Northeastern North Carolina Partnership for Public Health

HIV Prevention Strategic Plan Through 2010

Preface

Since the beginning of the AIDS epidemic more than 25 years ago, state and local health departments have been on the forefront of prevention.

Over the last two and a half decades HIV/AIDS prevention and treatment science has advanced dramatically. Mother-to-child transmission statewide has been drastically reduced in recent years from a high of 19 in 1993 to 2 perinatal HIV infections annually. Behavioral science has expanded the repertoire of targeted, effective prevention programs for populations at high risk for HIV infection, such as men who have sex with men, injection drug users, and women who engage in risky behaviors. Statewide and in many regions, capacity to design, deliver and evaluate interventions has also grown significantly. With the advent of new drug combinations to treat HIV infection and delay the onset of AIDS, there is renewed hope and cautious optimism about further reducing transmission as infected people's viral loads are diminished and their potential infectiousness is possibly reduced.

While much of this is true nationally, as noted in the Southern Manifesto, a 2003 publication of the National Association of State and Territorial AIDS Directors, the South has suffered a disparity in the amount of federal funds received compared to the impact of HIV/AIDS in these states. Rural Northeastern North Carolina has been particularly disparate as it attempts to address socioeconomic and demographic issues and their effect on the need for prevention and care related to HIV/AIDS.

In light of the aforementioned successes, 105 people per year in Northeastern North Carolina continue to become infected with HIV, a number that has remained relatively stable – *but unacceptably high* – for the past few years. And although the number of new infections has been static, the epidemic itself is not. In addition to the groups that have been at highest risk since the beginning of the epidemic – men who have sex with men – new populations are increasingly at risk for infection, particularly racial and ethnic minorities, women, and adolescents.

A strategic plan for HIV prevention and control is timely and essential in guiding efforts in Northeastern North Carolina to more effectively address HIV infection and AIDS. The Regional Planning Group (RPG 6) of the Statewide Community Planning Group (SCPG) has recently completed a revitalization process. It is the regional planning body charged with the responsibility for identifying the needs of the region, determining where gaps exist in service delivery and advising the state on what resources it needs to effectively address HIV in the region. The organization of the incubation project, NENCPPH and its identification of a five-year strategic plan, takes the effort to another level. Where state funding resources may be in limited supply for new and expanded initiatives, the strategic plan places the partnership in a strong position to approach CDC, HRSA, SAMHSA and other federal agencies to directly support a regional community collaborative that can effectively address HIV infection and AIDS.

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Introduction to HIV Prevention Strategic Plan

NENCPPH contracted with Andrew Sturdy, public health community planning consultant and co-chair of the NC Statewide Community Planning Group, to facilitate a HIV prevention strategic planning process that would encompass the nineteen counties within the partnership. Centers for Disease Control and Prevention's HIV Prevention Strategic Plan through 2005 was used as a model throughout the process. Although the national process took more than two years to complete, the resulting plan was an excellent framework from which to work.

In 2004, two documents were developed and presented that specifically addressed the epidemic as it affects the northeaster region of the state. The first published in November sponsored by ENCHAC, PACC, and the Statewide Community Planning Group is entitled 2004 HIV Care and Prevention Needs Assessment and Resource Inventory for Region 6 and Johnston, Wake and Wilson Counties. The second, published in December by NENCPPH, is entitled HIV Disease in Northeastern North Carolina. Both documents were extremely helpful in determining priorities that needed to be addressed in the strategic plan. A Power Point presentation, *Current Status of the HIV/AIDS Epidemic in Northeastern North Carolina*, can be found as Appendix A of this document.

Two additional documents were introduced as helpful resources. North Carolina Epidemiologic Profile for 2005 HIV/STD Prevention & Care Planning describes the HIV and STD epidemics among various populations in the state. CDC's publication, Advancing HIV Prevention: Interim Technical Guidance for Selected Interventions is a compendium of evidenced-based initiatives under its new initiative that emphasizes the need for HIV testing and prevention efforts in both clinical and non-clinical settings to help increase the number of infected persons who learn their status and are successfully referred into treatment and prevention services as early as possible.

On April 6, the process began with a community forum in Edenton at which nearly forty individuals representing a cross-section of community-based organizations, faith-based organizations, AIDS service providers, Elizabeth City University, NC health officials and consumers discussed and identified an overarching goal for the region and three specific goals to be accomplished by 2010. During the forum, those present discussed and developed suggestions for objectives and action steps to achieve the goals. A Summary of Community Input to Strategic Planning Process can be found as Appendix B.

On April 14, the goals and objectives were presented to the NENCPPH governing body at its meeting in Ocracoke. Those present reviewed recommended strategies to meet objectives and discussed and identified action steps to be implemented during the first year. It was the consensus of the group that the strategic plan is a work in progress and in coming months, additional action steps will be determined for implementation during the first three years to achieve five-year goals A Summary of Initial Action Plan is attached as Appendix C.

Successful Prevention Works on a Continuum

Successful prevention efforts avert HIV infection. The most effective prevention works at multiple levels simultaneously – on individual, social network and community levels as well as at the structural level – addressing the sometimes hidden societal barriers to effective prevention. Successful prevention provides support for healthy decision-making for people at risk for HIV infection and for those who are already infected, to help them avoid spreading the virus to others. *(See elements of Successful HIV Prevention Programs,* next page.)

The objectives and strategies should be designed to optimize the benefits of a continuum of HIV prevention and treatment, as reflected in the goals of the strategic plan. In this continuum:

Individuals use the full array of existing prevention interventions and services to adopt and maintain risk reduction behaviors. *(Goal 1)*

Individuals determine their HIV status through voluntary counseling and testing as early as possible after their exposure to HIV. *(Goal 2)*

If they test negative for HIV, they use the full array of existing prevention interventions and services to adopt and maintain HIV risk reduction. *(Goal 1)*

If they test positive for HIV, they use quality prevention services and work to adopt and sustain lifelong protective behaviors to avoid transmitting the virus to others. *(Goal 1, 2 and 3)*

If they are HIV-infected, they enter the care system as soon as possible to reap the benefits of ongoing care and treatment. *(Goal 3)*

Once in the care system, they benefit from comprehensive, high quality services, including mental health and substance abuse services; treatment for HIV infection; prevention, prophylaxis and treatment of opportunistic infections and other infections such as STDs and TB. *(Goal 3)*

In conjunction with other providers and support networks, they work to develop strategies to optimize adherence to their prescribed therapies. *(Goal 3)*

Elements of Successful HIV Prevention Programs

To succeed, HIV prevention efforts must be comprehensive and science-based. The following elements are required for prevention to work:

- An effective community planning process
- Epidemiologic and behavioral surveillance; compilation of other health and demographic data relevant to HIV risk, incidence and prevalence
- HIV counseling, testing and referral and partner counseling and referral, with strong linkages to medical care, treatment and needed prevention services
- Health education and risk reduction activities, including individual-, group- and community-level interventions.
- Accessible diagnosis and treatment of other STDs
- Public Information and education programs
- Training and quality assurance
- HIV prevention capacity-building activities
- An HIV prevention technical assistance assessment and plan
- Evaluation of major program activities, interventions and services

The goals, objectives and subsequent strategies of this strategic plan must address each of these essential components of a comprehensive prevention program.

NENCPPH's Goals for HIV Prevention

Overarching Partnership Goal

Through a collaborative network of NENCPPH, nongovernmental and other governmental agencies, reduce the number of new HIV infections in Northeastern North Carolina from 105 to 50 per year by 2010, focusing particularly on eliminating racial and ethnic disparities in new HIV infections.

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GOAL 1

By 2010, decrease by at least 50% the number of persons in Northeastern North Carolina at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.

Rationale

Based on the US Census 2003 population estimate for the nineteen partnership counties (425,292) and the percent of adults who admitted engaging in at-risk behavior during the previous year (4.1) reported through the BRFSS over-sampling conducted in 2003, it is estimated that approximately 17,400 people are at continued behavior risk for HIV infection. It is likely that this estimate is lower than the actual number of persons at behavioral risk, because of under-reporting among participants and the sample itself, which was a household survey and so excluded people in institutional settings including schools, prisons and the military.

Decreasing new infections in half and reducing the number of those at high risk for HIV infections by half are ambitious goals – but they can be accomplished with sufficient resources to deploy interventions of proven effectiveness.

To cut new infections in half, all the factors that affect an individual's ability to make healthy choices must be addressed. Communities must be equipped with local data to know who is at risk; they must direct resources to those most at risk; they must have an array of effective interventions available and the capacity to implement and evaluate them at the local level; and they must be able not only to address barriers and deter risky behaviors but promote healthy behavior, through a variety of individual and group interventions, community-level supports and structural level changes.

The goal of cutting new infections in half will not be achieved without significant progress in meeting all three of the partnership goals. Reducing the number of persons at behavioral risk is required. Ensuring that all those infected with HIV are aware of their status, in order to receive the benefits of improved HIV therapies as well as the benefits of counseling and support they need to reduce the risk of infecting others is vital, as described in goal 2. Additionally, HIV prevention must be integrated with other services and STD and TB screening and treatment, reproductive health services, mental health services and drug use prevention and treatment, as described in goal 3. Those at risk for or living with HIV infection are often at risk for other health problems. Integrating services, making it easier for people to seek and receive care and prevention interventions, will increase effectiveness as well as efficiency.

Objective 1: Among people living with HIV, increase the proportion who consistently engages in behaviors that reduce risk for HIV transmission and acquisition.

1. Implement community interventions to reduce stigma, discrimination and domestic violence surrounding HIV infection, focusing particularly on communities of color, whose members face stigma related to multiple factors including race/ethnicity, immigration status and/or socioeconomic status.
2. Implement HIV prevention interventions (e.g., individual, couples, groups, community, social marketing and structural level interventions) that address the diversity of individuals and populations living with HIV, as well as there partners, and their special needs, differentiating between those newly infected and those living with infection for more than 6 months.
3. Increase the percentage of infected persons who receive high quality partner counseling and referral services to ensure that partners potentially exposed to HIV receive counseling and testing and, if infected, are referred to appropriate early evaluation and care.
4. Improve screening, diagnosis and treatment of concomitant STDs, including hepatitis, and TB among persons with HIV infection, particularly those in the corrections system, and improve partner counseling and referral.
5. Implement evidence-based prevention programs for HIV-infected persons who use alcohol and other drugs (e.g., crack cocaine, crystal meth).

Objective 2: Among men who have sex with men (MSM), increase the proportion who consistently engages in behaviors that reduce risk for HIV acquisition or transmission.

1. Implement evidence-based behavioral HIV prevention programs for MSM (including the prevention of reversion for risky behavior by those currently practicing safer sex) – particularly for MSM of color, young MSM, MSM engaged in sex work and men housed in corrections system.
2. Assist in the improvement of surveillance of HIV/STD risk behaviors among MSM (gay- and non-gay-identified), bisexual and transgendered/gender variant persons, particularly sex workers.

3. Through technical assistance and capacity building, increase community collaborations with CBOs and other agencies that successfully provide demonstrably effective, culturally competent HIV prevention interventions for MSM.
4. Increase screening, diagnosis and treatment of STDs among MSM, including those within corrections systems.
5. Implement community interventions to reduce stigma, discrimination associated with sexual orientation and gender variance.
6. Implement evidence-based HIV prevention programs for MSM at risk for HIV, including those within the corrections systems, who use alcohol and other drugs (e.g., crack cocaine, crystal meth).
7. Based upon yet to be developed local epidemiologic and behavioral data, implement evidence-based HIV prevention programs for male-to-female transgendered/gender variant male persons who have sex with men, particularly those who engage in sex work for money, drugs or survival.

Objective 3: Among adolescents, increase the proportion who consistently engages in behaviors that reduce risk for HIV acquisition or transmission.

1. Implement evidence-based *community-based* HIV/STD prevention programs that help adolescents abstain from intercourse, delay intercourse and develop safer sexual practices – particularly for adolescents in high risk situations, especially out-of-school youth, gay/lesbian/bisexual/transgender and questioning youth, those who have been sexually abused, youth in detention and foster care, run-away youth, youth engaged in sex work and youth of color.
2. Implement evidence-based comprehensive *school-based* HIV/STD prevention programs that help all adolescents abstain from intercourse, delay intercourse and develop safer sexual practices, particularly youth of color and gay/lesbian/bisexual/transgender and questioning youth.
3. Through technical assistance and capacity building, increase community collaborations with CBOs and other agencies that successfully provide demonstrably effective, culturally competent HIV prevention interventions for the diversity of adolescents at risk.
4. Implement programs that help reduce adolescents' sexual risk-taking connected wit substance abuse.
5. Increase screening, diagnosis and treatment of HIV and other STDs among young people.
6. Implement evidence-based programs for constructive family communication around sexual behavior.

Objective 4: Among injecting drug users (IDUs), increase the proportion who abstain from drug use or, for those who do not abstain, use harm reduction strategies to reduce risk for HIV acquisition or transmission.

1. Implement culturally competent HIV prevention interventions targeting IDUs, particularly IDUs of color and those within corrections systems.

2. Through technical assistance and capacity building, increase community collaborations with CBOs and other agencies that successfully provide demonstrably effective, culturally competent HIV prevention interventions for IDUs.
3. Increase comprehensive services for IDUs, including HIV/STD testing (including hepatitis), substance abuse treatment, methadone maintenance and harm reduction programs to promote non-sharing of injection equipment and use of sterile injection equipment.
4. Provide incarcerated individuals with HE/RR and linkages to HIV, STD and substance abuse prevention and treatment programs, mental health programs and other community-based services.

Objective 5: Among at-risk sexually active women, and at-risk heterosexual men, increase the proportion who consistently engages in behaviors that reduce risk for HIV acquisition or transmission.

1. Implement evidence-based behavioral HIV prevention programs that strengthen the capacity of women, especially women of color and those engaged in sex work, to make and carry out decisions to reduce their sexual risk and increase their protective behaviors (e.g., correct, consistent and appropriate condom use, reductions in higher-risk sexual practices, early diagnosis and treatment of STDs).
2. Through technical assistance and capacity building, increase community collaborations with CBOs and other agencies that successfully provide demonstrably effective, culturally competent HIV prevention interventions for sexually active women and heterosexual men..
3. Increase the availability and acceptance of female-controlled HIV prevention technology (e.g., micobicides, female condoms, postexposure prophylaxis).
4. Implement evidence-based behavioral HIV prevention interventions in STD clinics, primary care and family planning settings, especially in communities of color.
5. Implement evidence-based behavioral HIV prevention programs for heterosexual men, especially men of color and those housed in corrections systems.
6. Implement evidence-based HIV prevention programs for persons at increased risk for HIV who use alcohol and other drugs (i.e., crack cocaine, crystal meth.).

Objective 6: Increase the proportion of people at higher risk for HIV who are tested for STDs and treated appropriately.

1. Increase awareness among HIV prevention providers of how STDs increase risk of HIV transmission and how to appropriately test and care for patients with STDs, including hepatitis B and C.
2. Increase the proportion of primary care providers who perform routine and periodic testing and provide needed treatment for STDs for people at risk for HIV and living with HIV (including those in correctional facilities).

3. Increase awareness among people living with HIV and people at increased risk for HIV of how STDs increase risk of HIV transmission.
4. Increase access to STD clinical care for people at increased risk for HIV and STDs by expanding service delivery venues to community-based organizations and nontraditional venues.
5. Increase the number of public counseling and testing sites offering voluntary STD screening.
6. Ensure that persons with other STDs receive counseling and voluntary testing for HIV.

GOAL 2

By 2010, through voluntary counseling and testing, increase from the current estimated 41.1% to 80% the proportion of HIV-infected people in Northeastern North Carolina who know they are infected and from 61% to 75% those identified in early stage of disease.

Rationale

For HIV-infected people to receive the benefits of improved HIV therapies and prophylaxis for opportunistic infections, as well as of client-centered counseling and other behavioral interventions to reduce the risk of infecting others, these individuals need to know their infection status. While at-risk sexually active people should be encouraged to be counseled and tested for HIV, prevention resources for counseling and testing must be targeted to those whose behaviors place them at increased risk for infection. During 2003, 33.2% of HIV cases were reported by a hospital within NENC, higher than those reported by hospitals statewide. Only 16.3% were reported by private doctors and 27% by Counseling and Testing Sites (CTS). Collaboration among private health care service providers and nontraditional CTS is an essential element of this goal.

New HIV cases in NENC are more likely to be reported at a later stage of disease (AIDS). In 2000 to 2003, 39% of new HIV disease cases were reported compared to 27.3% statewide (43% higher). It is imperative that strategies be developed and action steps be put into place to identify HIV cases at an early stage of the disease.

HIV counseling should not be a barrier to HIV testing, and testing should not be a barrier to counseling. Counseling and testing strategies for those who deny their risk, those who identify their risk but have not been tested and those who underestimate or are unaware of their risk will be different. Targeted approaches for each group are essential.

To achieve the goal of increasing the proportion of HIV-infected individuals who learn their serostatus through high-quality, client-centered voluntary counseling and testing, several crosscutting strategies must be implemented and maintained:

- HIV counseling and testing must remain voluntary and confidential and be provided in ways that address the cultural variations of our region's diverse communities to maximize the acceptance and delivery of testing services to at-risk communities.

- Evidenced-based programs, particularly those advocated by CDC, designed to increase knowledge of HIV infection status must be developed in collaboration with state and local partners (both governmental and nongovernmental organizations) and with the input from community leaders.

- New rapid testing technologies should be adopted to enable testing in nontraditional settings – such as street outreach programs, social venues and public service sites (e.g., DSS offices) – and to provide screening test results during initial patient encounters so that clients do not have to return for their test results. Strong collaborative efforts must be put into place between local health departments (LHDs), community-based organizations (CBOs), faith-based organizations (FBOs) and AIDS service organizations (ASOs). Any notions of being in competition with another agency must be replaced with joint initiatives through memoranda of agreement.

- Partner notification services to identify at-risk individuals who should be offered and testing should be increased.

Objective 1: Increase the motivation of at-risk individuals to know their infection status and decrease real and perceived barriers to HIV testing.

1. Implement strategies to address real and perceived barriers to testing – such as fears concerning being infected/testing positive, stigmatization, criminalization, parent/guardian notification, partner notification, violence and confidentiality (including the impact of implementing HIV named reporting), concerns about the availability and benefits of care and treatment, as well as cultural barriers – at community, societal and structural levels.
2. Increase surveillance to assess specific populations' testing behaviors, differentiating among those who have never been tested, those who are repeat testers and those who test frequently.
3. Implement strategies to address population-specific effects of risk-denial on individual motivation to be tested.
4. Implement marketing strategies to promote testing (including enhancing the at-risk public's knowledge of primary infection indicators and the benefits of testing) in at-risk groups, focusing particularly on population of color and special-needs populations, and differentiating among those who have never tested, those who are repeat testers and those who test frequently.
5. Implement population-specific, culturally competent models for voluntary, client-centered HIV counseling and testing, including couples testing, group-based approaches and alternative methods of providing results.
6. Implement population-specific, culturally competent models on integrating STD and HIV counseling and testing.
7. Through technical assistance and capacity building, increase community collaborations with community planning groups, CBOs and other agencies who

can capably address barriers to testing among the diversity of people at risk for HIV and living with HIV, but focusing particularly on communities of color and special-needs populations (e.g., deaf/hard of hearing, homeless, injection drug users, etc.).
8. Increase patient-level interventions to encourage those at risk for HIV infection to request testing.

Objective 2: Improve access to voluntary, client-centered counseling and testing in high seroprevalence communities and populations at risk, focusing particularly on populations with high rates of undiagnosed infection.

1. Increase access to anonymous and confidential testing, particularly in communities of color and communities with high HIV incidence or prevalence and/or high rates of other STDs.
2. Through technical assistance and capacity building, increase community collaborations with CBOs and other agencies that successfully provide demonstrably effective, culturally competent client-centered counseling programs and voluntary testing programs.
3. Increase the proportion of persons with conditions (e.g., tuberculosis, sexually transmitted diseases and hepatitis C) and/or behaviors (such as unprotected sex and multiple partners, injection drug use) that indicate HIV risk who receive voluntary counseling and testing.
4. Evaluate the effectiveness of various types of partner counseling and referral programs in order to increase the proportion of at-risk sexual or needle-sharing partners who are notified of their risk; receive counseling and voluntary testing; return for their test results; and, if infected, are referred to follow-up or, if negative, receive prevention services to reduce their risk.
5. Increase the availability of free or low-cost HIV testing at both clinical and non-clinical sites in high seroprevalence areas, including urgent care centers and emergency rooms, community-based organizations, STD clinics, substance abuse treatment centers, other street outreach programs, faith-based service centers, welfare offices and family planning clinics.
6. Increase the proportion of sexually active youth and young adults who are routinely offered HIV counseling and voluntary testing.
7. Increase surveillance to assess rates of testing, testing behaviors and knowledge of serostatus, particularly in communities of color and among special-needs populations.

Objective 3: Increase the number of providers who routinely provide VCT in health care settings (e.g., STD clinics, substance abuse treatment programs, family planning clinics, emergency rooms, community health centers), as well as nontraditional venues (e.g., social venues, public assistance programs, street outreach).

1. Implement education and training initiatives for physicians, nurses and other health care providers to promote and enhance culturally competent, client-centered, high-quality HIV/STD counseling and testing.
2. Promote VCT for appropriate Medicaid, Medicare and private-sector managed care plan enrollees.
3. Increase provider recognition of primary HIV infection and awareness of other medical conditions that may also be indicative of HIV disease in order to promote appropriate and timely testing.
4. Increase the availability of rapid testing using OraQuick that can be easily coupled with STD testing.
5. Implement provider-level and systems-level interventions to increase HIV testing.

Objective 4: Increase the percentage of people who know their results after testing.

1. Increase the availability and use of rapid tests to provide same-day screening results as well as other mechanisms to reduce turnaround time for results.
2. Increase surveillance of VCT sites to assess return rates, attitudes and behaviors, particularly in communities of color and among special-needs populations.
3. Implement patient incentives and other strategies to increase return rates.
4. Increase follow-up for seropositive individuals who do not return for their results

GOAL 3

By 2010, increase from the current estimated 50% to 80% the proportion of HIV-infected people in the Northeastern North Carolina who are linked to appropriate prevention, care and treatment services.

Rationale

In recent focus groups involving infected individuals within the region, the lack of multiple providers to render care to those needing help is the most critical barrier. Participants were aware of who the doctors are that care for HIV patients, but distance is the barrier. Access to transportation and the location of the medical providers limit clients from getting into treatment and remaining compliant with visits. The gap in getting to a provider when immediate medical attention is required can be a life-threatening event.

Mental health services are needed in conjunction with medical visits, also. Several participants acknowledged that their problems are many times associated with depression, isolation and fear. Most medical providers are not able to address psychological issues. Collaboration with mental health and public health providers would allow easier access for the patients and comprehensive services.

All infected people – regardless of when in the course of their illness they become aware they have HIV – are included in the following objectives and therefore in any strategies that are developed to meet the objectives. Clearly, it is ideal for people to begin treatment as soon as possible after infection. But many individuals may be infected for some time before seeking treatment and prevention services. The tactics to reach those who are newly infected and those who have been living with infection but have been out

of care are different and are described differently in the following objectives. Strategies to reach both should be developed accordingly. *While tactics may differ, what remains constant is the universal requirement that prevention providers coordinate and collaborate with other health agencies, such as ASOs, LMEs as well as other state and local partners, and with the local private medical sector, to achieve the objectives and developed strategies for this goal.*

Goal 3 also seeks to address two complementary but distinct types of services for people infected with HIV – services directed toward supporting their efforts to prevent further transmission and services directed toward their treatment and care. Most prevention providers do not have responsibility for care of infected individuals. That responsibility belongs to private providers and public clinics. Prevention providers such as LHDs are responsible, however, for prevention – and prevention programs for individuals who are already infected are an important way to avert further infections. Thus, many of the objectives, and strategies to be developed call for LHDs and other prevention providers to coordinate with other agencies whose chief responsibilities are care, in order to institute ongoing counseling and prevention messages that are needed throughout care.

Effective prevention efforts must address the spectrum of needs of those who are infected. Care for HIV-infected individuals must be comprehensive and reflect the fact that counseling for mental health, substance abuse and social service needs and linkage to required services helps the prevention effort and is also the right thing to do.

Objective 1: Reduce the disparities in access to prevention and care services that are experienced by communities of color, women and special-needs populations.

1. Promote cultural competence in prevention programs for HIV-infected persons.
2. Through technical assistance build the capacity of prevention providers serving HIV-infected persons of color to deliver culturally competent prevention services.
3. Through technical assistance develop the capacity for agencies that serve persons of color, women and special-needs populations to submit proposals to CDC, HRSA and other funding agencies that address prevention service needs of HIV-infected minorities, women and others with special needs.

Objective 2: Integrate prevention services, including adherence to treatment, for persons diagnosed with HIV and AIDS into delivery of patient care in both public and private sectors.

1. Implement programs integrating ongoing prevention, care, treatment and other support services for HIV-infected persons.
2. Incorporate appropriate care elements into prevention planning and prevention elements into Care Consortia.

Objective 3: Increase the proportion of persons who have been diagnosed with HIV who are successfully linked to culturally competent, science-based prevention services.

1. Ensure that HIV-infected persons tested at VCT sites obtain a comprehensive needs assessment and referral to prevention case management as needed no later than 3 months after learning their HIV status.
2. Encourage the establishment and maintenance of prevention service components in public HIV/AIDS outpatient clinics.
3. Through technical assistance, increase the capacity of public and private health care providers (physicians, physician assistants, nurses in public and private settings) to provide brief behavioral prevention counseling to HIV-infected persons and refer them to community-based organizations for further counseling as needed.
4. Develop approaches to monitoring HIV-infected persons to prevention services.
5. Integrate HIV prevention services into public and private health care systems that serve persons with HIV/AIDS.
6. Increase the capacity of religious and other community-based organizations to provide HIV prevention and support services for people with HIV/AIDS.

Objective 4: Increase the proportion of persons diagnosed with HIV who are successfully linked to medical care no later than 3 months after learning their HIV status or re-identified as being HIV-infected but out of care.

1. Provide published guidelines for best practices for enhancing successful linkage from post-test counseling to care and patient use of recommended medical services.

Objective 5: Increase the proportion of correctional facility detainees (incarcerated for at least 30 days) identified as HIV-infected who are provided HIV prevention, treatment and care services and who, upon release, are successfully linked to those services in the communities to which they return.

1. Promote comprehensive HIV needs assessments for HIV-infected detainees and promote the provision of services (including partner counseling and referral) that are indicated to prevent HIV and associated diseases such as other STDs, TB, hepatitis C and other communicable diseases.
2. Promote programs to provide culturally competent pre-release planning and l8inkage to community-based organizations for follow-up and needed case management services.
3. Secure resources and support to ensure that identified HIV-infected persons released from correctional facilities are successfully linked to ongoing prevention, care, mental health, substance abuse and community services within their communities.
4. Secure resources and support to facilitate access to education, counseling, voluntary testing and early intervention services for identified HIV-infected individuals in alternative sanction programs (e.g., drug courts) and probation programs.
5. Support HIV-related services and work toward reducing structural impediments to effective prevention (e.g., condom bans) for inmates demonstrating the economic,

individual and public health benefits of preventing, identifying and treating HIV, STD and TB among incarcerated populations.

Objective 6: Increase the proportion of HIV care providers offering routine, periodic STD screening and treatment to HIV-infected individuals.

1. Increase awareness of HIV prevention providers of how STDs (including hepatitis B and C) increase the probability of HIV transmission and acquisition and how to appropriately test and care for patients with STDs.
2. Advocate for increasing the proportion of primary care providers for people with HIV who perform initial as well as ongoing periodic risk assessment and STD screening and ongoing treatment as part of routine clinical care for HIV-infected persons in public, private and correctional settings.
3. Increase the number of HIV counseling and testing sites offering voluntary STD screening.
4. Increase awareness among people living with HIV of how STDs increase the probability of HIV transmission and acquisition.
5. Increase access to STD clinical care for people at increased risk for HIV and STDs by expanding service delivery venues to community-based organizations, substance abuse and mental health treatment centers and nontraditional venues.

Objective 8: Increase the proportion of HIV care providers offering routine, periodic TB screening and treatment to HIV-infected clients.

1. Increase awareness of HIV care providers of how TB impacts health of patients with HIV disease.
2. Advocate for the increase in proportion of primary care providers for people with HIV who perform TB screening and ongoing treatment as part of routine clinical care for IV-infected persons in public, private and correctional settings.
3. Increase awareness among people living with HIV of how TB impacts health of people with HIV disease.

Appendix A

Current Status of the HIV/AIDS Epidemic in Northeastern North Carolina

April, 2005

- 103 new disease cases were reported in NENC in 2004
- 523 cases reported 2000-2004 for an average per year of 104.6.
- 1169 cases reported 1994-2004 for an average per year of 106.3.

HIV Rate Per 100,000 Population

- 2000-2003 NENC average rate was 24.3.
- 2000-2003 state average rate was 20.8.
- Eight NENC counties had three year average rate (2002-2004) higher than the state (21.7) – Hertford (71.7), Edgecombe (55.2), Martin (35.9), Bertie (30.6), Hyde (29.8), Warren (23.5), Perquimans (23.0) and Washington (22.4). (Pasquotank was 21.3).

Reported Mode of Transmission NENC HIV Cases 2000-2003

- MSM accounted for 20.1% of total and 33.1% of male cases.
- Heterosexual contact accounted for 23.2% of total, 16.9% of males and 36.6% of females
- IDU accounted for 10.2% of total, 12.3% of males and 5.2% of females.
- 42.6% of total, 39.4% of male and 49.3% of female cases were NIR.

IDU Note for Planning Region 6

- IDU alone accounted for 9.8% of cases in 2003 compared to 11.9% in 1999 – a reduction of 17.6%.
- Statewide, IDU alone accounted for 9.4% of cases in 2003 compared to 17.6% in 1999 – reduction of >46%.

Demographic Characteristics of Newly Reported Cases 2000-2003

- 67.9% male; 32.1% female
- 82.9% African American; 12.6% White; 3.6% Hispanic; 0.8% Other
- Average incidence rate among males 2.3 times that of females.

Demographic Characteristics of Newly Reported Cases 2000-2003 (Cont.)

- NENC median age for female cases was 39 years and 42 years for males compared to NC median age of 37 for females and 38 for males. Those in NENC tend to be older.
- Of particular note is 17.9% of females were 20-29 years compared to 9.3% of males.
- Approximately one out five were fifty years or older.

ALERT!!!

- New HIV cases in NENC are more likely to be reported at a later stage of disease.
- 39% were reported after they had already progressed to AIDS – 43% higher than other NC counties (27.3%).
- Males 1.4 times more likely to be diagnosed or reported late and cases between 30 and 49 years more likely to be identified at the AIDS stage.

Reporting Facilities

- Hospital – 33.2%
- Counseling and testing site – 27%
- Private doctor – 16.3%
- Correctional facility – 10%
- Other type – 12.3%

In NENC, cases are more likely to be reported by a hospital compared to cases in other parts of the state.

Behavior and Knowledge

(BRFSS – 2003)

- Only 9.5% of adults have had a physician speak with them about prevention through condom use.
- Only 41.1% of adults have ever been tested for HIV.
- 94 % believe it is very important to know your HIV status by getting tested.
- 4.1% had engaged in a high risk behavior during the last year.
- 87.1% believe that there are treatments to help someone with HIV live longer.

Consumer of Services Data

(2004 HIV/AIDS Needs Assessment for Region 6, Johnston, Wake and Wilson Counties)

- **During 2003, 1,513 clients received services funded through Ryan White Title II. Distribution by race/ethnicity, sex and age similar to characteristics of PLWHA living in region at end of 2003.**
- **There is an estimated 3,767 PLWHA living in the service area.**

Service Priorities

- **Consumers ranked primary medical care as the highest priority (75%) followed by case management (65%), help finding low income housing (62%), transportation/rides (62%), support groups (60%), and mental health counseling (46%).**
- **Providers ranked low income housing as the highest priority (86%) followed by transportation (66%), case management (60%), food bank/receiving groceries (53%), medical care (46%), help paying utility bills (46%) and support groups (40%).**

Service Gaps

- **Consumers identified housing assistance as the number one service gap (what they needed but could not get). Second was transportation.**
- **Psychosocial support ranked very high as a service gap. Consumers shared feelings of being alone and isolated.**

OBSERVATIONS

- **Generally there is a shortage of health care professionals within the service area. Access to specific HIV treatment and care is often difficult. Clients travel long distances for specific HIV treatment.**
- **There are very few services in the service area funded through HRSA Ryan White Act Title III and IV funds. There are no known CDC directly funded initiatives in the region.**

OBSERVATIONS

- **Substance abuse and mental health issues continue to affect this region, particularly those affected by HIV. Proximity along I-95 corridor is a contributing factor.**
- **Lack of provider involvement in informing clients of at-risk behaviors was identified as a gap in service.**

OBSERVATIONS

- **All health departments provide HIV testing however none offer testing at non-traditional sites during non-traditional hours.**
- **Many health department outreach activities target the general population and some target high risk groups such as drug users and minority youth. None target persons living with HIV or medical providers.**

OBSERVATIONS

- **Some health departments use media to communicate information about HIV; Most utilized newspaper; two reported utilizing radio, none reported utilizing television.**

Recommendations

- **Regional HIV prevention and care planning should include discussions about increasing financial resources. This would include collaborative initiatives submitted to HRSA, CDC and OMH. Care and prevention planning groups should stay in regular contact with state and federal legislators drawing attention to the severe need for resources that exists in the region.**

Recommendations

- **With the assistance of NC Division of MH/DD/SA, care and prevention planners should collaborate with LMEs to develop strategies that will reduce mental health and substance abuse service disparities. Efforts by collaborating partners should be directed toward bringing SAMHSA CSAP and CSAT funds to the region to address the problem.**

Recommendations

- **With the assistance of the Branch, NENCPPH and other planners should develop strategies for implementation within the region using CDC's recommendations for incorporating HIV prevention into medical care of PLWHA as outlined in the July 18, 2003 MMWR.**

Recommendations

- **Learn more about why HIV cases in NENC are diagnosed at a later stage of the disease, and address this problem**
- **Learn more about promptness of treatment coverage of new HIV cases**
- **Increase media communication about HIV and AIDS in NENC**
- **Address the need to change social norms/perceptions about HIV in NENC**

Recommendations

- **Explore intervention strategies described in CDC Advancing HIV Prevention**
- **Assess HIV-related educational needs of medical care providers in NENC**
- **Increase communication with hospitals and other organizations interested in HIV prevention and care in NENC**

Appendix B

Summary of Community Input
to
Strategic Planning Process

On April 6, 2005, 38 individuals representing a cross section of HIV service providers within the catchment area met in Edenton to discuss the current status of HIV disease in Northeastern North Carolina and to recommend goals and objectives that should be included in a five-year strategic plan. There was great discussion related as to what is required to meet goals and objectives. A primary requirement was the establishment of strong collaborative partnerships between health departments, other governmental agencies such as D.S.S. and LMEs and nongovernmental agencies such as CBOs, ASOs and FBOs.

Identifying an overarching goal and three specific goals was not difficult. However, identifying specific objectives within each goal was. As is often the case, limited with a short period of time for discussion, participants are apt to identify strategies and/or action steps rather than true objectives.

The group divided into three sub-groups, each of which discussed one of the three goals. For ease of identity the three goals were abbreviated as: 1. Education, 2. Counseling and Testing, and 3. Care and Prevention Integration. Each group was asked to identify at least five objectives for the goal assigned to it. Discussion was lively and focused. Each group was then asked to report out their findings as noted as follows:

<u>Goal 1</u>

- Education of HIV/AIDS/STD and Reducing Risk Behavior on an annual basis (May – April) through the following events. Each county would do the following:

May Elder Fair/Aging Expo – Know how to educate the population (i.e., survey, brochures, PLWHA consumer perspectives, lectures, etc.)

June National HIV Testing Day/Education – Contact local CBOs to provide testing and education at nontraditional sites. If community does not have a participating agency, then LHD would provide.

October
Partnership for children inter agency initiative with DSS, churches, CBOs, LHDs and Juvenile Justice authorities participating. The state would provide the main speaker.

December
World AIDS Day

February Substance Abuse Awareness Month

Goal 2 Increasing the number of people knowing their HIV/AIDS status.

Objectives

- Partnership will implement a social marketing campaign within the 19 counties by January 1, 2006. Included in the campaign will be TV, increased brochure distribution, testing, importance of test results and early treatment.
- By March 31, 2006, host four community forums per county within the 19 county region.
- By November 15, 2006, we will recruit 10 peer education opinion leaders and providers per county in pre- and post-test counseling, rapid testing and prevention case management.
- Increase testing sites, traditional and nontraditional, by 50% by 2010.
- Administer 5,000 rapid HIV tests with a post-test counseling rate of 50% by 2010.

Goal 3 Increase the number of people in care and prevention services.

Objectives

- By December 2005, develop a resource directory for HIV providers that includes case management services, testing and treatment services.
- By March 2006, provide 3 trainings for HIV providers, case managers, testing and treatment services personnel that focuses on standardized protocol.
- Reduce disparities within access to prevention and care services by 10% per year through 2010.
- Reduce the time lapse between diagnosis, medical care and case management by 30 days.
- Develop and maintain adherence support group within each county by 2010.

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Summary of Initial Action Plan

At the Ocracoke retreat, those present discussed and identified potential action steps that could be put into place during the first year of the plan. As noted earlier, the strategic plan is a works in progress and additional action steps will be identified as time goes on. The following initial steps were identified according to each goal. It should be noted that some action steps may be implemented to achieve more than one objective within each goal.

Goal #1: *By 2010, decrease by at least 50% the number of persons in Northeastern North Carolina at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions.*

1. Implement community interventions to reduce stigma, discrimination and domestic violence surrounding HIV infection, focusing particularly on communities of color, whose members face stigma related to multiple factors including race/ethnicity, immigration status and/or socioeconomic status.
2. Implement HIV prevention interventions (e.g., individual, couples, groups, community, social marketing and structural level interventions) that address the diversity of individuals and populations living with HIV, as well as there partners, and their special needs, differentiating between those newly infected and those living with infection for more than 6 months.
3. Implement a social marketing campaign utilizing the assistance of the Branch in providing strategies and materials.
4. Educate public health and Medicaid providers on the need and methodology of integrating prevention for those testing positive.
5. Through the assistance of care consortia and other technical assistance resources, develop a comprehensive list of care providers within NENCPPH.
6. Identify what resources are available for implementation of other action steps and pursue methods of obtaining them.

Goal #2: *By 2010, through voluntary counseling and testing, increase from the current estimated 41.1% to 80% the proportion of HIV-infected people in Northeastern North Carolina who know they are infected and from 61% to 75% those identified in early stage of disease.*

1. Support and assist with ECU's project "Commit to Prevent".
2. Develop and implement methods of nontraditional outreach testing.
3. Develop and implement methods of testing inmates throughout the region and develop protocols that assist them in accessing care and prevention case management upon release. This would include drafting language directed to health plans for correctional facilities, day reporting centers and parole/probation.
4. Target adolescents through SHAC and collaboration with school nurses.
5. Further discuss the need for rapid testing in traditional and nontraditional venues.

6. Target African Americans through culturally sensitive and appropriate interventions.
7. Further discuss promoting testing by Medicaid providers.

Goal #3: *By 2010, increase from the current estimated 50% to 80% the proportion of HIV-infected people in the Northeastern North Carolina who are linked to appropriate prevention, care and treatment services.*

1. Develop and implement methods of education to providers in integration of prevention into all levels of care and treatment.
2. Insist that prevention is is implemented in all levels of case management throughout the region.
3. Review the unfunded case management grant application and discuss with IPH the potential for funding through another source.