	0.0%	N/A	Unknown	34	22.7%	N/A
Other/Unknown	14	9.3%	N/A	Total	150	100.0%	0.8
Total	150	100.0%	0.8				

2008 data provisional.

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

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

2007							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	199	59.2%	2.2	0 - 12	0	0.0%	0.0
Female	137	40.8%	1.4	13 - 19	2	0.6%	0.1
Other/Unknown	0	0.0%	N/A	20 - 24	11	3.3%	0.9
Total	336	100.0%	1.8	25 - 29	40	11.9%	3.5
Race/Ethnicity				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	178	53.0%	1.5	30 - 39	88	26.2%	3.7
Black, Non-Hispanic	91	27.1%	3.1	40 - 49	104	31.0%	3.8
Hispanic	41	12.2%	1.1	50 - 59	56	16.7%	2.3
Asian/Pacific Islander	3	0.9%	N/A	60+	35	10.4%	0.8
Amer. Indian/Alaskan	0	0.0%	N/A	Unknown	0	0.0%	N/A
Other/Unknown	23	6.8%	N/A	Total	336	100.0%	1.8
Total	336	100.0%	1.8				
2008							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	213	64.0%	2.3	0 - 12	0	0.0%	0.0
Female	119	35.7%	1.2	13 - 19	2	0.6%	0.1
Other/Unknown	1	0.3%	N/A	20 - 24	10	3.0%	0.8
Total	333	100.0%	1.8	25 - 29	36	10.8%	3.1
Race/Ethnicity				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
White, Non-Hispanic	170	51.1%	1.5	30 - 39	97	29.1%	4.1
Black, Non-Hispanic	87	26.1%	2.9	40 - 49	98	29.4%	3.7
Hispanic	35	10.5%	0.9	50 - 59	54	16.2%	2.2
Asian/Pacific Islander	7	2.1%	N/A	60+	27	8.1%	0.6
Amer. Indian/Alaskan	0	0.0%	N/A	Unknown	9	2.7%	N/A
Other/Unknown	34	10.2%	N/A	Total	333	100.0%	1.8
Total	333	100.0%	1.8				

2008 data provisional.

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

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

2007							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	9,133	61.6%	99.4	0 - 12	0	0.0%	0.0
Female	5,645	38.1%	58.9	13 - 19	93	0.6%	5.5
Other/Unknown	40	0.3%	N/A	20 - 24	369	2.5%	30.6
Total	14,818	100.0%	79.0	25 - 29	545	3.7%	47.9
				30 - 39	1,477	10.0%	62.7
Race/Ethnicity				40 - 49	4,580	30.9%	169.5
White, Non-Hispanic	5,535	37.4%	48.1	50 - 59	5,897	39.8%	240.3
Black, Non-Hispanic	998	6.7%	34.0	60+	1,771	12.0%	41.7
Hispanic	750	5.1%	19.5	Unknown	86	0.6%	N/A
Asian/Pacific Islander	80	0.5%	N/A	Total	14,818	100.0%	79.0
Amer. Indian/Alaskan	0	0.0%	N/A				
Other/Unknown	7,455	50.3%	N/A				
Total	14,818	100.0%	79.0				
2008							
Gender				Age Groups			
	Cases	% Total	Rate		Cases	% Total	Rate
Male	13,968	62.0%	150.9	0 - 12	0	0.0%	0.0
Female	8,477	37.6%	87.9	13 - 19	224	1.0%	13.3
Other/Unknown	76	0.3%	N/A	20 - 24	684	3.1%	56.1
Total	22,521	100.0%	119.2	25 - 29	1,031	4.6%	88.7
				30 - 39	2,297	10.3%	97.8
Race/Ethnicity				40 - 49	6,103	27.4%	227.7
White, Non-Hispanic	8,070	35.8%	70.5	50 - 59	8,603	38.7%	344.3
Black, Non-Hispanic	1,734	7.7%	58.3	60+	3,309	14.9%	76.7
Hispanic	1,875	8.3%	47.0	Unknown	0	0.0%	N/A
Asian/Pacific Islander	156	0.7%	N/A	Total	22,251	100.0%	117.8
Amer. Indian/Alaskan	0	0.0%	N/A				
Other/Unknown	10,686	47.4%	N/A				
Total	22,521	100.0%	119.2				

2008 data provisional.

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

**HIV COUNSELING AND TESTING DATA
Florida**

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

2007 Exposure Category	Number of Tests	Number Positive	Percent Positive	Gender	Number of Tests	Number Positive	Percent Positive
Male Sex With Male/IDU	1,158	124	10.7	Male	130,209	3,304	2.5
Male Sex With Male	19,560	1,560	8.0	Female	190,282	1,632	0.9
Injecting Drug User	12,621	272	2.2	Unknown	4,902	113	2.3
Sex Partner at Risk	5,536	311	5.6	Total	325,393	5,049	1.6
Child of Woman with HIV/AIDS	1,262	24	1.9	Race/ Ethnicity	Number of Tests	Number Positive	Percent Positive
STD Diagnosis	17,175	136	0.8	White	107,032	1,070	1.0
Sex for Drugs or Money	2,321	47	2.0	Black	124,978	2,749	2.2
Hemophilia/Blood Recipient	0	0	#DIV/0!	Hispanic	79,630	1,055	1.3
Victim of Sexual Assault	14,393	209	1.5	Asian	3,231	17	0.5
Health Care Exposure	6,268	58	0.9	Am. Native	765	9	1.2
Heterosexual	225,029	1,759	0.8	Other	1,920	12	0.6
No Acknowledged Risk	3,111	29	0.9	Unknown	7,837	137	1.7
Unknown	16,959	520	3.1	Total	325,393	5,049	1.6
Total	325,393	5,049	1.6	Total	325,393	5,049	1.6

2008 Exposure Category	Number of Tests	Number Positive	Percent Positive	Gender	Number of Tests	Number Positive	Percent Positive
Male Sex With Male/IDU	1,444	152	10.5	Male	150,664	3,690	2.4
Male Sex With Male	22,282	1,861	8.4	Female	213,716	1,749	0.8
Injecting Drug User	12,521	227	1.8	Unknown	2,778	101	3.6
Sex Partner at Risk	13,156	844	6.4	Total	367,158	5,540	1.5
Child of Woman with HIV/AIDS	1,817	31	1.7	Race/ Ethnicity	Number of Tests	Number Positive	Percent Positive
STD Diagnosis	54,066	473	0.9	White	110,253	1,143	1.0
Sex for Drugs or Money	5,623	135	2.4	Black	151,170	3,121	2.1
Hemophilia/Blood Recipient	0	0	0.0	Hispanic	90,163	1,102	1.2
Victim of Sexual Assault	11,723	81	1.3	Asian	3,331	22	0.7
Health Care Exposure	6,078	29	0.0	Am. Native	941	15	1.6
Heterosexual	222,980	1,268	0.6	Other	2,382	21	0.9
No Acknowledged Risk	4,123	23	0.6	Unknown	8,918	116	1.3
Unknown	11,345	416	3.7	Total	367,158	5,540	1.5
Total	367,158	5,540	1.5	Total	367,158	5,540	1.5

Section 2 – Table 1a: HIV and AIDS New Cases & HIV/AIDS Deaths (excl DOC).

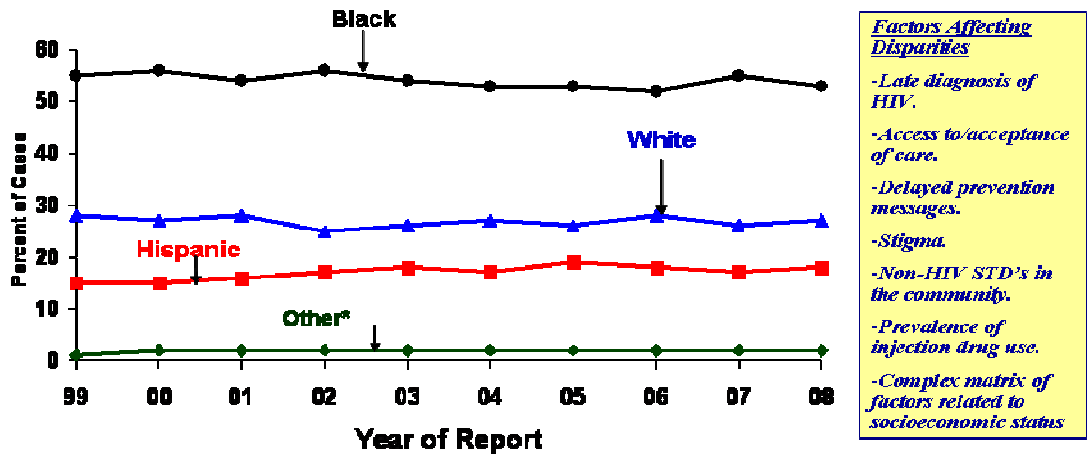
Florida

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Reported in 2007 & 2008					HIV Cases (regardless of current AIDS Status) Reported in 2007 & 2008					HIV/AIDS Case Deaths in 2007 & 2008				
	AIDS New Cases are defined as the number of new AIDS cases reported during the period specified, data as of 12/31/08.					HIV Cases (regardless of current AIDS Status) Reported: is defined as the number of new HIV cases reported during the period specified, data as of 12/31/08.					HIV or AIDS cases that died (regardless of cause) in 2008, data as of 03/31/08.				
Race/Ethnicity	2007	% of Total	2008	% of Total	% change	2007	% of Total	2008	% of Total	% change	2007	% of Total	2008	% of Total	% change
White, not Hispanic	985	26%	1,302	28%	32.2%	1856	32%	2,474	35%	33.3%	654	27%	685	29%	4.7%
Black, not Hispanic	2020	54%	2,446	52%	21.1%	2624	45%	3,122	44%	19.0%	1,290	53%	1,210	50%	-6.2%
Hispanic	653	17%	867	18%	32.8%	1262	22%	1,422	20%	12.7%	407	17%	440	18%	8.1%
Asian/Pacific Islander	20	1%	21	0%	5.0%	27	0%	33	0%	22.2%	5	0%	6	0%	20.0%
American Indian/Alaskan Native	1	0%	9	0%	800.0%	9	0%	16	0%	77.8%	0	0%	0	0%	#DIV/0!
Not Specified/Other	53	1%	56	1%	5.7%	46	1%	44	1%	-4.3%	69	3%	61	3%	-11.6%
Total:	3,732	100%	4,701	100%	26.0%	5,824	100%	7,111	100%	22.1%	2,425	100%	2,402	100%	-0.9%
Gender	2007	% of Total	2008	% of Total	% change	2007	% of Total	2007	% of Total	% change	2007	% of Total	2008	% of Total	% change
Male	2439	65.4%	3,197	68.0%	31.1%	4029	69.2%	5,151	72.4%	27.8%	1,634	67.4%	1,694	70.5%	3.7%
Female	1293	34.6%	1,504	32.0%	16.3%	1795	30.8%	1,960	27.6%	9.2%	791	32.6%	708	29.5%	-10.5%
Total:	3,732	100.0%	4,701	100.0%	26.0%	5,824	100.0%	7,111	100.0%	22.1%	2,425	100.0%	2,402	100.0%	-0.9%
Age at Diagnosis (Years)	2007	% of Total	2008	% of Total	% change	2007	% of Total	2008	% of Total	% change	2007	% of Total	2008	% of Total	% change
0- 2 years	3	0.1%	5	0.1%	66.7%	84	1.4%	45	0.6%	-46.4%	0	0.0%	1	0.0%	#DIV/0!
3-12 years	5	0.1%	8	0.2%	60.0%	78	1.3%	45	0.6%	-42.3%	0	0.0%	1	0.0%	#DIV/0!
13-19 years	52	1.4%	75	1.6%	44.2%	238	4.1%	244	3.4%	2.5%	10	0.4%	12	0.5%	20.0%
20-24 years	159	4.3%	218	4.6%	37.1%	588	10.1%	720	10.1%	22.4%	29	1.2%	28	1.2%	-3.4%
25-29 years	320	8.6%	367	7.8%	14.7%	726	12.5%	806	11.3%	11.0%	75	3.1%	92	3.8%	22.7%
30-39 years	989	26.5%	1,179	25.1%	19.2%	1,537	26.4%	1,730	24.3%	12.6%	374	15.4%	378	15.7%	1.1%
40-44 years	664	17.8%	873	18.6%	31.5%	870	14.9%	1,121	15.8%	28.9%	415	17.1%	372	15.5%	-10.4%
45-49 years	646	17.3%	757	16.1%	17.2%	717	12.3%	992	14.0%	38.4%	486	20.0%	397	16.5%	-18.3%
50-59 years	663	17.8%	891	19.0%	34.4%	724	12.4%	1,061	14.9%	46.5%	660	27.2%	722	30.1%	9.4%
60+ years	231	6.2%	328	7.0%	42.0%	262	4.5%	347	4.9%	32.4%	376	15.5%	399	16.6%	6.1%
Total:	3,732	100.0%	4,701	100.0%	26.0%	5,824	100.0%	7,111	100.0%	22.1%	2,425	100.0%	2,402	100.0%	-0.9%

HIV data (for 2008) includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually

Section 2: Figure 1: Trends or changes in the AIDS case data (RACE)

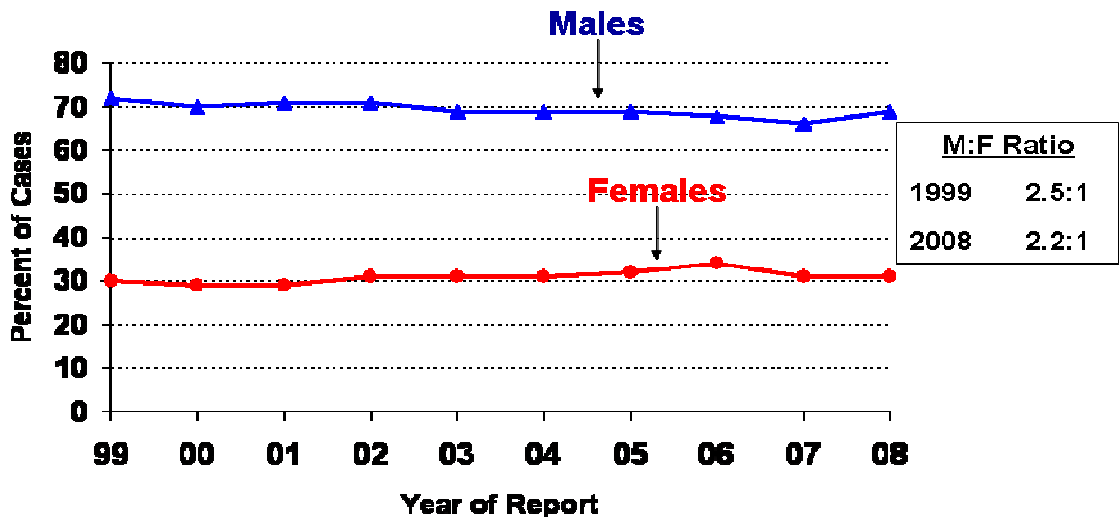
Percent of AIDS Cases by Race/Ethnicity* And Year of Report, Florida, 1999-2008



Comment: In 2008, blacks accounted for 53% of reported AIDS cases, but only 15% of the population. Hispanic cases remain stable at 18% in 2008. Disparities are even more evident among women: Annually, more than 70% of female AIDS cases have been reported among black women since 1988. HIV case reporting, implemented in mid-1997, has shown a very similar distribution of cases by race/ethnicity and sex. Over the past 10 years, AIDS cases have decreased among whites by 4% and blacks by 4%, however, a 6% increase of new AIDS cases was observed among Hispanics.
 *Other includes American Indian/Alaska Native, Asian/Pacific Islander, and Multi-racial.

Section 2: Figure 2: Trends or changes in the AIDS case data (GENDER)

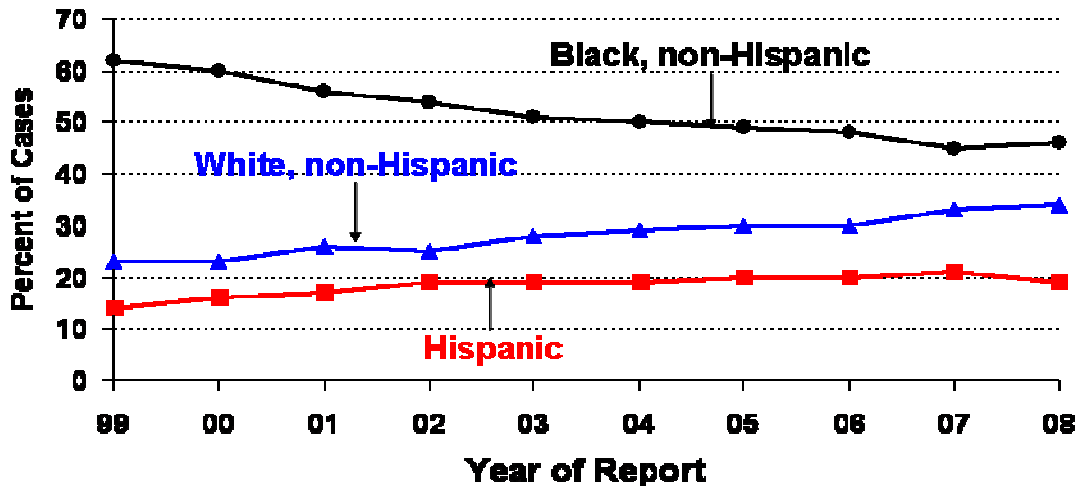
Percent of Adult AIDS Cases By Sex and Year of Report, Florida, 1999-2008



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

Section 2: Figure 3: Trends or changes in the HIV (regardless of AIDS status) case data (RACE)

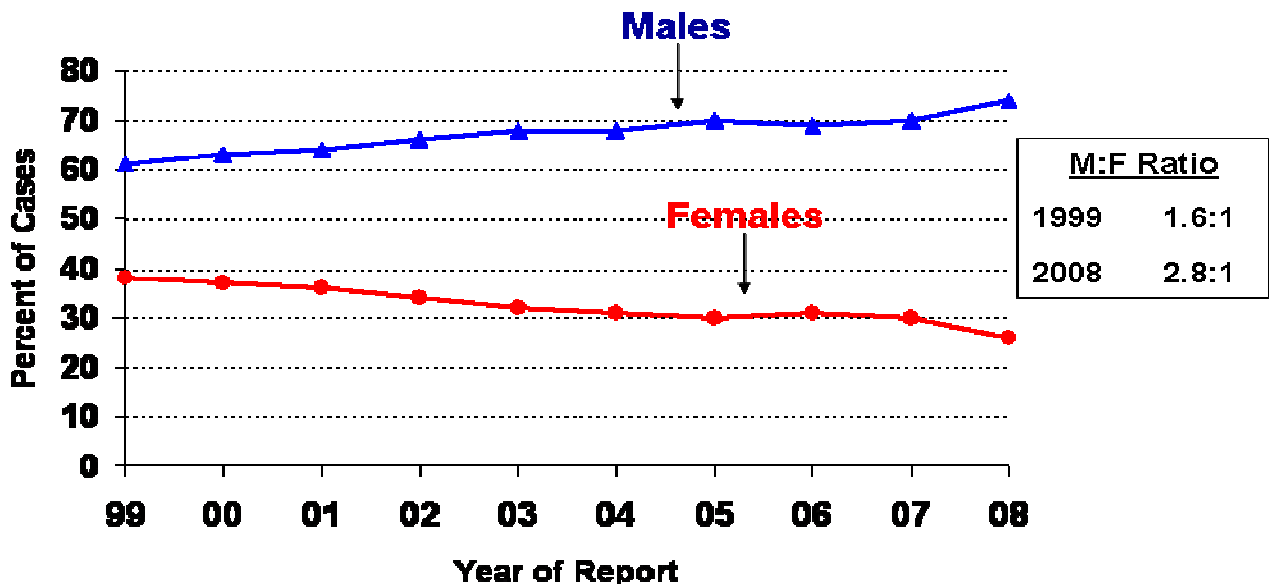
Percent of Adult HIV Cases by Race/Ethnicity* and Year of Report Florida, 1999-2008



Comment: The percent of black HIV cases has decreased by 25% from 1999 to 2008. In contrast, increases were observed among both white (47%) and Hispanic (26%) HIV cases over this same time period. *Other races represent less than 1% of the cases and are not included.

Section 2: Figure 4: Trends or changes in the HIV (regardless of AIDS status) case data (GENDER)

Percent of Adult HIV Cases By Sex and Year of Report, Florida, 1999-2008



Comment: The trend for HIV cases by sex is the opposite of that for AIDS cases. Recent trends in HIV transmission are best described by the HIV case data. The relative increases in male HIV cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM), which may influence future AIDS trends.

Attachment 6 Co-Morbidities / Other Factors / Surrogate Markers Florida

Documented Co-morbidity cases in 2008	Prevalence of the HIV/AIDS Population in this Area	Prevalence Rate of this Indicator per 100,000 living HIV/AIDS Cases from this Area	Data Source	Date of Data	Prevalence Rate of this Co-morbidity within the general population of this Disease in this Area
	N= 86,410				
AIDS Cases diagnosed through 2008 with Tuberculosis diagnosed in 2008	61	70.6	HARS	Data through 2008 (data as of 04/09)	5.0
Infectious Syphilis reported in 2008 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	229	265.0	PRISM	Data through 2008 (data as of 04/09)	5.2
Gonorrhea reported in 2008 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	468	541.6	PRISM	Data through 2008 (data as of 04/09)	120.1
Chlamydia reported in 2008 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	409	473.3	PRISM	Data through 2008 (data as of 04/09)	364.6
Hepatitis C (defined as <i>any</i> HIV/AIDS case noted with a history of acute and/or chronic viral Hepatitis C and documented in HARS and/or MERLIN)	5,304	6,138.2	HARS (local use variable) and/or matched with reported cases in the Hepatitis database	Data through 2008 (data as of 04/09)	651.7

Other Factors / Surrogate Markers Documented in 2008	Prevalence of the HIV/AIDS Population in this Area	Prevalence Rate of this Indicator per 100,000 living HIV/AIDS Cases from this Area	Data Source	Date of Data
Homelessness (defined as any living HIV/AIDS case who was homeless at diagnosis of HIV or AIDS and documented in HARS)	1,316	1,523.0	HARS (address variable)	Data through 2008 (data as of 04/09)
Substance Abuse (defined as any living HIV/AIDS case noted with a history of substance abuse, e.g., alcohol, methamphetamine, cocaine, inhalants, etc. and documented in HARS)	11,617	13,444.0	HARS (local use variable)	Data through 2008 (data as of 04/09)
Chronic Mental Illness (defined as any living HIV/AIDS case noted with a history of mental illness and documented in HARS)	2,089	2,417.5	HARS (local use variable)	Data through 2008 (data as of 04/09)
MSM (estimated seroprevalence of males with HIV/AIDS who have an MSM or MSM/IDU risk)	41,069	47,528.2	(Determined by PLWHA data)	Data through 2008 (data as of 04/09)
IDU (estimated seroprevalence of persons with HIV/AIDS who have and IDU or MSM/IDU risk)	11,908	13,780.8	(Determined by PLWHA data)	Data through 2008 (data as of 04/09)
Release of FL Department of Corrections Cases into the Local Area	Total Offenders Released	HIV-infected Offenders Released	Data Source	Date of Data
		Number % HIV+		
Offenders who returned to the Area in 2008	37,277	1,397 3.7%	Dept. of Corrections Offender-based Information System	CY 2008, data as of 03/09
Offenders who returned to the Area in 2007	36,510	1,451 4.0%	Dept. of Corrections Offender-based Information System	CY 2007, data as of 02/08
Offenders who returned to the Area in 2006	34,311	1,487 4.3%	Dept. of Corrections Offender-based Information System	CY 2006, data as of 01/07

Section 2 – Table IV: Socio-Economic Data of the General Population

Data on Unemployment, Poverty levels and Insurance coverage are not readily available for the PLWHA cases

Race/ Ethnicity	Civilian Labor Force Unemployed		Population Living Below 100% Poverty		Without insurance coverage including without Medicaid.	
	Number	Percent	Number	Percent	Number	Percent
White	535,343	4.7%	1,374,093	9.6%	1,156,900	14.7%
Black	169,002	9.1%	623,982	23.4%	540,600	26.0%
Hispanic	150,390	5.4%	590,568	16.5%	1,057,700	33.2%
Other*	37,117	6.5%	137,200	18.2%	64,000	18.0%
Total	891,852	6.4%	2,725,843	16.9%	2,819,200	23.0%

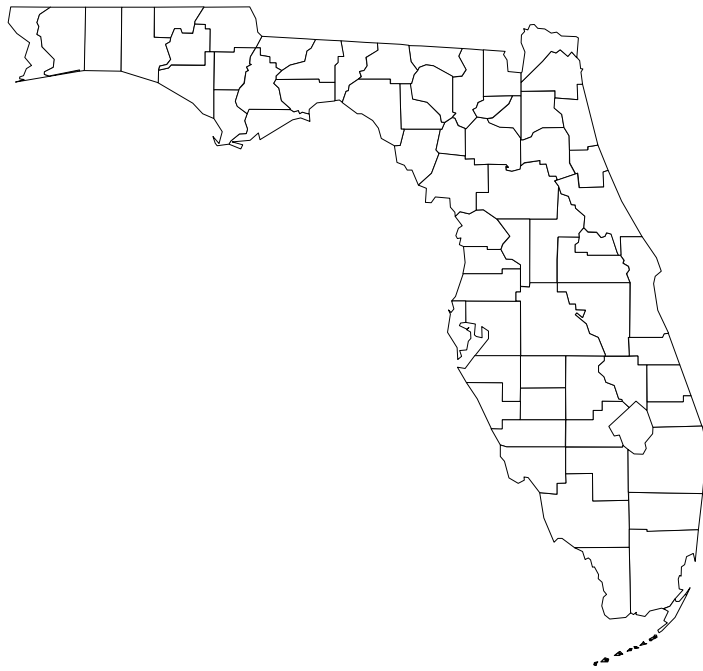
Selected Socioeconomic Indicators, Florida (U.S. Census 2000)

*Other race includes Asian/Hawaiian, Native American/Alaska Native, Other and multiple races.

Section 2 – Table 1b: Background Data Used for the Calculations of AIDS Prevalence, and HIV (not AIDS) Prevalence (excl DOC), Florida.

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Case Prevalence (excl DOC) through 2008 as of 04/09		HIV (not AIDS) Case Prevalence (excl DOC) through 2008 as of 04/09		HIV/AIDS Case Prevalence PLWHA (excl DOC) through 2008 as of 04/09	
	AIDS Case Prevalence is defined as the number of reported AIDS Cases as of the date specified.		HIV Case Prevalence is defined as the number of reported living HIV (not AIDS) cases as of the date specified.		HIV/AIDS Case Prevalence is defined as the number of reported living HIV (not AIDS) and AIDS cases as of the date specified.	
Race/Ethnicity	# number	% of Total	# number	% of Total	# number	% of Total
White, not Hispanic	15,138	31.4%	11,706	30.6%	26,844	31.1%
Black, not Hispanic	23,100	47.9%	18,168	47.5%	41,268	47.8%
Hispanic	9,187	19.1%	7,797	20.4%	16,984	19.7%
Asian/Pacific Islander	143	0.3%	158	0.4%	301	0.3%
American Indian/Alaskan Native	33	0.1%	49	0.1%	82	0.1%
Not Specified/Other	578	1.2%	353	0.9%	931	1.1%
Total:	48,179	100.0%	38,231	100.0%	86,410	100.0%
Gender	# number	% of Total	# number	% of Total	# number	% of Total
Male	33,975	70.5%	25,262	66.1%	59,237	68.6%
Female	14,204	29.5%	12,969	33.9%	27,173	31.4%
Total:	48,179	100.0%	38,231	100.0%	86,410	100.0%
Current Age on 12/31/08 (Years)	# number	% of Total	# number	% of Total	# number	% of Total
0- 2 years	4	0.0%	28	0.1%	32	0.0%
3-12 years	114	0.2%	254	0.7%	368	0.4%
13-19 years	521	1.1%	539	1.4%	1,060	1.2%
20-24 years	646	1.3%	1,763	4.6%	2,409	2.8%
25-29 years	1,457	3.0%	3,461	9.1%	4,918	5.7%
30-39 years	8,059	16.7%	9,678	25.3%	17,737	20.5%
40-44 years	8,842	18.4%	6,705	17.5%	15,547	18.0%
45-49 years	10,488	21.8%	6,475	16.9%	16,963	19.6%
50-59 years	13,065	27.1%	6,762	17.7%	19,827	22.9%
60+ years	4,983	10.3%	2,566	6.7%	7,549	8.7%
Total:	48,179	100.0%	38,231	100.0%	86,410	100.0%

Chapter Three: Community Service Assessment



Introduction:

The PPG Community Service Assessment was developed using data from an online community needs assessment survey, an analysis of Florida’s HIV prevention funding by target population, National HIV Behavioral Surveillance (NHBS) in Miami-Dade and Broward counties (the state’s HIV/AIDS epicenter), and other research studies, as well as community input. Based on these sources, we have identified the following HIV prevention service needs.

Community Needs Assessment Survey Findings:

- Inadequate transportation (70.2%), insufficient funding (61.3%), and homeless issues (56.5%) were the most commonly reported barriers to providing HIV prevention services.
 - Interventions that address underlying risk factors for HIV infection, such as a lack of housing and transportation, should be developed.
- Internet-based interventions and social network recruitment for counseling, testing, and linkage were the two most common unmet needs reported (37.3% each) in the community needs assessment survey. Other leading responses included “group support” (33.9%), “Comprehensive Risk Counseling and Services” (26.3%), “motivational interviewing” (26.3%), and “cell-phone-based interventions” (25.6%).
 - Interventions need to be developed or adapted to address methods of communicating and meeting sex partners through the use of technology, while continuing to offer face-to-face individual and group-level prevention services.
- Agencies reporting service activities beyond HIV/AIDS (74.5%) were more likely than agencies solely providing HIV/AIDS services (31.4%) to report needing technical assistance in the community needs assessment survey.
 - The specific needs for technical assistance were not addressed in the survey and are in need of further study. DOH should work to explore and address these technical assistance needs.

To view the Community Needs Assessment Survey Findings, see Appendix A.

2009 HIV Prevention Funding Snapshot Findings

Figure 1. PLWHA Through 2007 by Priority Population, N=84,945

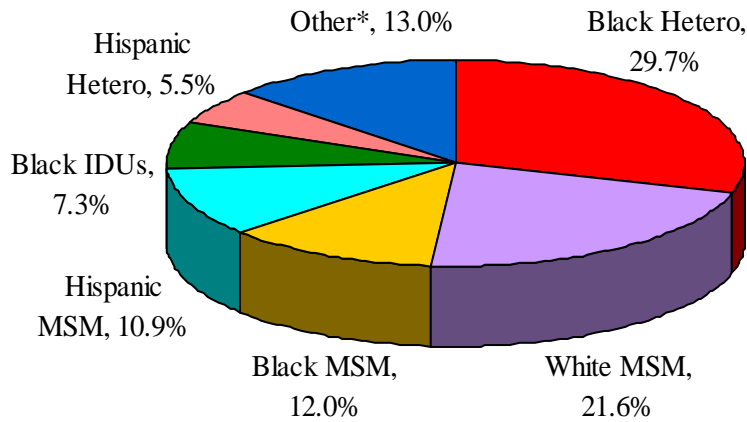
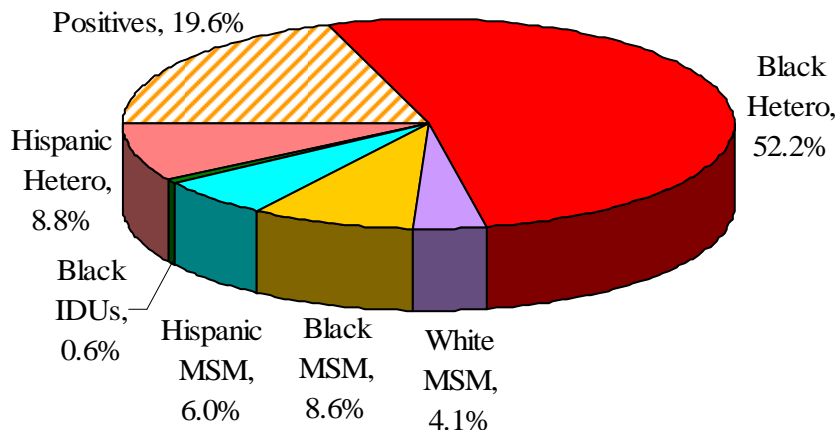


Figure 2. 2009 Targeted Funding by Priority Population, \$21,588,420



- As shown in Figure 2, while over half (52.2%) of the 2009 prevention funding targeted to the 2009 statewide priority populations was allocated to HIV-negative black heterosexuals (priority population #2), one-fifth (19.6%) of the funding was allocated to HIV-positive persons (priority population #1).
 - DOH should ensure that adequate funding is allocated to HIV-infected populations so that HIV-infected persons are offered prevention services and remain in care.
- MSM account for 44.5% of persons reported to be living with HIV/AIDS in Florida through 2007 (Figure 1), yet only 18.7% of the 2009 prevention funding targeted to the 2009 statewide priority populations was allocated to HIV-negative MSM (8.6% for black MSM, 6.0% for Hispanic MSM, and 4.1% for white MSM) (Figure 2).

- DOH should identify new funding sources to address the disproportionate prevention funding for white, Hispanic, and black MSM.
- While black IDUs account for 7.3% of persons reported to be living with HIV/AIDS in Florida through 2007 (Figure 1), only 0.6% of the 2009 prevention funding targeted to the 2009 statewide priority populations was allocated to HIV-negative black IDUs (Figure 2).
 - DOH should identify new funding sources to address the disproportionate prevention funding for black IDUs.

To view the 2009 HIV Prevention Funding Snapshot, see Appendix F.

Findings from National HIV Behavioral Surveillance (NHBS) in South Florida

- NHBS data collected in Miami-Dade and Broward counties (2004-2007) suggest that a variety of prevention efforts are needed to reach sizeable numbers of persons at risk for HIV infection. Participation in an HIV prevention intervention in the past 12 months was reported by less than one-fifth of participants (4-18%) in each risk group sampled (MSM, IDUs, and heterosexually-active adults in areas with high rates of HIV/AIDS and poverty). However, receipt of HIV testing (40-70%) and of free condoms (21-84%) in the past 12 months were reported by a much greater proportion of participants.
 - DOH, community planning groups, and service providers should continue to enhance outreach (with accompanying services and linkages) to each of the priority populations throughout the state.
- Of the NHBS participants who did not test for HIV in the past 12 months, the most frequently reported reasons for not seeking an HIV test were 1) perceived low risk for HIV infection, 2) fear of an HIV-positive diagnosis, and 3) not having time.
 - DOH and service providers should ensure that a variety of prevention messages are used to promote and address barriers to accessing services such as HIV testing.
- NHBS data suggest that conspiracy beliefs and HIV prevention and transmission myths may be common in certain communities. A sizeable proportion of heterosexually-active adults sampled within areas with high rates of HIV/AIDS and poverty believed in the effectiveness of at least one HIV prevention myth (27%) or transmission myth (39%). Notably, approximately two-thirds of participants believed that information about HIV/AIDS is being held back from the public (64%) and that a cure for HIV/AIDS is being withheld from the poor (67%). Over one-third (35%) of participants indicated that HIV could be transmitted through mosquitoes. Holding conspiracy beliefs and false beliefs on HIV transmission and prevention adds to stigma and has been associated with behaviors that can lead to increased HIV prevalence (e.g., decreased or improper condom use, avoidance of HIV testing).
 - Prevention efforts should address conspiracy beliefs and common prevention and transmission myths.
- A wealth of research, including NHBS, reveals increased rates of HIV infection and/or risk behaviors among various populations with underlying factors or characteristics associated with HIV infection. In addition to race/ethnicity and risk group, such populations may be identified by geographic location, poverty, incarceration, homelessness, social network, and substance abuse (e.g., crack/cocaine, methamphetamine, ecstasy, amyl nitrates, alcohol).

- Prevention efforts should consider and further utilize the vast array of information and methods available to effectively target at-risk populations.
- Less than 4% of IDUs sampled reported receiving free sterile syringes or injection equipment in the past 12 months.
 - DOH should work to eliminate barriers to implementing evidence-based prevention programs for IDUs, including harm reduction programs.

To view the 2004-2007 National HIV Behavioral Surveillance findings from South Florida, see Appendix B.

Findings from other recent research/community input

- Young MSM (YMSM) are particularly at risk for HIV infection. Research has found that gay, lesbian, and bisexual (GLB) youth who had supportive or non-hostile responses from parents around their sexual orientation had better long term health outcomes than those whose parents were hostile toward them being GLB (Ryan, 2009).
 - These data suggest that YMSM should be linked to prevention and support services. It is implied that providing support to families and increasing acceptance of gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth could greatly impact their health outcomes. Further, more information should be learned about the family experience of black GLBTQ youth. Young black MSM have some of the highest HIV infection rates and often report a lack of familial support.
- Studies have found that anti-gay ballot initiatives may have a negative impact on the mental well-being of GLBT persons (Rostosky, Riggle, Horne, & Miller, 2008), and negatively influence HIV infection rates (Francis & Mialon, 2009). Numerous studies have examined the association between sexual orientation and teen substance use and found that GLB youth reported higher rates of cigarette, alcohol, and marijuana use, as well as other illicit drugs, some subpopulations of GLB youth (lesbians and bisexuals) use at 300-400% the rate of heterosexual youth. These disparities likely stem from the discrimination and stigma faced by young GLB persons. (Marshal et al., 2008)
 - DOH should continue efforts to address homophobia and promote activities that further acceptance and social support for MSM. Interventions that address anti-MSM stigma and discrimination while simultaneously recognizing and addressing substance use in MSM populations should be developed.
- HIV/AIDS literature available on male-to-female (MTF) transgender women suggests that this population may be disproportionately impacted, yet very little prevention or research funding is directed at this population. A recent meta-analysis of transgender HIV prevention research conducted from 1990-2003 (Herbst et al., 2008) revealed that over one-fourth (28%) of MTFs in studies with HIV testing components tested HIV positive. Furthermore, stigma has been found to interplay with HIV risk behaviors (e.g., unprotected sex, survival sex work, substance use) among transgender populations.
 - More data, interventions, and resources need to be directed to preventing HIV among Florida's transgender populations and addressing transgender stigma.

Summary of Recommendations

- Interventions should be developed that address underlying risk factors for HIV infection, such as a lack of housing and transportation.
- Interventions need to be developed to address changes in how persons at risk use technology to communicate and network, while still offering face-to-face individual and group support.
- DOH should work to explore and address the technical assistance needs of providers, especially those who offer more than just HIV/AIDS services.
- DOH should ensure that all HIV-infected persons have access to appropriate prevention services and that they remain in care to reduce the spread of infection to their partners.
- DOH should identify new funding sources to address the disproportionate prevention funding for white, Hispanic, and black MSM.
- DOH should identify new funding sources to address the disproportionate prevention funding for black IDUs.
- DOH should work to eliminate barriers to implementing evidence-based prevention programs for IDUs, including harm reduction programs.
- DOH, community planning groups, and service providers should continue to enhance outreach (with accompanying services and linkages) to each of the priority populations throughout the state.
- DOH and service providers should ensure that a variety of prevention messages are used to promote and address barriers to accessing services such as HIV testing.
- Prevention efforts should address conspiracy beliefs and common prevention and transmission myths.
- Prevention efforts should consider and further utilize the vast array of information and methods available to effectively target at-risk populations.
- DOH should continue efforts to address homophobia and promote activities that further acceptance and social support for MSM. Interventions that address anti-MSM stigma and discrimination while simultaneously recognizing and addressing substance use in MSM populations should be developed.
- DOH should work with service providers and community members to ensure that all YMSM have access to appropriate prevention and support services, including individual and family counseling, as needed.
- More data, interventions, and resources need to be directed to preventing HIV among Florida's transgender populations and addressing transgender stigma.

Goals and Objectives

Goal #1: Reduce the number of new HIV infections in Florida by 10% by 2012, focusing particularly on eliminating racial and ethnic disparities in new HIV infections.

Key Action Steps	Evaluation Method (Outcome Measure)	Staff/Agency Responsible	Completion Date
(1) Maintain an HIV prevention planning process, which ensures that resources and processes are targeted to meet the needs of priority populations.			
❖ Maintain the HIV prevention Community Planning process	Convene the PPG at least twice per year.	Prevention	Dec. 31, 2012
❖ Encourage and mentor the local Community Planning Process	Provide technical assistance sessions, at least 5 per year, to encourage continued local community planning.	Prevention	Dec. 31, 2012
❖ Utilize the demonstration project process to elicit innovative, short-term pilot projects.	Intervention team of the Prevention Section will compile list of all demonstration projects submitted.	Prevention	Dec. 31, 2012
(2) Ensure that HIV prevention services are provided to high-risk populations, including HIV-infected persons. Utilize strategies that have been proven to be effective, culturally sensitive in manner, and allow for adapting and tailoring innovative, untested demonstration projects.	Monitoring outcomes indicate that providers met the deliverables.	Prevention	Dec. 31, 2012
❖ Monitor and evaluate prevention programs twice annually.	Monitoring completed.	Prevention	Dec. 31, 2012
❖ Train prevention staff to effectively implement evidence-based interventions and ensure training is offered in multiple delivery mediums, i.e. webinars.	Conduct survey of training needed throughout the state.	Prevention	Dec. 31, 2012
❖ Provide appropriate HE/RR tools to CHDs, contracted CBOs and the general public, i.e. HIV 101, brochures, etc.	Statewide materials resource inventory conducted, outcomes compiled and reported.	Prevention	Dec.31, 2012
❖ Conduct statewide multi-media awareness campaign.	Report on statewide media activities at PPG meetings.	Prevention	July 1, 2012
❖ Coordinate nationally recognized awareness events such as; World AIDS Day, Black HIV/AIDS Awareness Day and others.	Report of observance activities.	Prevention	Dec. 31, 2012

❖ Provide statewide access to Information & Referral to Spanish, English and Haitian/Creole speaking persons as well as the hearing impaired.	Maintain Hotline contract.	Prevention	July 1, 2012
(4) Ensure that baseline data is collected and trends monitored on an ongoing basis.			
❖ Collect, analyze and disseminate data from surveillance and special epidemiologic studies.	Potential data sources evaluated for applicability and funding for studies requested.	Surveillance & Prevention	July 1, 2012

Goal#2: By 2012, through voluntary counseling and testing, increase by 10% the proportion of HIV-infected people in Florida who know they are infected.

(1) Encourage at-risk persons to know their infection status by reducing real and perceived barriers to HIV testing.			
❖ Recommend that CHDs and CBOs train CTL staff that is cultural competent of the population served.	Review and update as needed the cultural competency section of the 500/501 training manual.	Prevention	July 1, 2012
❖ Services are provided in languages spoken and/or read by the population served, including sign language.	Include language requirements in job descriptions and/or provide linkage to translation services.	Prevention	July 1, 2012
❖ Provide written materials that are linguistically, culturally and developmentally appropriate.	Ensure providers receive appropriate materials.	Prevention	July 1, 2012
❖ Ensure referrals are provided in a way that takes into account cultural differences.	Identify agencies that have a history of serving the target population.	Prevention	July 1, 2012
(2) Ensure that HIV counseling, testing, and linkage services are provided to at-risk populations through outreach.			
❖ Provide testing through TOPWA and jail programs.	Reports from TOPWA and jail programs on testing conducted in each setting.	Prevention	Dec. 31, 2012
❖ Conduct HIV prevention and linkage projects for substance abusers.	Coordinate with trained substance abuse providers.	Prevention	July 1, 2012
❖ Work with health education staff to ensure that outreach is conducted in appropriate locations and targeted towards appropriate populations.	Continue contract monitoring activities and establish benchmarks.	Prevention	Dec. 31, 2012
❖ Recommend providers collaborate and partner with other agencies and programs to conduct targeted outreach.	Continue monitoring efforts and establish benchmarks.	Prevention	Dec. 31, 2012

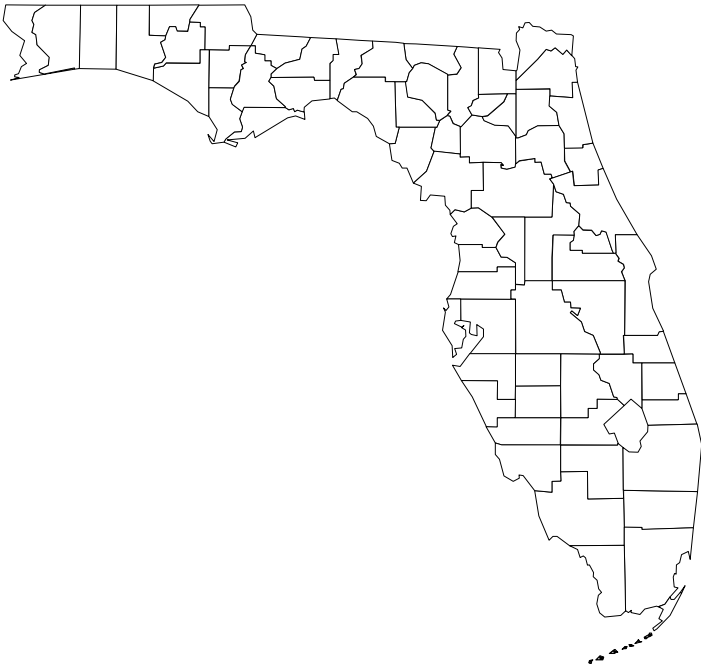
❖ Train contracted providers to conduct culturally competent outreach.	Continue training activities to augment and enhance providers' expertise.	Prevention	June 30, 2012
❖ Provide adequate training to all outreach workers who will be providing CTL.	Include cultural competency training in outreach training modules.	Prevention	July 1, 2012
❖ Identify real and perceived barriers to testing.	Barriers identified through surveys and interviews.	Prevention	July 1, 2012
❖ Provide education to health care providers regarding the value of risk assessment.	Increased knowledge among providers.	Surveillance & Prevention	Dec. 31, 2012
(3) Increase the percentage of persons who receive their results after testing for HIV.		Prevention	July 1, 2012
❖ Develop and implement strategies to reduce barriers to persons receiving test results.	Ensure current/best practices are shared with providers.	Prevention	Dec. 31, 2012
(4) Ensure linkage to care of all newly tested HIV-infected individuals.		Prevention	Dec. 31, 2012
(5) Ensure that baseline data is collected and trends are monitored on an ongoing basis.	Multi-disciplinary workgroup maintained.	Prevention	July 1, 2012
❖ Collect, analyze and disseminate data from surveillance and special epidemiologic studies.	Potential data sources are evaluated for applicability and funding requested for studies	Prevention	July 1, 2013

Goal #3: By 2012, increase by 10% the proportion of HIV-infected people in Florida who are linked to appropriate prevention, care and treatment services.

(2) Ensure that all persons who test positive through publicly funded HIV counseling, testing and linkage sites are linked to appropriate medical and support services.			
❖ Encourage test sites to develop and implement systems for tracking referrals.	Systems are in place as indicated by QI visits and contract monitoring.	Prevention	July 1, 2012
❖ Identify barriers to completion of referrals. Develop appropriate strategies to address identified barriers.	Strategies are developed and implemented with funded providers.	Prevention	Dec. 31, 2012
❖ Maintain Minority AIDS Initiative (MAI) program according to HRSA guidance.		Patient Care & Prevention	Dec. 31, 2012

(3) Ensure that all HIV-positive incarcerated persons are linked to appropriate community services prior to release.			
❖ Provide pre-release planning services in all DOC facilities.	Contract monitored annually.	Prevention	July 1, 2012
❖ Maintain and expand the network of providers willing and able to serve ex-offenders.	Maintain the interagency Corrections Infections Workgroup and the Disease Lockdown publication.	Prevention	July 1, 2012

Chapter Four: Priority Populations



PRIORITY SETTING PROCESS

The current priority setting methodology was designed and implemented by the Prevention Planning Group (PPG) in 2008 to ensure the selection of target populations and the allocation of resources were in a fair and uniform manner across the state. Guidelines to use the Three-Fold Path Methodology tool were developed by the PPG Methodology Workgroup. The purpose of the guidelines was to assist each partnership to assess a local population's need for prevention efforts. All local prevention planning groups submitted prioritized populations for their areas except area 11A.

The three-fold path methodology consists of the following:

A. Path 1: HIV Case Data (50% of Weight)

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

The CDC requires priority setting to be "data driven." HIV case data is a stronger indicator of where new infections are occurring than AIDS case data. At this point, HIV case reporting has been in place for 10 years.

B. Path 2: Disproportionate Impact (25% of Weight)

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

This methodology relies on disproportionate impact to assist in prioritizing populations. The greater the impact of HIV on a particular population, the larger priority it will become. As the impact of HIV on a population decreases, the population will move lower on the priority list.

C. Path 3: Community Planning Partnership Deliberation (25% Weight)

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

After reviewing the results of the three-fold methodology furnished by the local planning groups, and then aggregating the results, the following were determined to be Florida's Priority Populations.

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

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

Local Area Priorities

1. Area 1

- (1.) White MSM
- (2.) Black MSM
- (3.) Black Heterosexual
- (4.) White IDU
- (5.) Black IDU
- (6.) White Heterosexual

2. Area 2A

- (1.) White MSM
- (2.) Black MSM
- (3.) Black Heterosexual
- (4.) Black IDU
- (5.) White Heterosexual
- (6.) White IDU

3. Area 2B

- (1.) Black MSM
- (2.) Black Heterosexual
- (3.) White MSM
- (4.) Hispanic MSM
- (5.) Black IDU
- (6.) White Heterosexual

4. Areas 3 & 13

- (1.) Black MSM
- (2.) Black IDU
- (3.) White MSM
- (4.) Black Heterosexual
- (5.) White Heterosexual
- (6.) White IDU

5. Area 4

- (1.) Black MSM
- (2.) Black Heterosexual
- (3.) White MSM
- (4.) Black IDU
- (5.) White Heterosexual
- (6.) White IDU

6. Areas 5, 6 & 14

- (1.) Black Heterosexual

- (2.) Black MSM
- (3.) White MSM
- (4.) Hispanic Heterosexual
- (5.) Hispanic MSM
- (6.) White Heterosexual

7. Area 7

- (1.) White MSM
- (2.) Black MSM
- (3.) Black Heterosexual
- (4.) Hispanic MSM
- (5.) Black IDU
- (6.) Hispanic Heterosexual

8. Area 8

- (1.) White MSM
- (2.) Hispanic MSM
- (3.) Black MSM
- (4.) Black Heterosexual
- (5.) Hispanic Heterosexual
- (6.) White Heterosexual

9. Area 9

- (1.) Black Heterosexual
- (2.) Black MSM
- (3.) White MSM
- (4.) Hispanic MSM
- (5.) Hispanic Heterosexual
- (6.) Black IDU

10. Area 10

- (1.) White MSM
- (2.) Black Heterosexual
- (3.) Black MSM
- (4.) Hispanic Heterosexual
- (5.) Hispanic MSM
- (6.) White Heterosexual

11. Area 11A

- (1.) Black Heterosexual

- (2.) Hispanic MSM
- (3.) Black MSM
- (4.) Black IDU
- (5.) Hispanic Heterosexual
- (6.) White MSM

12. Area 11B

- (1.) White MSM
- (2.) Black Heterosexual
- (3.) Black MSM
- (4.) Hispanic Heterosexual
- (5.) Hispanic MSM
- (6.) Black IDU

13. Area 12

- (1.) Black MSM
- (2.) White MSM
- (3.) Hispanic MSM
- (4.) Black Heterosexual
- (5.) White Heterosexual
- (6.) Hispanic Heterosexual

14. Area 15

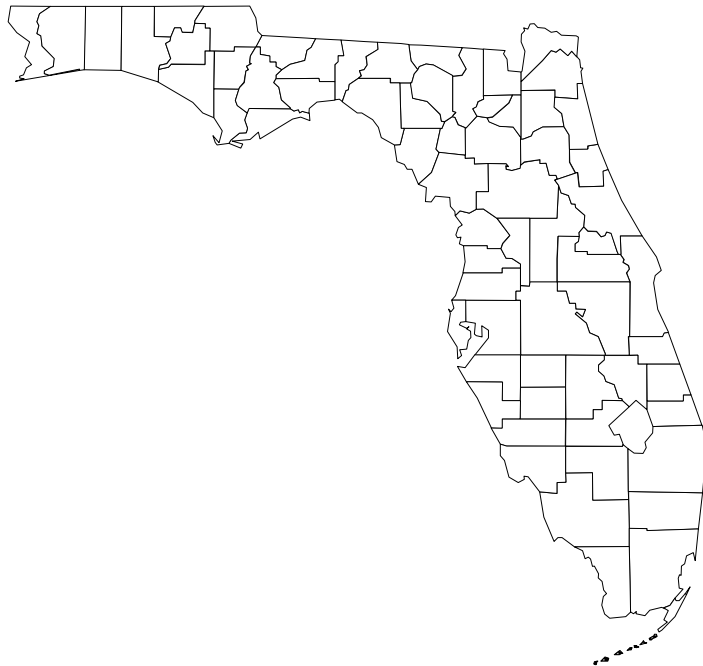
- (1.) Black Heterosexual
- (2.) Black MSM
- (3.) Black IDU
- (4.) White MSM
- (5.) Hispanic MSM
- (6.) White IDU

Recommended Interventions/Strategies to Reach Priority Populations

- **Black Heterosexuals-** VOICES, BART, WILLOW, CRCS, POL, Community PROMISE, RAPP, Healthy Relationships, Partnership for Health, RESPECT, SISTA, Youth Empowerment Project (Demo), FLOW (Demo), HIV/AIDS Ministries- FAITH (Demo), MISTERS Program (Demo), Safe in the City, CRCS, Social Networks Strategy, Targeted Outreach, Faith Talk (CTG), Community Awareness Events and Mobilization Activities, HIV 101 Classes, Roundtable Discussions w/Community Leaders (CTG), CTL, ARTAS
- **White Heterosexuals-** VOICES, WILLOW, CRCS, POL, Community PROMISE, Healthy Relationships, Partnership for Health, RESPECT, MISTERS Program (Demo), Safe in the City, CRCS, Social Networks Strategy, Targeted Outreach, Community Awareness Events and Mobilization Activities, HIV 101 Classes, CTL
- **Hispanic Heterosexuals-** VOICES, WILLOW, CRCS, POL, Community PROMISE, Healthy Relationships, Partnership for Health, RESPECT, MISTERS Program (Demo), Safe in the City, CRCS, Social Networks Strategy, Targeted Outreach, Youth Empowerment Project (Demo), FLOW (Demo), Community Awareness Events and Mobilization Activities, HIV 101 Classes, LUCES Videos, CTL

- **Black MSM-** D-Up!, Mpowerment, 3MV, POL, Social Networks Strategy, VOICES, Safe in the City Partnership for Health, CRCS, LIFE, UJIMA Men's Collective, Community Awareness Events and Mobilization Activities, HIV 101 Classes, Targeted Outreach, CTL, ARTAS
- **White MSM-** Mpowerment, POL, Social Networks Strategy, VOICES, Safe in the City Partnership for Health, CRCS, LIFE, Community Awareness Events and Mobilization Activities, HIV 101 Classes, Targeted Outreach, CTL
- **Hispanic MSM-** Mpowerment, POL, Social Networks Strategy, VOICES, Safe in the City, Partnership for Health, CRCS, LIFE, Community Awareness Events and Mobilization Activities, HIV 101 Classes, Targeted Outreach, CTL
- **Black IDU-** CRCS, Safety Counts, MISTERS (Demo), NHBS (Miami), Targeted Outreach , HIV 101 Classes, ARTAS
- **White IDU-** CRCS, Safety Counts, MISTERS (Demo), NHBS (Miami), Targeted Outreach, HIV 101 Classes, MIP (training in September)
- **Hispanic IDU-** CRCS, Safety Counts, MISTERS (Demo), NHBS (Miami), Targeted Outreach, HIV 101 Classes, MIP (training in September)
- **HIV-positives-** LIFE, CRCS, Healthy Relationships, WILLOW, Partnership for Health, ARTAS

Chapter Five: Linkages and Coordination



Linkages and Coordination

General Population

Sexually Transmitted Diseases (STD)- The Bureaus of HIV/AIDS and STD have for over 20 years, been fully integrated at the service delivery level for partner services. HIV prevention programs and testing venues provide educational materials on STD prevention. Many of our jail HIV testing programs do concurrent STD testing and all of our STD clinics offer HIV testing. Most mobile testing programs offer testing for STDs, including HIV. In 2008, there were over 85,000 HIV tests conducted in STD clinics throughout Florida. Staff members refer individuals who utilize HIV/STD screenings to HIV/STD prevention interventions if they are determined to be at high risk for HIV and/or STD transmission.

Preventing STDs is one of the best strategies for preventing HIV transmission. The bureau funds over 70 STD staff that provide disease prevention/intervention services directly related to reducing the incidence of STDs, including HIV. Joint screenings, partner services, training, provider education, cluster investigation, and field treatment are just a few of the activities conducted by HIV/STD staff around the state.

Targeted Outreach for Pregnant Women Act (TOPWA) programs offer HIV and pregnancy testing as well as prevention, education and linkage to care. All TOPWA and Minority AIDS Initiative (MAI) programs conduct HIV/STD prevention education through street outreach. MAI providers coordinate with CHDs and STD clinics to provide STD testing and treatment.

Many of the evidence-based HIV prevention interventions focus on STD risk reduction methods in addition to HIV prevention. Interventions such as VOICES/VOCES, Safe in the City, Project SAFE, and RESPECT are designed to be used in either STD or public health clinic settings. Local area health educators discuss STD prevention when educating about HIV and provide participants with accurate information on STDs, their symptoms, and treatment.

Hepatitis- Many of the state's HIV testing programs already incorporate hepatitis screening and/or immunization. Jail screening programs, STD clinics, and mobile unit rapid testing programs have been very proactive in integration activities. A Miami-based hepatitis community-based organization is one of the largest rapid testing providers in the state and offers a full array of services to their at risk target population. The perinatal coordinators for HIV and hepatitis B meet regularly to take advantage of opportunities to collaborate on behalf of their shared at-risk population. Many of the evidence-based HIV interventions integrate risk reduction methods for hepatitis in addition to HIV; this can be seen most often in interventions intended for injection drug users who are at high risk for both HIV and Hepatitis C Virus (HCV). DOH and CBO staffs use drug treatment centers to recruit individuals at risk of HIV/HCV co-infection into prevention interventions. Since hepatitis is often linked to injection drug users, the bureau funds drug treatment centers to implement evidence-based interventions.

Selected Jail Linkage programs have staff supported through prevention funding to conduct hepatitis testing of inmates. To further integrate HIV and hepatitis testing, the HIV test request form (DH1828) has been modified to collect information on hepatitis. Counselors can now use one form for data collection when clients are being tested for both HIV and hepatitis.

CDC Directly-funded Community Based Organizations (CBOs)- The bureau values the collaborative relationships between the program office, local programs, and CDC directly funded CBOs. One major area of collaboration is in rapid testing. The bureau provides training, quality assurance visits, technical assistance, and other assistance as needed to directly funded CBOs in an effort to maintain positive working relationships with our community partners and provide the best services possible to our clients. These partners are an active part of the community planning process as well. In addition, the bureau collects and reports PEMS HIV testing data on behalf of these organizations. Many of these CBOs

implement evidence-based HIV prevention interventions to serve their priority populations. The bureau provides them with technical assistance and requests capacity building trainings on their behalf.

HIV/AIDS Care Programs- Clients who test positive through DOH testing programs are referred to medical services upon notification of their status and counselors follow-up with the clients to ensure a linkage was made. High-risk negatives are referred to additional services such as STD or hepatitis screening.

MAI providers link HIV-infected clients to the AIDS Drug Assistance Program (ADAP) for medication.

In April 2008, through our prison pre-release planning program, a new position (the Community Linkage Coordinator) was implemented in Broward and Miami-Dade counties to provide intensive linkage services to HIV-infected prison inmates returning to the area. The Community Linkage Coordinator provides active referrals to medical care and provides assistance in completing eligibility paperwork to ensure continuity of care and treatment.

Clients that test positive for HIV can enroll in any of our interventions for people living with HIV/AIDS. Facilities that provide care programs for those individuals living with HIV/AIDS usually keep information about our programs on-hand and offer it to those who would benefit from such programs. Some of these interventions are: Partnership for Health, L.I.F.E., CRCS, and Healthy Relationships. The bureau has DOH staff trained as trainers for the Partnership for Health intervention and currently has five health department clinics across the state implementing the intervention.

When an HIV-infected woman delivers a baby, six weeks of Retrovir syrup is prescribed for that newborn. In the instance of a mother with no money to pay for the medication and no medical insurance (such as an undocumented immigrant) we have instituted the Baby Rxpress Program. A voucher is provided to the perinatal nurse who can exchange it for the medicine at the local Walgreen's, and the invoice comes to the bureau. The process ensures that the medicine can be provided before the mother leaves the hospital, and there is no lapse in treatment.

Substance Abuse Prevention & Treatment Programs- Conventional and rapid HIV testing continues to be offered at numerous drug treatment centers, including methadone clinics. Persons tested through all of our registered testing programs are routinely assessed for substance abuse issues and referred to treatment as needed. In 2008, over 11,000 HIV tests were done in substance abuse treatment centers.

MAI providers coordinate with substance abuse clinics to promote education, prevention information, and treatment, as well as receive referrals for HIV-positive clients. TOPWA educates women on the dangers of substance abuse during pregnancy and actively refers women who are chemically dependent to substance abuse treatment.

A representative from the Substance Abuse program office attends the Corrections Infections Workgroup, and shares information regarding issues that affect our common clients. The Florida Jail Linkage Programs (JLP) and Pre-Release Planning Program (PRPP) coordinate with substance abuse treatment centers to provide education, treatment, and prevention to recently released ex-offenders. Notable collaborations include the Broward Outreach Center in Broward County which provides temporary housing and substance abuse treatment services and Village South in Miami which provides inpatient and outpatient substance abuse treatment and prevention services to HIV-infected ex-offenders.

Drug treatment centers are funded to implement evidence-based HIV prevention interventions that address both high-risk sexual and drug use behaviors; many of these interventions are designed both for injection and non-injection drug users. We recently had some local DOH staff trained as trainers in the Safety Counts intervention which aims to reduce high-risk drug use and sexual behaviors that are related to the transmission of HIV and hepatitis.

Juvenile and Adult Criminal Justice- In 2008, 16 funded jail linkage programs (JLP) around the state tested 36,709 jail inmates in provided 8,539 referrals to various social services. Inmates testing positive

through the jail linkage programs receive active referrals to medical care, prenatal care (if necessary), and partner services. Inmates also receive education and discuss risk reduction strategies. Also in 2008, in an effort to increase testing efforts in juvenile justice facilities, DOH evaluated testing programs and supported existing programs by providing rapid HIV testing kits free of charge. A notable collaboration includes the University of Miami Adolescent Outreach and Education Center's Promote2Prevent HIV testing program in the Miami-Dade juvenile detention facilities.

The prison HIV PRPP continues to provide discharge planning services to HIV-infected prison inmates statewide. Planners coordinate with local community providers and schedule medical care appointments to ensure continuity of care and treatment.

The bureau partnered with the Department of Corrections and the Department of Juvenile Justice to sponsor the First Annual Infectious Disease in Correctional Facilities Summit. The summit brought together over 300 correctional healthcare and security staff to promote education and collaboration for the improvement of inmate care, treatment, and prevention related to infectious diseases. Topics presented and discussed at the summit included HIV/AIDS, Tuberculosis, hepatitis, sexually transmitted diseases, and MRSA.

The bureau has recently taken an active role in training CBO and DOH staff in the *Survive Outside Project: Bloodlines* for youth in DJJ facilities or alternative schools. This intervention aims to educate youth on how to prevent HIV/STD transmission and learn the skills necessary to stay HIV and STD free after being released from their current facility. DOH is working with The Department of Education (DOE) to get CBOs, CHDs, and jail nurses trained to deliver this intervention to youth. CBO and DOH staff currently provides the VOICES/VOCES prevention intervention to incarcerated adults in many Florida jails.

TB Clinics and Programs- HIV testing continues to be available in all TB clinics in the state, with two now offering rapid HIV testing. All persons testing HIV positive are referred for TB screening and all persons diagnosed as a TB case or suspect are tested for HIV. The bureaus of HIV and TB have integrated quality assurance programs, eliminating the need for both bureaus to visit the same clinic and look at the same records.

State and Local Mental Health Departments- MAI-ARTAS providers coordinate with mental health agencies to receive referrals for individuals who were recently diagnosed with HIV and MAI providers refer HIV-positive clients with mental health issues for treatment in return.

Headquarters staff participates in the Corrections Infections Workgroup, an interagency workgroup dedicated to information sharing, program development and evaluation, and advocacy on issues related to HIV/AIDS, STD, TB and/or hepatitis in correctional settings. Recently we have extended this collaboration to the Department of Children and Families Mental Health Office. Representatives from the mental health office participate in the workgroup and disseminate information to staff regarding HIV/AIDS, hepatitis, Tuberculosis, and STDs.

Family Planning and Women's Health-TOPWA program contracts were amended to require linkage to family planning services for every pregnant client enrolled. Postpartum women are automatically enrolled in the Medicaid Family Planning Waiver for one year if Medicaid paid for the baby's birth, and this coverage is available for another year if the woman applies.

In 2008, HIV headquarters' staff participated on the Black Infant Mortality Workgroup through the Office of Women's Health, the Governor's Summit on Women's Health, and the Women's Health Interagency Network.

The bureau funds many agencies to provide prevention interventions that are designed specifically for women and address a multitude of risk factors that women sometimes face. Some of these interventions are: SISTA, RAPP, WILLOW, and AMIGAS.

State and Local Education Agencies-The bureau continues to partner with the Department of Education to share information and to collaborate on initiatives. In 2008, we purchased ten licenses for the Get Real About AIDS school curriculum, which teaches grade appropriate comprehensive sexual health. Staffs around the state work with local teachers and school boards to implement this curriculum. It can also be adapted for youth not in school. Some of our CHDs have approached their local school boards with requests to have the Get Real About AIDS curriculum implemented in local schools. So far, the St. Lucie County school board has approved the curriculum with minor changes which represents a great stride forward for Florida's sexual health education programs. More counties are pursuing the task of getting accurate and comprehensive HIV/STD education into their local schools.

The bureau has been working with DOE to disseminate the *Survive Outside Project: Bloodlines* to youth in various settings (e.g., DJJ, alternative schools, after-school programs, foster homes, etc.). We are planning to collaborate with DOE to get both DOH and DOE staff trained to train CBOs and CHDs around the state so they can deliver this intervention to youth in their areas.

Health fairs and HIV/STD testing are held at state colleges and universities. Several college health centers are registered HIV test sites.

National Testing Day- National HIV Testing Day (NHTD) is an annual campaign coordinated by the [National Association of People with AIDS](#) to encourage people of all ages to "Take the Test, Take Control." Many events are scheduled throughout Florida to increase testing for the general population.

World AIDS Day- World AIDS Day is observed every year on December 1st. World AIDS Day provides governments, national AIDS programs, faith organizations, community organizations, and individuals with an opportunity to raise awareness and focus attention on the global AIDS epidemic.

Prevention for Positives

MAI-ARTAS- The bureau currently funds seven minority community-based organizations to increase and continue minority participation in the AIDS Drug Assistance Program. The Antiretroviral Treatment Access Study (ARTAS) is implemented as a tool to improve linkage to care for HIV-infected minorities that are not in care.

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. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. The sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

Partnership for Health- is a one-on-one, brief provider-administered safer sex intervention for HIV-positive persons in care. The intervention emphasizes the importance of the patient-provider relationship to promote patients' healthful behavior. At each clinic visit, the provider delivers a brief counseling session (3-5 minutes) with messages that focus on self-protection, partner protection, and disclosure.

L.I.F.E. (Learning Immune Function Enhancement- is a structured risk reduction prevention-counseling program that attracts, retains, and motivates HIV-infected clients through its emphasis on health enhancement. For the HIV-positive individual, his or her own health and survival becomes a powerful motivation for risk reduction. All program content is based on published research in medicine, psychology and allied health sciences.

Positive Living- is an annual statewide conference to empower HIV-positive people to take control of their health through education, awareness, and support.

Black Heterosexuals

Sistas Organizing to Survive- Sistas Organizing to Survive (SOS) is a grassroots mobilization of black women in the fight against HIV and AIDS. In Florida, one in 68 non-Hispanic black women are known to be living with HIV/AIDS. This compares with approximately one in 1,281 non-Hispanic white women, and one in 472 Hispanic women. For over 15 years, HIV/AIDS has been the leading cause of death among black women aged 25-44 years in Florida.

The Sistas Organizing to Survive movement aims to educate black women about the impact of HIV/AIDS and to develop an action plan that prevents the further spread of HIV/AIDS and other diseases in Florida's black communities. Recently, the Florida Department of Health hosted the first SOS: Sistas Organizing to Survive conference in Orlando, FL. Almost 600 consumers, health providers, and community leaders participated in the event. Over 300 women actively pledged to engage in a statewide education network that encourages black women to become participatory in their own health.

Silence Is Death- The Bureau of HIV/AIDS produced a report entitled "Silence is Death: The Crisis of HIV/AIDS in Florida's Black Communities. The report documents racial/ethnic disparities according to several persons living with HIV/AIDS (PLWHA) (reported cases) measures in the 20 Florida counties with a total of at least 600 PLWHA through 2005. The report was written to serve as a community mobilization tool to assist counties to break the silence by raising awareness about HIV/AIDS among blacks; encourage local governments and communities to expand and strengthen their responses to the HIV/AIDS epidemic among blacks; encourage individuals to be tested for HIV/AIDS; increase access to HIV prevention and care services; reduce barriers to HIV testing, prevention and care by reducing HIV/AIDS stigma; and to stimulate the development of a plan to address the disproportionate impact that HIV/AIDS is having on black communities.

Black Leaders Advisory Group- The Bureau of HIV/AIDS established a black and Latino Leaders Advisory Group in an effort to address HIV/AIDS issues in Florida's black and Latino communities. The advisory group consists of Black and Latino community leaders that were nominated by their community and department staff from around the state. The role of the group is to serve as a voice for the black and Latino community and to make recommendations to the bureau on the HIV/AIDS issues affecting Florida's black and Latino communities.

Organizing to Survive: The HIV/AIDS Crisis Among Florida's Women- The HIV/AIDS epidemic in Florida impacts all racial/ethnic groups of women in unacceptable ways. HIV/AIDS has reached crisis proportions among minority women and black women, in particular. Compared with white women, all groups of minority women have significantly greater AIDS case rates, but the black-white disparity is widest by far. The epidemic presents a unique set of challenges to the community, public health workers, and providers of HIV prevention and care.

This report seeks to mobilize women to confront and overcome their vulnerability to HIV/AIDS. To achieve this broad aim, an analysis of Florida's HIV/AIDS data among women by race/ethnicity is presented, together with a realistic set of recommendations. The goal is to stimulate the development and implementation of community action plans to prevent the further spread of HIV/AIDS among women living in Florida.

National Black HIV/AIDS Awareness Day- February 7 is National Black HIV/AIDS Awareness Day. National Black HIV/AIDS Awareness Day is a community mobilization effort that emphasizes the disproportionate impact that HIV/AIDS is having among blacks and encourages individuals to be counseled and tested for the virus. Each year, the Bureau of HIV/AIDS encourages community-based organizations, faith-based organizations, and county health departments from across the state to conduct educational and

outreach activities, HIV testing and many other special events that will empower and mobilize black communities in the fight against HIV and AIDS

Women and Girls Day-National Women and Girls HIV/AIDS Awareness Day (NWGHAAD) is a nationwide initiative coordinated by the Office on Women's Health (OWH) to raise awareness of the increasing impact of HIV/AIDS on women and girls. It serves as an opportunity for organizations across the country to come together to provide support, encourage discussion, and educate women and girls about prevention, the importance of getting tested, and how to lead a normal, healthy life despite being infected.

Faith Initiative-The Florida Department of Health, Bureau of HIV/AIDS has renewed its commitment to assist faith-based organizations in addressing HIV/AIDS in the state of Florida. The Bureau of HIV/AIDS has been working with communities of faith since the beginning of the HIV/AIDS epidemic. Our long standing commitment with faith-based organizations has resulted in more testing, education, and outreach throughout the state.

Our faith-based initiative is not about a single faith; it is inclusive of all denominations. The goals of the faith initiative are to expand opportunities for faith-based organizations to strengthen their capacity to meet the HIV/AIDS needs of Floridians; and to mobilize congregations and communities to respond to the HIV/AIDS crisis regardless of race, ethnicity or behavior.

African American Testing Initiative (AATI)- The CDC awarded the Bureau of HIV/AIDS \$4.7 million to implement the African American Testing Initiative (AATI). This initiative focuses on reaching HIV-infected persons, primarily non-Hispanic blacks, who are unaware of their infection. The bureau's goal in one year is to conduct 125,000 HIV tests and identify 2,000 new HIV infections each year. The project focuses primarily on rapid testing in clinical settings, e.g., hospital emergency departments and community health centers

Man UP-The Crisis of HIV/AIDS Among Florida's Men- This report seeks to mobilize men to eliminate their risk for acquiring and transmitting HIV/AIDS. The report also seeks to encourage men to "Man Up" and take responsibility for the consequences of their sexual actions and other HIV risk behaviors, for the benefit of themselves and their partners. The goal is to stimulate the development and implementation of community action plans to prevent the further spread of HIV/AIDS among Florida's men and their partners.

Black MSM

Statewide Black Men who Have Sex with Men (MSM) AIDS Coordinator- In an effort to further address HIV/AIDS disparities among Florida's black men who have sex with men and at the request of the Black Leaders Advisory Committee, the bureau designated a Statewide Black MSM Coordinator to help reduce HIV/AIDS among black MSM. The position is located at the Palm Beach County Health Department and reports to the Statewide Minority AIDS Coordinator located in Tallahassee. This position is responsible for planning and coordinating HIV/AIDS activities in Florida's black MSM communities.

UJIMA Men's Collective- The goals of this annual conference are to provide a forum for black men to develop life skill strategies in a non-threatening environment to enhance their lives to better understand themselves and their community; develop leadership and pro-active decision-making skills; empower black men to develop a sense of community with other black men; commit to offer volunteer service to the Ujima Men's Collective or some community-based organization in their area.

Out In the Open: The Continuing Crisis of HIV/AIDS Among Florida's Men Who Have Sex with Men- The Out In the Open report was created to address HIV/AIDS issues in Florida's MSM populations. The objectives of the report were: reinvigorate HIV prevention efforts and strategies for MSM and mobilize MSM leaders to support the reduction of risky behavior; enlist the support of sufficient numbers of MSM to stem the tide of new HIV infections; inform local governments and communities about 1) the nature of the epidemic and its impact on MSM, and 2) the damaging effects of stigma and homophobia; encourage local government, communities and leaders to reprioritize and enhance their HIV prevention strategies targeting

MSM; increase HIV testing and linkage to care among MSM; reduce barriers to HIV prevention, testing and care by getting a constructive dialogue about HIV/AIDS related stigma and homophobia out in the open; provide data to HIV prevention and care community planners to support new interventions, prioritization of initiatives, epidemic analysis, and grant writing; and stimulate the development of local plans for community mobilization and innovative HIV prevention interventions for MSM.

Black MSM Advisory Group- The Black MSM Advisory Group consists of black gay men leaders that were nominated by their community and department staff from around the state. The role of the group is to serve as a voice for the black MSM community and to make recommendations to the bureau on the HIV/AIDS issues affecting Florida's black gay men.

Finding Our Voices: Mobilizing Black Gay Men DVD- is a community mobilization initiative to stop the spread of HIV and AIDS among black gay men. The purpose of the DVD is to raise awareness and to mobilize black gay men to respond to the HIV/AIDS crisis in their communities. The goals are to raise awareness about the ongoing crisis among black gay men and to promote greater understanding about issues surrounding HIV/AIDS that affect black gay men. The Florida Department of Health, Bureau of HIV/AIDS encourages individuals, providers, and communities to promote strategies for effective interventions to reduce new infections and encourage black gay men to get tested for HIV.

White MSM

Out In the Open: The Continuing Crisis of HIV/AIDS Among Florida's Men Who Have Sex with Men- The Out In the Open report was created to address HIV/AIDS issues in Florida's MSM populations. The objectives of the report were: reinvigorate HIV prevention efforts and strategies for MSM and mobilize MSM leaders to support the reduction of risky behavior; enlist the support of sufficient numbers of MSM to stem the tide of new HIV infections; inform local governments and communities about 1) the nature of the epidemic and its impact on MSM, and 2) the damaging effects of stigma and homophobia; encourage local government, communities and leaders to reprioritize and enhance their HIV prevention strategies targeting MSM; increase HIV testing and linkage to care among MSM; reduce barriers to HIV prevention, testing and care by getting a constructive dialogue about HIV/AIDS-related stigma and homophobia out in the open; provide data to HIV prevention and care community planners to support new interventions, prioritization of initiatives, epidemic analysis, and grant writing; and stimulate the development of local plans for community mobilization and innovative HIV prevention interventions for MSM.

S-MEN- is an HIV prevention, secondary prevention, community mobilization, and social marketing campaign for Broward County Men who have Sex with Men (MSM). The project is funded by the Florida Department of Health. The S-MEN campaign is comprised of the following components: 1) advertisements in gay print media and billboards; 2) products (gym towels, t-shirts, gym bags, coolers, bat bags, magnets, dog tags, cocktail napkins and coasters) promoted and distributed at bars, clubs, bathhouses, gyms, sporting events, fundraisers, and festivals; 3) development and promotion of website S-MEN.ORG; 4) community volunteer meetings and forums 5) development of community email list; and 6) media coverage. The campaign endorses healthy alternative activities in the MSM community such as sport leagues, gyms and sober events, but also participates in activities at bars and bathhouses. More than two dozen small and large events took place throughout 2008 to promote the campaign.

White MSM Advisory Group-The White MSM Advisory Group consists of white gay men leaders that were nominated by their community and department staff from around the state. The role of the group is to serve as a voice for the white MSM community and to make recommendations to the bureau on the HIV/AIDS issues affecting Florida's white gay men

Southeastern Gay Men's Health Summit- is an annual meeting that brings together MSM from Florida and other southeastern states. The meeting is designed to mobilize MSM and reinvigorate prevention efforts.

Gay Days- Initiated in 1991, Gay Days in Orlando originally started as a one day celebration at the Magic Kingdom of Walt Disney World. On the first Saturday in June, gays and lesbians were invited to "Wear Red and Be Seen". As time went on, the one-day celebration evolved into a week-long event for the gay and lesbian community. Since the inception of Gay Days, attendance has grown from 3,000 that first year to well over 135,000. The Bureau HIV/AIDS and Orange County Health Department provide HIV awareness messages and HIV/STD testing during this event.

Hispanic MSM

"Damaris" and "MSM Latino" are two public service announcements targeted towards Latinas and Latino MSM at highest risk for HIV infection. The MSM Latino PSA targets gay-identified men and non-gay identified men who have sex with other men. The PSAs air in radio/TV media and coordinated/organized settings (e.g. physicians' waiting rooms, health fairs, community events, video bars, etc.).

"Quien No Te Protege, no Te Merece" is a supplemental video to be used as part of the VOICES/VOCES intervention targeting Latinos. VOICES/VOCES is one of the behavioral interventions currently included within CDC's compendium of effective behavioral interventions. Produced by the Miami-Dade County Health Department, Office of HIV/AIDS, the video is intended to be used with Latino gay men and includes a diverse cast of characters.

Out In the Open: The Continuing Crisis of HIV/AIDS Among Florida's Men Who Have Sex with Men- The Out In the Open report was created to address HIV/AIDS issues in Florida's MSM populations. The objectives of the report were: reinvigorate HIV prevention efforts and strategies for MSM and mobilize MSM leaders to support the reduction of risky behavior; enlist the support of sufficient numbers of MSM to stem the tide of new HIV infections; inform local governments and communities about 1) the nature of the epidemic and its impact on MSM, and 2) the damaging effects of stigma and homophobia; encourage local government, communities and leaders to reprioritize and enhance their HIV prevention strategies targeting MSM; increase HIV testing and linkage to care among MSM; reduce barriers to HIV prevention, testing and care by getting a constructive dialogue about HIV/AIDS-related stigma and homophobia out in the open; provide data to HIV prevention and care community planners to support new interventions, prioritization of initiatives, epidemic analysis, and grant writing; and stimulate the development of local plans for community mobilization and innovative HIV prevention interventions for MSM.

Hispanic MSM Advisory Group-The Hispanic MSM Advisory Group consists of Hispanic gay men leaders that were nominated by their community and department staff from around the state. The role of the group is to serve as a voice for the Hispanic MSM community and to make recommendations to the bureau on the HIV/AIDS issues affecting Florida's Hispanic gay men.

Hispanic Heterosexuals

Statewide Latino AIDS Coordinator- In an effort to further address HIV/AIDS disparities among Florida's Latinos and at the request of the Latino Leaders Advisory Committee, the bureau designated a Statewide Latino AIDS Coordinator to help reduce HIV/AIDS among Latinos. The position is located at the Miami-Dade County Health Department and reports to the Statewide Minority AIDS Coordinator located in Tallahassee. This position is responsible for planning and coordinating HIV/AIDS activities in Florida's Latino communities.

Organizing to Survive: The HIV/AIDS Crisis Among Florida's Women- The HIV/AIDS epidemic in Florida impacts all racial/ethnic groups of women in unacceptable ways. HIV/AIDS has reached crisis proportions among minority women and black women, in particular. Compared with white women, all groups of minority women have significantly greater AIDS case rates, but the black-white disparity is widest by far. The epidemic presents a unique set of challenges to the community, public health workers, and providers of HIV prevention and care.

This report seeks to mobilize women to confront and overcome their vulnerability to HIV/AIDS. To achieve this broad aim, an analysis of Florida's HIV/AIDS data among women by race/ethnicity is presented, together with a realistic set of recommendations. The goal is to stimulate the development and implementation of community action plans to prevent the further spread of HIV/AIDS among women living in Florida.

LUCES (Latinas Unidas Contra el SIDA)- LUCES is a community mobilization initiative that was created to heighten the awareness about HIV/AIDS and encourage Latina women to get tested for HIV. LUCES is also the name of the Latina Women's Advisory Group. The primary goals of the LUCES DVD are: raise awareness about the magnitude of HIV/AIDS among Latina Women in Florida's communities; strengthen Latina Women's ability to take charge and control of their sexual health; connect Latina Women to HIV/AIDS resources; offer tools to enable Latina women to educate others about HIV/AIDS and HIV prevention where they live, work, play, learn and worship; and increase the capacity of Latina women to build effective responses to the HIV/AIDS epidemic in local communities.

Amigas - Amigas is a study designed to adapt an HIV prevention intervention found to be effective for African American women. The study is now entering its pilot phase and is currently recruiting Latinas into the study. This effort is spearheaded by the Miami-Dade County Health Department, Office of HIV/AIDS, in collaboration with researchers Ralph DiClemente and Gina Wingood. Upon completion of the study phase, the intervention will be considered for inclusion in CDC's compendium of effective behavioral interventions.

Latino Leaders Advisory Group- The Bureau of HIV/AIDS established a Black and Latino Leaders Advisory Group in an effort to address HIV/AIDS issues in Florida's black and Latino communities. The advisory group consists of black and Latino community leaders that were nominated by their community and department staff from around the state. The role of the group is to serve as a voice for the black and Latino community and to make recommendations to the bureau on the HIV/AIDS issues affecting Florida's black and Latino communities.

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Café Latino- The Orange County Health Department/Area 7 HIV/AIDS Program Office in collaboration with the US-Mexico Border Health Association invites the public to attend Café Latino. Café Latino is a community forum to evaluate the needs of HIV prevention and education in the Latino community of Central Florida. The meetings have been utilized to network with community providers and become educated on HIV/AIDS prevention and care services available in the Orlando area. By holding this community event, the Café Latino Coalition wants to let the Hispanic community know the resources available for them, provide information and education on various health topics, and give them the opportunity to have health screenings accessible to them

National Latino AIDS Awareness Day- October 15 is National Latino AIDS Awareness Day. This day is set aside to heighten awareness about HIV/AIDS and encourage individuals to get tested for HIV. Each year, the bureau encourages county health departments, community-based organizations and the community as a whole to plan and participate in HIV/AIDS activities that promote awareness and encourages individuals to get tested for HIV. Statewide NLAAD events usually include HIV/AIDS outreach,

counseling, testing, referral services, health fairs, educational presentations and condom distribution in Latino communities.

25 Myths / 25 Realities (25 Mitos/ 25 Realidades): The Hispanic AIDS Awareness Program (HAAP), Miami-Dade County Health Department and the acclaimed TV/theater producer Miguel Ferro were the producers of 25 Myths / 25 Realities (25 Mitos/ 25 Realidades), an HIV/AIDS Latino Public Service Announcement (PSA) Campaign. This campaign has secured the support of 27 Latino celebrities who through their image and voices recorded 25 public service announcements that address the truth about HIV/AIDS myths. The 25 television and print public service announcements are now available at the HAAP web site, www.HispanicAIDS.org.

Palabras Sabias - (words of wisdom) is a Latino HIV/AIDS social marketing campaign designed to increase HIV/AIDS awareness. Commonly-used Spanish phrases are combined with HIV prevention messages. The campaign uses posters and vintage cards to promote HIV prevention, testing, and linkage to care. They are intended to be used in prevention educational efforts at community events and outdoor print media. The posters are intended to reach heterosexual Latinos and Latinas, while the vintage card series targets Latino gay men.

Postivo Soy- (I am Positive) is a half-hour video about four Latino men living with AIDS. The four men discuss issues related to HIV disclosure, medication adherence, and HIV prevention. The video, in Spanish with English subtitles, is a tool to be used in prevention interventions targeting HIV-positive individuals, addressing HIV/AIDS related stigma and medication adherence

Women and Girls Day-National Women and Girls HIV/AIDS Awareness Day (NWGHAAD) is a nationwide initiative coordinated by the Office on Women's Health (OWH) to raise awareness of the increasing impact of HIV/AIDS on women and girls. It serves as an opportunity for organizations across the country to come together to provide support, encourage discussion, and educate women and girls about prevention, the importance of getting tested, and how to lead a normal, healthy life despite being infected.

Faith Initiative-The Florida Department of Health, Bureau of HIV/AIDS has renewed its commitment to assist faith-based organizations in addressing HIV/AIDS in the state of Florida. The Bureau of HIV/AIDS has been working with communities of faith since the beginning of the HIV/AIDS epidemic. Our long standing commitment with faith-based organizations has resulted in more testing, education, and outreach throughout the state.

Our faith-based initiative is not about a single faith; it is inclusive of all denominations. The goals of the faith initiative are to expand opportunities for faith-based organizations to strengthen their capacity to meet the HIV/AIDS needs of Floridians; and to mobilize congregations and communities to respond to the HIV/AIDS crisis regardless of race, ethnicity or behavior.

Man UP-The Crisis of HIV/AIDS Among Florida's Men- This report seeks to mobilize men to eliminate their risk for acquiring and transmitting HIV/AIDS. The report also seeks to encourage men to "Man Up" and take responsibility for the consequences of their sexual actions and other HIV risk behaviors, for the benefit of themselves and their partners. The goal is to stimulate the development and implementation of community action plans to prevent the further spread of HIV/AIDS among Florida's men and their partners.

White Heterosexuals

Organizing to Survive: The HIV/AIDS Crisis Among Florida's Women- The HIV/AIDS epidemic in Florida impacts all racial/ethnic groups of women in unacceptable ways. HIV/AIDS has reached crisis proportions among minority women and black women, in particular. Compared with white women, all groups of minority women have significantly greater AIDS case rates, but the black-white disparity is widest by far.

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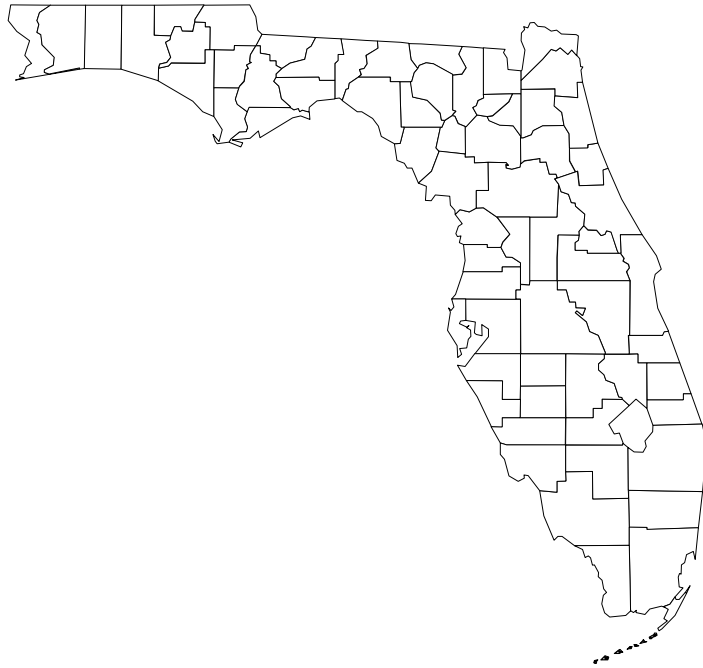
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APPENDICES



Appendix A: PPG Community Needs Assessment Analysis Summary and Discussion

Introduction

The following is a summary of findings from the comprehensive community needs assessment conducted by the Florida Comprehensive Planning Network Prevention Planning Group (PPG) during April and May of 2009.

The purpose of this survey was to collect information on HIV prevention needs among various stakeholder groups in Florida. The survey provided respondents an opportunity to report to the PPG the HIV prevention programming and service needs within their agency and/or community.

Methods

Survey questions were designed for multiple stakeholder groups, including prevention service clients, prevention service providers, and persons living with HIV/AIDS (PLWHA). Questions assessed a range of variables, including respondent demographics and risk behaviors, agency information, receipt and/or delivery of prevention services, and needs for technical assistance. The survey consisted of 56 questions.

The PPG selected an internet-based format for the survey to facilitate broad survey dissemination and data collection within a short time period and to minimize costs. The questionnaire was created on the Survey Monkey website and disseminated to county health departments and community-based organizations via email announcements containing a link to the questionnaire. Participating agencies were also encouraged to post the link on their websites. Respondents completed the questionnaire on the Survey Monkey website and submitted their responses electronically.

Responses were maintained and summarized by Survey Monkey. PPG members and Bureau of HIV/AIDS staff members performed a review of significant findings; significant response patterns and relationships are reported below. Please note that no probability sampling techniques were used. Thus, there is no way to determine the generalizability of observations, and conclusions cannot be extended beyond the survey respondents.

Findings

Demographics of respondents: Of the 281 persons that started the survey, 227 (80.8%) completed the survey. The number of responses to each survey item varied. Thus, findings are reported based on the number of responses to each survey item, and the term “respondent” is specific to each question. When asked about their sex, 51.0% identified as female and 49.0% identified as male (no respondents identified as transgender). When asked about their race, nearly half (48%) of respondents identified as black or African American, 44.4% as white, 6.6% as multiracial, and 1% as Asian/Native Hawaiian/ Pacific Islander. When asked about their ethnicity, 16% of the respondents identified as Hispanic/Latino/a and 84% percent identified as non-Hispanic/Latino/a. When asked about their age, more respondents selected the 45-54 age group (32.1%) than any other age group. The majority of respondents reported completing college (55.6%).

Key questions: Respondents were asked if they needed services and whether that need was met. Of those responding to these items (n= 191 and 188), very few indicated that they needed an HIV test and/or partner services but did not receive them (2.1%, and 2.7%, respectively). Of 188 respondents, none indicated that they needed condoms and were unable to obtain them. Only 3.2% indicated that they needed some form of an HIV education session but were unable to receive it; and 6.9% indicated an unmet need for prevention services (including HIV testing, information on HIV, information on proper condom use) from their physician.

Of 227 respondents, 143 (63.0%) indicated some organizational affiliation. Of these 143 respondents, 44.1% described their organization as “public,” and 55.9% described their organization as “private, not-for-profit.” Approximately two-thirds of respondents (68.3%) described their organization as providing HIV/AIDS services as part of a larger service program, and one-third (31.7%) described their organizations as providing HIV/AIDS services exclusively. Though other funding sources were common, “state funding” was the most commonly reported (81.4%) organizational funding source. The majority (56.5%) of respondents’ organizations serve local areas; only six (4.6%) serve the entire state.

Survey results show delivery of a broad range of prevention services. A majority (87.8%, n=131) report providing HIV counseling, testing, and linkage (CTL) services. Of these CTL providers, nearly three-fourths (71.8%) offer rapid testing. Evidence-based behavioral interventions provided vary widely. VOICES/VOCES (53.2%), SISTA (50.0%), and Healthy Relationships (36%) were the most commonly implemented EBIs. See Table 2 for more information.

Respondents were asked whether their agency needed technical assistance. Of the 121 answering this question, 42.1% said yes. Reported barriers to services ranged widely. Inadequate transportation (70.2%), insufficient funding (61.3%), and homeless issues (56.5%) were the most commonly reported barriers (n=124). The survey gathered information on agencies’ unmet needs for prevention services. Internet-based interventions and social network recruitment for counseling, testing, and linkage were the two most common unmet needs (37.3% each). Other leading responses included “group support” (33.9%), “Comprehensive Risk Counseling and Services” (26.3%), “motivational interviewing” (26.3%), and “cell-phone-based interventions” (25.6%).

The populations targeted by responding agencies are summarized in Table 3. Blacks/African Americans were the most targeted population, as they were targeted by nearly every responding agency (97.7%).

Key relationships: As shown in Table 1, agencies represented in this survey with service activities beyond HIV/AIDS (74.5%) were more likely than agencies solely providing HIV/AIDS services (31.4%) to report needing technical assistance. Our ability to perform other bivariate analyses was limited due to high numbers of skipped questions (further discussed in the limitations section).

Table 1. Is your agency in need of additional technical assistance?			
	Yes	No	Response Totals
HIV/AIDS services are the only services we provide.	31.4% (16)	47.8% (33)	40.8% (49)
HIV/AIDS services are part of a larger services program.	74.5% (38)	63.8% (44)	68.3% (82)
Answered question	51	69	120

Limitations

Two substantial survey limitations should be noted. First, no probability sampling techniques were used to conduct this needs assessment. Thus, there is no way to determine the generalizability of observations, and conclusions from this survey cannot be extended beyond the survey respondents. Second, there are significant patterns of skipped questions throughout the data. Typically, agency and behavioral items only received responses from one-half to two-thirds of respondents, and even demographic items were not well-completed. It appears that a minority of respondents replied to all items, regardless of their status as a prevention service provider or a client. The extent of skipped items is relatively consistent throughout the data and does not increase substantially for items later in the survey. There are no means available to determine if respondents’ failure to complete survey items were linked to technical (computer) issues.

Conclusions

The purpose of this survey was to collect information on HIV/AIDS prevention needs among various stakeholder groups in Florida. Respondents provided information about themselves, their agencies (in many cases), and their perceptions on the HIV prevention needs of their communities. Though needs for technical assistance exist, responses suggest broad implementation and availability of HIV prevention services, including HIV testing, prevention interventions, and condoms. These activities appear to target a vast range of risk populations.

Comprehensive Community Needs Assessment

Table 2: Intervention Inventory

	Answered question	126
	Skipped question	155
	Response Percent	Response Count
ARK (Assisting in Rehabilitating Kids)	0.8%	1
BART (Becoming a Responsible Teen)	0.8%	1
Be Proud! Be Responsible	0.0%	0
BRAINE (Brief Alcohol Intervention for Needle Exchangers)	0.0%	0
Brief Group Counseling	13.5%	17
CHOICES	1.6%	2
CLEAR (in person) Choosing Life: Empowerment, Actions, Results	0.8%	1
Cognitive Behavioral STD/HIV Risk Reduction	15.9%	20
Communal Effective - AIDS Prevention	5.6%	7
Community PROMISE (Peers Reaching Out/Modeling Intervention Strategies)	10.3%	13
Condom Promotion	54.0%	68
!Cuidate!	0.0%	0
Doing Something Different	0.0%	0
EXPLORE	0.0%	0
Female and Culturally Specific Negotiation	6.3%	8
Focus on Kids (FOK)	0.8%	1
Focus on Youth (Kids) + ImPACT	1.6%	2
Healthy Relationships	36.5%	46
HIP (Health Improvement Project)	2.4%	3
HIV Education and Testing	74.6%	94
Holistic Health Recovery Program	0.8%	1
Insights	0.8%	1
Intensive AIDS Education	6.3%	8
"Light": Living In Good Health Together	0.0%	0
L.I.F.E. (Learning Immune Function Enhancement)	1.6%	2
Many Men, Many Voices (3MV)	19.8%	25
Modelo de Intervencion Psychomedica (MIP)	0.0%	0
Mpowerment	4.8%	6
Nia: A Program of Purpose	1.6%	2
Partnership for Health (PfH)	15.9%	20
Personalized Cognitive Risk Reduction Counseling	7.9%	10
Popular Opinion Leader (POL)	4.0%	5
Project Connect	3.2%	4
Project FIO (the Future Is Ours)	0.8%	1
Project RESPECT (brief counseling)	7.1%	9
RESPECT Brief Counseling + Booster	8.7%	11
Project S.A.F.E.	1.6%	2
Real AIDS Prevention Project (RAPP)	0.8%	1
Safer Sex	37.3%	47
Safety Counts	3.2%	4

Comprehensive Community Needs Assessment

Table 2: Intervention Inventory

SEPA (Salud, Educacion, Prevencion y Autocuidado)	0.0%	0
SHIELD (Self-Help in Eliminating Life-Threatening Diseases)	0.0%	0
SHILE (Sistering, Informing, Healing, Living and Empowering)	0.0%	0
SISTA (Sistas Informing Sistas About Topics on AIDS)	50.0%	63
Sisters Saving Sisters	3.2%	4
Sniffer	0.8%	1
START (STD/AIDS Risk Reduction Trial)	1.6%	2
Street Smart	5.6%	7
SUMIT (Seropositive Urban Men's Intervention Trial) Enhanced--Peer Led	0.0%	0
Together Learning Choices (TLC)	0.0%	0
VOICES/VOCES	53.2%	67
WHP (Women's Health Promotion)	1.6%	2
WILLOW (Women Involved in Life Learning from Other Women)	0.0%	0
Women's Co-Op	0.8%	1
Other Evidence-Based Intervention Not Listed		24

Comprehensive Community Needs Assessment**Table 3: Targeted Populations**

	Answered question	129
	Skipped question	152
	Response Percent	Response Count
African American/Black	97.7%	126
Hispanic/Latino	82.2%	106
Other Race/Ethnicity	62.0%	80
Asian	36.4%	47
Females	82.9%	107
Males	85.3%	110
Persons Over the Age of 55	55.8%	72
Youth (Under 18)	48.8%	63
Young Adults (18-24)	80.6%	104
MSM	76.7%	99
Incarcerated/ex-offenders	61.2%	79
Substance Abusers	58.1%	75
Transgender	57.4%	74

Appendix B: National Behavioral Surveillance Findings

National HIV Behavioral Surveillance Findings, South Florida, 2004-2007

The Florida Department of Health, Bureau of HIV/AIDS is collaborating with the University of Miami and the CDC to conduct National HIV Behavioral Surveillance (NHBS) in South Florida. NHBS involves a repeated, cross-sectional survey of populations at high risk for HIV infection: men who have sex with men (MSM), injection drug users (IDU), and heterosexuals at risk for HIV infection (HET). NHBS activities are implemented in rotating cycles so that data are collected from each risk group approximately once every three years; these study cycles are referred to as NHBS-MSM, NHBS-IDU, and NHBS-HET. Individuals who consent to participate undergo an anonymous interview and are paid for their time. NHBS is conducted in over 20 US metropolitan statistical areas with high AIDS prevalence rates. The first three cycles of data collection were conducted in Miami-Dade and Broward counties. The overarching goal of NHBS is to help evaluate and direct local and national prevention efforts.

Eligibility Criteria: Eligibility for each NHBS cycle listed below was limited to persons who reported residence in Miami-Dade, Broward, or Palm Beach counties; being between 18-50 years of age; not previously participating in the NHBS cycle; and the ability to complete the interview in English or Spanish.

NHBS-MSM: The first cycle of data collection (July 2004 – April 2005) focused on MSM. Venue-based sampling was used to recruit a sample of 1,540 MSM in Miami-Dade and Broward counties. Staff was able to collect HIV testing data from a subsample of 258 MSM in Miami-Dade County. Eligibility for this study cycle was limited to men; analyses were limited to men who self-reported oral or anal sex with a male in the past 12 months.

NHBS-IDU: The second cycle of data collection (May 2005 – February 2006) focused on IDUs. Respondent-driven sampling (respondents refer others to participate) was used to recruit 934 IDUs in Miami-Dade and Broward counties. HIV testing was not included as a part of this study cycle, but was offered to participants upon completion of their interview. Eligibility for this study cycle was limited to persons who reported injecting non-prescription drugs in the past 12 months and had physical evidence of recent injection (e.g., fresh track marks, abscesses) or knowledge of injection practices.

NHBS-HET: The third cycle of data collection (January - October 2007) focused on heterosexuals at risk for HIV infection. For this cycle, CDC defined a heterosexual at risk for HIV infection as an adult with (1) a physical or social connection to a high-risk area and (2) at least one opposite-sex partner in the past year. High-risk areas were defined as geographic areas with high rates of heterosexually-acquired HIV and poverty. To identify these areas, staff used U.S. Census Bureau poverty data and Florida DOH HIV/AIDS case data. Within the selected high-risk areas, staff used venue-based sampling to obtain a sample of 1,224 eligible participants. While the research team conducted sampling in areas known to have high HIV/AIDS prevalence rates, staff did not target high-risk venues within these areas. The vast majority of the randomly selected venues from which participants were recruited (e.g., grocery stores, Laundromats, street venues) represent places people go to conduct common activities. Staff collected HIV testing data from participants in both counties (N=1,222). Eligibility for this study cycle was limited to persons who reported having vaginal or anal sex with a member of the opposite sex in the last 12 months.

Table 1. Miami-Dade and Broward County Preliminary NHBS Findings, Three Risk Populations, 2004-2007

Measure	Population		
	MSM (2004-2005) N=1,540	IDUs (2005-2006) N=934	Heterosexuals (2007) N=1,224
Tested HIV+	21% (Miami serosurvey, N=258)	N/A	8% (6% excluding persons with IDU or MSM risk in lifetime)
Portion of sample with previously undiagnosed HIV infection	10% (Miami serosurvey, N=258)	N/A	4%
Self-reported as HIV+	16%	16%	4%
Tested for HIV in past 12 months*	70%	62%	40%
Top three reasons for not testing in past 12 months	1) Low risk for HIV, 2) afraid of finding out HIV+, 3) didn't have time	1) Low risk for HIV, 2) afraid of finding out HIV+, 3) didn't have time	1) Low risk for HIV, 2) afraid of finding out HIV+, 3) didn't have time
Ever tested for HIV	94%	96%	79%
Received free condoms in past 12 months	84%	56%	21%
Participated in an HIV prevention intervention (ILI or GLI) in past 12 months [†]	18%	14%	4%
Had unprotected sex at last sex act [§]	50%	67%	70%
Reused needle/syringe at last injection	--	29%	--
Reused injection equipment (e.g., cookers, cottons, water) at last injection	--	52%	--
Received free sterile syringes in past 12 months	--	3%	--
Received free sterile injection equipment in past 12 months	--	2%	--
Used crystal methamphetamine in past 12 months	18% (Subsample, N=946)	8%	--
Used crack or cocaine in past 12 months	15%	73%	28%
Participated in drug treatment in past 12 months	9% (Crystal meth users, N=175)	35%	11% (Crack or cocaine users, N=344)
Ever participated in drug treatment	18% (Crystal meth users, N=175)	69%	51% (Crack or cocaine users, N=344)

* Analysis excludes persons diagnosed with HIV over 12 months ago.

[†] ILI, individual-level intervention: a one-on-one conversation with an outreach worker, counselor, or prevention program worker about preventing HIV (excluding HIV pre- and post-test counseling sessions); GLI, group-level intervention: an organized session involving a small group of people to discuss ways to prevent HIV.

[§] Unprotected sex: vaginal or anal sex without the use of a condom during the entire act.

Appendix C: Priority Setting Tool

Priority Setting Tool for Florida's Prevention Planning Group, to be used with Four Fold Path Methodology and Advancing HIV Prevention (AHP)
Florida

LIVING HIV/AIDS CASES THROUGH 2007 Age 13+ by Race and Mode of Exposure*

2003-2005	Heterosexual		MSM	IDU	TOTAL
	M+F	Males	M+F	M+F	
White	3798	18497	8757	3438	
Black	23691	8757	2130	5109	
Hispanic	4601	9298	2130	383	
TOTAL	32290	36552	10678	79519	

HIV Cases Reported 2005-2007 Age 13+ by Race and Mode of Exposure*

2003-2005	Heterosexual		MSM	IDU	TOTAL
	M+F	Males	M+F	M+F	
White	874	3711	3	780	
Black	4684	2438	866	383	
Hispanic	1085	2047	383	2029	
TOTAL	6643	8196	1252	16868	

Percent of Cases	Heterosexual		MSM	IDU	TOTAL
	M+F	Males	M+F	M+F	
White	5%	22%	5%	5%	
Black	28%	14%	5%	5%	
Hispanic	6%	12%	2%	2%	100.0%

*Cases with no identified risks (NIRS) have been redistributed into known risks
**Florida Population Estimates for the mid-year (2004)
***MSM=MSM and MSM/IDU cases & Male IDU=IDU and MSM/IDU cases, Therefore these two groups are NOT mutually exclusive

Step 1.
Place the population with the largest percentage in the first position, the next largest percentage in the second position etc., down to the lowest in the final position.

Ranking of Data by Percent of Cases			Ranking of Data by Population		
Rank	Population	% of cases	Rank	Population	% of cases
1	B-Hetero	28%	1	B-Hetero	28%
2	W-MSM	22%	7	B-IDU	5%
3	B-MSM	14%	3	B-MSM	14%
4	H-MSM	12%	5	H-Hetero	6%
5	H-Hetero	6%	9	H-IDU	2%
6	W-Hetero	5%	4	H-MSM	12%
7	B-IDU	5%	6	W-Hetero	5%
8	W-IDU	5%	8	W-IDU	5%
9	H-IDU	2%	2	W-MSM	22%
		100%			100%

Annual Population Data Estimates** 2004 Population Data For Ages 13+

	Males		Females	TOTAL
White	4,792,416	5,091,997	9,884,413	
Black	976,884	1,079,809	2,056,693	
Hispanic	1,271,353	1,272,451	2,543,804	

The population data are 2004 population estimates. Rates per risk group will be calculated as follows, per the PPG:
MSM=# MSM cases X 100,000 / (specific race male pop X 7%)
IDU=# IDU cases X 100,000 / (specific race pop X 2%)
Hetero AT RISK=#Hetero cases X 100,000 / (specific race * (50% male and 50% female pop))

Step 2. Calculated LIVING HIV/AIDS Case Rates per 100,000 pop Age 13+ by Race and Mode of Exposure*

2003-2005	Heterosexual AT RISK		MSM	IDU
	M+F	Males	M+F	M+F
White	76.8	5513.6	1738.9	12420.1
Black	2323.3	12806.0	12420.1	4186.4
Hispanic	361.7	10448.3	4186.4	

Step 3.
Place the population with the largest RATE in the first position, the next largest percentage in the second position etc., down to the lowest in the final position.
The larger the number, the larger the disproportionate impact, thus the higher the rank.

Ranking of Data by Rate per 100,000 Pop			Ranking of Data by Population		
Rank	Population	Rate	Rank	Population	Rate
1	B-MSM	12,806.0	6	B-Hetero	2,323.3
2	B-IDU	12,420.1	2	B-IDU	12,420.1
3	H-MSM	10,448.3	1	B-MSM	12,806.0
4	W-MSM	5,513.6	8	H-Hetero	361.7
5	H-IDU	4,186.4	5	H-IDU	4,186.4
6	B-Hetero	2,323.3	3	H-MSM	10,448.3
7	W-IDU	1,738.9	9	W-Hetero	76.8
8	H-Hetero	361.7	7	W-IDU	1,738.9
9	W-Hetero	76.8	4	W-MSM	5,513.6

THREE FOLD PATH METHODOLOGY and Advancing HIV Prevention (AHP) Tool						
Populations	50% of weight HIV Case Data Rank	25% of weight Disproportionate Impact Rank	25% of weight CPP Rank	Sum of each of the Ranks	Divided by 3	Final Priority Rank
B-Hetero	1	6	8	15	5	5
B-IDU	7	2	16	25	8.3	8.3
B-MSM	3	1	7	11	3.7	3.7
H-Hetero	5	8	18	31	10.3	10.3
H-IDU	9	5	23	37	12.3	12.3
H-MSM	4	3	11	18	6	6
W-Hetero	6	9	21	36	12	12
W-IDU	8	7	23	38	12.7	12.7
W-MSM	2	4	8	14	4.7	4.7

Appendix D

Acronym List

3MV	Many Men, Many Voices
AATI	African American Testing Initiative
AMEN	Acknowledge, Mobilize, Educate, Now
ARTAS	Antiretroviral Treatment Access Study
ASAP	AIDS Service Association of Pinellas
BART	Becoming a Responsible Teen
BRG	Blackmon Roberts Group
CAN	Community AIDS Network
CAP	Comprehensive AIDS Program of West Palm Beach
CDC	Centers for Disease Control and Prevention
CFHM	The Convention of Florida Health Ministries
CMWP	Center for Multicultural Wellness & Prevention
CRCS	Comprehensive Risk Counseling and Services
CTG	Closing the Gap
CTL	Counseling, Testing, and Linkage (Florida DOH terminology)
CTR	Counseling, Testing, and Referral (CDC terminology)
DACCO	Drug Abuse Comprehensive Coordinating Office
D-Up	Defend Yourself
FAITH	Finding Alternatives, Initiating and Transforming Hope
FFPB	Families First of Palm Beach (Formerly CCMO)
FLOW	Future Leaders Of the World
FWAF	Farmworker Association of Florida
GLCC	Gay & Lesbian Community Center of S. Florida
GR	General Revenue
HHCCF	Hope and Help Center of Central Florida
HP	HIV Prevention
HRSA	Health Resources and Services Administration
JASMYN	Jacksonville Area Sexual Minority Youth Network
LIFE	Learning Immune Function Enhancement Project
MAACA	The Minority Alliance for Advocating Community Awareness and Action
MAI	Minority AIDS Initiative
MCRHS	Manatee County Rural Health Services
MDEI	Minority Development and Empowerment
MISTERS	Men Involved in STD Training Empowerment Research Study
MUJER	Mujeres, Unidas, En Educacion y Reforma
NEED	Nehemiah Educational & Economic Development
OASIS	Okaloosa AIDS Support and Informational Services
PfH	Partnership for Health

PG	Prevention Grant (from CDC)
POL	Popular Opinion Leader
Community PROMISE	Peers Reaching Out and Modeling Intervention Strategies for HIV/AIDS Risk Reduction in their Community
RAPP	Real AIDS Prevention Project
SoBAP	South Beach AIDS Project
SNS	Social Network Strategies
THAP	Tampa-Hillsborough Action Plan
TOPWA	Targeted Outreach for Pregnant Women Act
VOICES/VOCES	Video Opportunities for Innovative Condom Education and Safer Sex
WBFPRC	West Bartow Front Porch Revitalization Council
WILLOW	Women Involved in Life Learning from Other Women
YEP	Youth Empowerment Program

Appendix E

Evidence-Based Interventions Florida Department of Health, Bureau of HIV/AIDS

B.A.R.T. (Becoming A Responsible Teen) is a group-level, education and behavior skills training intervention designed to reduce risky sexual behaviors and improve safer sex skills among African American adolescents. The 8 intervention sessions, delivered to groups of 5-15 youth, provide information on HIV and related risk behaviors and the importance of abstinence and risk reduction.

Brother-to-Brother: Hot, Healthy, and Safe is a three-session behavioral intervention aimed at reducing HIV infection among African-American gay and bisexual men. Sessions are designed to foster positive self-identity development, educate participants about HIV/AIDS risk, teach assertiveness, and encourage the sharing of commitments and strategies for risk reduction among group members. Participants gain mastery through role-play, group discussion, and behavioral skills exercises.

CLEAR (Choosing Life: Empowerment, Actions, Results) is a 3-module intervention that is delivered in one-on-one sessions to young people living with HIV. Each of the 3 modules is comprised of 6 sessions that focuses on different target behaviors.

Community PROMISE is a community-level HIV prevention intervention that relies on peer advocates to distribute role model stories of positive behavior change to members of the target population (role model stories are written from interviews with the target population). Besides reducing risk behaviors, the prevention messages can be used to encourage peers to seek HIV counseling and testing services and other prevention and treatment services. The intervention is based on Stages of Change and other behavioral theories, and can be implemented with various populations including IDUs, MSM, sex workers, and partners of high risk individuals. For Community PROMISE to be effective, members of the target population must be able to identify with one another and openly communicate about risk factors.

CRCS (Comprehensive Risk Counseling and Services) is an individual-level intervention, formerly referred to as Prevention Case Management, designed to help HIV-positive and HIV-negative persons who are at high risk for HIV transmission or acquisition to reduce risk behaviors and address the psychosocial and medical needs (i.e., "Life Plus" issues) that contribute to risk behavior or poor health outcomes.

d-Up: Defend Yourself! Is a community-level intervention for black men who have sex with men (MSM). D-up! Is a cultural adaptation of the Popular Opinion Leader (POL) intervention and is designed to change social norms and perceptions of black MSM regarding condom use.

Focus on Youth with ImPACT is a community-based intervention that provides youth with the skills and knowledge they need to protect themselves from HIV and other STDs. The curriculum, founded on the Protection Motivation Theory, uses fun, interactive activities, such as games, role plays and discussions to convey prevention knowledge and skills. There is also a short component for parents, Informed Parents and Children Together (ImPACT) that assists them in areas such as parental monitoring and effective communication.

Get Real About AIDS is a skills-based, HIV risk reduction curriculum, designed for high school students. It consists of 15 sessions, delivered over consecutive days, and utilizes interactive activities, discussion, role-playing, simulation, and videos to give teens the knowledge and skills to reduce their risk of HIV infection. The overall goal of Get Real About AIDS is to reduce sexual risk behaviors by delaying the initiation of sex. The program goal for youth who choose to have sex is to encourage them to abstain from drug use, to use condoms consistently and correctly, practice monogamy, and get tested for HIV.

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. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure and behavior. The sessions create a context where people can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

L.I.F.E. (Learning Immune Function Enhancement) is a structured risk reduction prevention-counseling program that attracts, retains, and motivates HIV (+) clients through its emphasis on health enhancement. For the HIV positive individual, his or her own health and survival becomes a powerful motivation for risk reduction. All programs content is based on published research in medicine, psychology and allied health sciences.

Many Men, Many Voices (3MV) is a six- or seven-session, group level STD/HIV prevention intervention for gay men of color. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia.

MIP is an individual-level, intensive HIV prevention intervention for active injection and non-injection drug users that integrates community-based recruitment, individualized counseling and comprehensive case management to facilitate behavior change that leads to an overall healthier life for the participant.

Mpowerment is a community-level intervention for young MSM. The intervention combines informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay and bisexual men with HIV prevention, safer sex, and risk reduction messages. The intervention is run by a core group of 12 to 20 young gay and bisexual men from the community and paid staff coordinators. The core group members, along with other volunteers, design and carry out all project activities.

Nia is a video-based motivational skills-building small-group intervention consisting of 6-10 participants in each group. The intervention includes videos, movie clips, and discussion to educate men about HIV/AIDS, elevate their mood, and entertain them while reinforcing information and motivating behavior change.

Partnership for Health is a one-on-one, brief provider-administered safer sex intervention for HIV-positive persons in care. The intervention emphasizes the importance of the patient-provider relationship to promote patients' healthful behavior. At each clinic visit, the provider delivers a brief counseling session (3-5 minutes) with messages that focus on self-protection, partner protection, and disclosure.

Popular Opinion Leader (POL) is a community-level intervention that has wide potential for adaptation to risk populations defined by the need for promotion of a risk reduction supportive norm in the context of shared social networks clustered around popular, credible, and trusted individuals (or POLs). The POLs are recruited to have one-on-one conversations with peers in their friendship groups at a wide range of venues and settings. These conversations should endorse a norm that supports risk reduction (e.g., using condoms, getting tested for HIV).

Project SMART: AIDS Education for Drug Users in Short-Term Treatment was developed for use in short-term in-patient drug treatment programs and encompasses two distinct interventions: a short informational program, and a longer enhanced version that includes behavioral skills training. The intervention is delivered in small-group format, with 4-10 participants per group.

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

This intervention relies on peer-led outreach activities, including: stage based encounters, role model stories and brochures, community networking, referrals, safer sex discussions and condom distribution. The intervention objectives are to increase consistent condom use by women and their partners, to change community norms so that practicing safer sex is seen as the acceptable norm, and to involve as many people in the community as possible. The program has three phases: 1) community assessment, 2) community mobilization, and 3) maintenance.

RESPECT is a one-on-one, client-focused HIV/STD prevention counseling intervention, consisting of 2 brief interactive counseling sessions. In the first session (20 minutes) of the brief intervention, HIV counselors help STD clinic patients to identify personal risk factors and barriers to risk reduction and work with patients to develop an achievable personalized risk-reduction plan.

S.A.F.E. is a small group, motivational and skill building intervention to reduce risky sexual behaviors and STDs among minority women. The 3 intervention sessions, delivered to groups of 5-6 women, emphasize recognizing risk, increasing commitment to change behavior, and facilitating the acquisition of protective skills.

Safety Counts is a client-centered intervention for users of illicit drugs (injection or non-injection drugs) that aims to reduce high-risk drug use and sexual behaviors that are related to the transmission of HIV and Hepatitis. The intervention is a behaviorally focused, seven-session intervention, including both structured and unstructured activities in group and individual settings over four to six months. The intervention can be implemented with both HIV-negative and HIV-positive clients.

SEPA (Salud, Educación, Prevención y Autocuidado) is a six-session, culturally-tailored, small-group, skills building intervention designed to prevent high-risk sexual behaviors among low-income Mexican and Puerto Rican women. The intervention, delivered to groups of 11-13 women, promotes self-efficacy, builds skills and focuses on topics including: HIV/AIDS in the community, human anatomy and sexuality, education about HIV and other STDs, condom use, negotiation of safer sex, and preventing domestic violence.

SiHLE is a small group, skills training intervention to reduce risky sex behavior among African-American adolescent females. Through interactive discussions in groups of 10-12 girls, the intervention 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.

SISTA (Sisters Informing Sisters about Topics on AIDS) is a group-level, gender and culturally relevant intervention, designed to increase condom use among heterosexually active African American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, coping, and skills training around sexual risk reduction behaviors and decision-making.

Street Smart is a multi-session, skills building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use. Sessions address improving youths' social skills, assertiveness and coping through exercises on problem solving, identifying triggers, and reducing harmful behaviors. Agency staff also provides individual counseling and trips to community health providers.

TLC (Together Learning Choices) is a small-group intervention designed for youth and young adults living with HIV. TLC consists of 2 modules: Stay Healthy and Act Safe. The Stay Healthy module consists of 12 sessions to promote positive health behaviors. Intervention sessions are focused on coping with learning one's seropositive status, addressing issues of disclosure, and helping youth to implement new daily routines to stay healthy and actively participate in health care decisions.

VOICES/VOCES is a group-level, single-session, video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Participants, grouped by gender and ethnicity, view an English or Spanish video on HIV risk behaviors and condom use and take part in a facilitated discussion.

WILLOW is a small group, skills-training intervention for women living with HIV. Through interactive discussions within groups of 8-10 women, the intervention emphasizes gender pride and informs women how to identify and maintain supportive people in their social networks. The intervention enhances awareness of HIV transmission risk behaviors, discredits myths regarding HIV prevention for people living with HIV, teaches communication skills for negotiating safer sex, and reinforces the benefits of consistent condom use.