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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.
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• Volunteers throughout the state
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September 12, 2012

On behalf of the Florida Department of Health (DOH), HIV/AIDS and Hepatitis Program and Florida’s HIV Prevention Planning Group (PPG) we are pleased to submit the 2012-2014 HIV Prevention Plan for Florida. The plan presents Florida’s roadmap for addressing HIV/AIDS and preventing new HIV infections. This comprehensive plan was developed through the collaborative efforts of the PPG, DOH, local HIV prevention planning bodies, and communities infected and affected by HIV/AIDS.

The 2012-2014 HIV Prevention Plan is the result of many hours work and the collective effort of the PPG and various stakeholders. In the spirit of collaboration, the PPG worked with stakeholders to developed priorities for HIV prevention services and to identify strategies and interventions to meet the needs of those most at risk of transmitting or acquiring HIV. It is our hope this document provides relevant information and will be utilized as a tool to better address HIV/AIDS. We thank you for reading this plan.

Since the early days of the epidemic, community planning has remained critically important. Our community planning process has always been based on the belief that determining the best way to respond to local HIV prevention needs and priorities is through local decision-making. Communities must be full partners. Together we can develop and implement a shared vision committed to ending this epidemic.

Sincerely,

Valerie Mincey                Bobby Davis
Valerie Mincey                Bobby Davis
Community Co-chair            Public Health Co-chair
Introduction
At the end of 2010, 95,335 Florida residents were known to be living with HIV/AIDS. In 2010, 5,022 adults and 20 young (age <13) Floridians were newly diagnosed with HIV/AIDS in Florida. Florida ranked second among states in the estimated number of Acquired Immune Deficiency Syndrome (AIDS) cases diagnosed in 2009 (most recent year available for US data). That year, a total of 4,799 (14% of total US) AIDS cases were diagnosed in New York, followed by 4,392 (13%) in Florida and 3,760 (11%) in California. Cumulatively, Florida ranks third behind New York and California.

Data statements such as those above, the guiding principles of the National HIV/AIDS Strategy (NHAS), High-Impact Prevention (HIP), and the need to reduce the number of new HIV infections, are the forces that drive Florida’s Community Planning process and the development of the 2012-2014 State of Florida Jurisdictional HIV Prevention Plan. After more than 30 years of the HIV/AIDS epidemic, Florida continues to be severely impacted by the disease. This plan serves as a roadmap for reducing new HIV infections, increasing the number of HIV-infected persons who know they are infected, and increasing the number of HIV-infected persons who are linked to prevention, care, and treatment services.

**The Jurisdictional HIV Prevention Plan**

The HIV planning process produces a Jurisdictional Prevention Plan, jointly developed by the Department of Health (DOH) and the Prevention Planning Group (PPG) that includes specific, high-priority HIV prevention strategies and interventions targeted to defined populations. The plan should be one that is: current; evidence based; adaptable as new information becomes available; tailored to the specific needs of the state; and widely distributed in an effort to provide a road map for prevention that can be used by all prevention providers in the state. There are fourteen planning partnerships in Florida. The partnerships represent the diverse and various geographic regions, racial and ethnic groups, high-risk populations, and varied perspectives regarding HIV prevention in the state. Each partnership area submitted standardized plan elements with local flavor and community input to help inform the development of a statewide plan.

The 2012-2014 State of Florida Jurisdictional HIV Prevention Plan consists of the follow components:

- **Epidemiologic Profile**: An HIV/AIDS epidemiologic profile that describes the epidemic in Florida
- **Needs Assessment, Resource Inventory, and Gap Analysis**: A description of met and unmet HIV prevention needs in target populations to be reached by primary HIV prevention interventions, and barriers in reaching populations.
- **Interventions and Strategies**: A description of HIV prevention strategies and interventions targeting populations at greatest risk for transmitting and/or acquiring HIV.
Chapter 1: HIV Planning In Florida
The Florida Comprehensive Planning Network (FCPN)

The Florida Comprehensive Planning Network (FCPN) was formed January 1, 2004, and consists of three planning entities: the PPG, the patient care planning group (PCPG) and the Florida Viral Hepatitis Council. Each planning group of the FCPN advises the Department of Health (DOH), HIV/AIDS and Hepatitis Program on matters related to HIV prevention, patient care and hepatitis. The FCPN works in collaboration with DOH to develop comprehensive HIV/AIDS prevention, patient care, and hepatitis plans.

Membership of the FCPN consists of representatives from across the state that are selected from local health departments, local HIV/AIDS planning groups (CPG’s) and local patient care consortia. 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, professional representative), Person Living with HIV/AIDS (PLWHA)/consumer, Youth (consumer if possible, or representative of youth group involving youth ages 18-25), and Transgender.

What are Planning Partnerships?

The state of Florida is divided into seventeen distinct geographical areas. There are fourteen planning partnerships covering those seventeen areas conducting patient care and prevention planning. No funding is provided to conduct the prevention planning activities within the 14 planning partnerships; however, every partnership continues to plan and conduct prevention efforts. Partnerships continue to name representatives to the PPG and submit priority populations and local prevention plans. Each member from the local partnership is responsible for representing the needs and concerns of the local partnership on the statewide body, while also assuring the implementation of the FCPN guidelines by the local area.

Nominations for PPG membership are solicited through an open process and candidates are selected based on criteria that have been established by the PPG and the Department. Membership selection for the PPG is based on even and odd number year partnership elections. During the two-year community planning period, even number areas hold nominations during the first year and odd number area nominations take place during the second year. Elected members serve two-year terms.
Thompson, Maria 1 Prevention
McLaughlin, Cindy 1 Prevention Alternate
VACANT 1 Public Health
VACANT 1 Public Health Alternate
Mincey, Valerie 2A Prevention
Hutchison, Valerie 2A Prevention Alternate
Hubbard, Niya 2B Prevention
Hubbard, Sylvia 2B Prevention Alternate
Blocker, Keith 2B Public Health
Jackson, Leroy 2B Public Health Alternate
Bailey, Shane 3 & 13 Prevention
Crossman, Amber 3 & 13 Prevention Alternate
Mims, Joseph 4 Prevention
Carter, Debrah 4 Prevention Alternate
Bass, Bernadette 5, 6, & 14 Prevention
Wright, JaDawn 5, 6, & 14 Prevention Alternate
Cohen, Lisa 5, 6, & 14 Public Health
Boyd, Keith 5, 6, & 14 Public Health Alternate
Clemons, Iris 7 Prevention
Curry, John 7 Prevention Alternate
Acevedo, John 8 Prevention
VACANT 8 Prevention Alternate
Proenza, Nilda 8 Public Health
VACANT 8 Public Health Alternate
White, Sandra 9 Prevention
Miller, Eric 9 Prevention Alternate
Love, Juliette 10 Prevention
White, Felicia 10 Prevention Alternate
Ullah, Evelyn 10 Public Health
Rodriguez, Joshua 10 Public Health Alternate
Martin, Charles W. 11A Prevention
Nunnally-Bain, Kalentha 11A Prevention Alternate
Traylor, Derrick 11B Prevention
Knighten, Yul 11B Prevention Alternate
Bell, Laverne 12 Prevention
Whipper, Dena 12 Prevention Alternate
Poitier, Cynthia 15 Prevention
Martinez, Eric 15 Prevention Alternate
Hendley, Nathaniel At-Large PLWHA
Bargar, Ken At-Large Alternate PLWHA
Toal, Philip At-Large Substance Abuse
Jefferson, Marlinda At-Large Alternate Substance Abuse
Merkan, Dan At-Large Behavioral Sciences
VACANT At-Large Behavioral Sciences
Martin, Charles W. Co-Chair Community
Davis, Bobby Co-Chair Department of Health
Section II: HIV Prevention Planning

What is HIV Planning?

HIV planning is a process through which people from different walks of life, interests, responsibilities, and involvement in HIV come together as a group to inform and support the development and implementation of a Jurisdictional HIV Prevention Plan. The group’s charge is to develop specific strategies to enhance coordinated, collaborative, and seamless access to HIV prevention, care, and treatment services (including mental health, substance abuse, and co-infections of viral hepatitis, STDs, and TB) for the highest-risk populations.

HIV planning is based on the belief that local planning is the best way to respond to local HIV prevention needs and priorities. HIV planning should improve HIV prevention programs by strengthening the 1) scientific basis, 2) community relevance, 3) key stakeholder involvement, 4) population or risk-based focus of HIV prevention interventions in each project area, and 5) communication and coordination of services across the continuum of HIV prevention, care, and treatment. Planning should include social determinants of health associated with HIV/AIDS and sexually transmitted diseases, infectious diseases, substance abuse, and mental health.

Fundamentals of HIV Planning

There are three fundamental tenets that guide the HIV planning process:

- **Parity:** The condition whereby all members of the HIV prevention planning group have the skills and knowledge for input and participation, as well as equal voice in voting and other decision-making activities.
- **Inclusion:** The assurance that the views, perspectives, and needs of all affected communities are included and involved in a meaningful manner in the planning process.
- **Representation:** The assurance that those who are representing a specific community truly reflect that community’s values, norms, and behaviors.

Other fundamental ideals of HIV planning are that 1) HIV planning is a participatory and collaborative process to ensure that key stakeholders, communities, and tribal, governmental, or non-governmental agencies engage in active and ongoing dialogue with the HD in the development and implementation of the Jurisdictional HIV Prevention Plan to reach the goals of NHAS; 2) the planning process must actively encourage and seek out key stakeholders and community participation; 3) nomination for membership should be solicited through an open process, and candidate selection should be based on criteria established by the health department and the planning group; 4) comprehensive participation is critical to the success of the jurisdictional plan and HIV planning process; and 5) planning groups must adopt a high-
impact approach to HIV prevention activities in their communities, as well as utilize the most current epidemiologic surveillance and evidence-based data to guide the planning process.

**HIV Planning Process**

The HIV planning process consists of three steps:

- **Stakeholder Identification**- Identifying community members, key stakeholders, and other HIV service providers involved in HIV prevention, care, and treatment services to participate in a comprehensive engagement process.

- **Engagement Process**- Developing a collaborative and coordinated engagement process that results in greater access to HIV prevention, care, and treatment services for the most disproportionately affected populations and moves the jurisdiction towards a greater reduction in HIV incidence and HIV-related health disparities.

- **Jurisdictional Plan Development, Implementation, and Monitoring**- Informing and monitoring the development (or update) and implementation of the Jurisdictional HIV Prevention Plan to ensure that the engagement process supports the Jurisdictional HIV Prevention Plan and to ensure that the plan is progressing towards reducing HIV incidence and HIV-related health disparities in the jurisdiction.
Chapter 2: Epidemiologic Profile
Chapter 2
Overview

The purpose of the epidemiologic profile is to provide a picture of the HIV/AIDS epidemic in Florida. The profile details the impact of the HIV/AIDS epidemic within various populations and identifies characteristics of both HIV-infected and HIV-negative persons in Florida. This profile is designed to describe the current status of HIV/AIDS in Florida and provide a thorough description of the HIV/AIDS epidemic among various populations. Data presented in this profile is utilized as a guide for prioritizing HIV prevention needs and services.

This profile seeks to describe the HIV/AIDS epidemic in Florida by answering the following questions:

1. What are the sociodemographic characteristics of Floridians?
   It is essential to understand the demographic and social characteristics of a population in order to better understand how HIV/AIDS impacts various groups within the general population.

2. What is the scope of the HIV/AIDS epidemic in Florida?
   HIV/AIDS surveillance data provides a picture of the overall burden of disease in Florida, the disproportionate impact of HIV/AIDS on various populations, and identifies trends.

3. What are the indicators of risk for HIV infection among high-risk populations in Florida?
   Indicators of risk for HIV/AIDS are factors that can serve as markers for increased risk behaviors that are known to be associated with HIV infection. Identifying indicators of risk also helps to explain trends in HIV infection.

The profile is divided into three sections. Section I describes general population demographics and social characteristics. Section II provides a picture of the HIV/AIDS epidemic in Florida. Lastly, section III addresses underlying factors contributing to HIV/AIDS trends.

Data Sources

Two data sources were used to develop this profile. The sources are detailed below with a description of their strengths and limitations included.
American Community Survey

All sociodemographic data presented in this chapter are pulled from the American Community Survey (ACS), a nationwide survey conducted every year to provide up-to-date information about the social and economic characteristics of communities. The ACS is a critical element in the Census Bureau's decennial census program. The ACS collects information such as age, race, income, commute time to work, home value, veteran status, and other important data.

Strengths and Limitations:

The ACS is an ongoing survey that provides data every year. This data is helpful for having an up-to-date snapshot of the population and for understanding how the population changes. However, because the ACS produces one-year estimates annually for geographic areas with a population of 65,000 or more, smaller areas may not be reflected in the survey results.

Florida HIV/AIDS Surveillance Data

The Surveillance Section of the HIV/AIDS and Hepatitis Program collects and maintains surveillance data for HIV/AIDS in Florida. Florida utilizes a passive and active surveillance system for reporting HIV and AIDS cases. Local county HIV/AIDS surveillance offices report case information through the electronic HIV/AIDS Reporting System (e-HARS), and the state updates e-HARS on a continual basis. Confidential name reporting of HIV infection was implemented in Florida on July 1, 1997. Surveillance staffs execute active and aggressive case-finding strategies through regular medical records review and contact with local CBO’s, private providers, hospital infection control staff, and laboratory personnel. Surveillance in Florida identifies HIV-related conditions at various points along the spectrum of the disease from reporting of HIV infection, to death certificate review for HIV/AIDS-related mortality.

Strengths and Limitations:

HIV/AIDS surveillance data plays a vital role in how Florida determines HIV/AIDS resource needs, allocation methodologies, and carries out program planning and implementation. However, the data can only provide estimates of HIV infection because not all persons who are infected are tested and reported.
Section I: Sociodemographic Characteristics of the General Population of Florida

Despite prevention efforts to reduce HIV infections, some groups of people are affected more by HIV/AIDS. The NHAS identifies “reducing HIV-related disparities and health inequities” as one of the strategies three main overarching goals. In order to fully address HIV-related disparities and health inequities, it’s important to understand and address the social, cultural, and economic factors linked to poor health outcomes in the context of how they impact populations. Understanding the sociodemographic characteristics of a population is essential to fully understanding and addressing the health needs of that population.

Utilizing sociodemographic data helps to identify populations that may be at a great risk for poor health outcomes. Data on income, education, and social characteristics can also help identify underlying factors, referred to as social determinants of health, which can contribute to poor health conditions. Social determinants of health refer to the complex and interrelated set of economic and social conditions that influence the health of individuals and communities. Social determinants of health like poverty, unequal access to healthcare, lack of education, stigma, and racism are factors linked to health disparities and inequities.

Population Characteristics

The state of Florida is the fourth most populous state in the United States, with an estimated 18,537,969 people in 2009, with 9.4 million (51%) females and 9.1 million (49%). The U.S. 2010 census shows 18% growth in the population size from 2000 to 2010, compared to the national U.S. population’s change at 10%.

Age

Florida’s Population is significantly older than the general U.S. population, with a median age of 40 compared to the U.S. median age of approximately 37 years of age. Seventy-eight percent (78%) of Floridians were 18 years and older in 2009 (Figure 1.1). Forty-nine percent (49%) of males and 51% of females were over the age of 18 in 2009. When compared to the national average Florida has a higher percentage of individuals 65 years and older who make up 17% of Florida’s total population compared to the nations at 13%. In Florida, most cases of HIV/AIDS are reported in individuals between 40-49 years of age. In 2008 and 2009, Florida’s Office of Vital Statistics reported that HIV/AIDS was the sixth leading cause of death among persons 25-44.
Race, Ethnicity and Gender

In terms of race and ethnicity, for persons reporting one race and being non-Hispanic, 59% reported being white; 16% reported being black; less than 0.5% reported being American Indian/Alaskan Native; 2% reported being Asian; less than 0.5 percent reported being Native Hawaiian or Other Pacific Islander; and 3% reported some other race. Twenty-two percent (22%) of Floridians reported being Hispanic. (Figure 1.2)

For women over the age of 18, 51% were white, non-Hispanic; 53% were black non-Hispanic; and 49% were Hispanic. Forty-nine percent (49%) of males reported being white; 47% reported being black; and 51% were Hispanic. (Figure 1.3)
Figure 1.3. Percentage of Population 18 Years of Age and Older by Race, Ethnicity, and Sex, Florida 2009.

Distribution of the General Population 18 Years of Age and Older by Race, Ethnicity, and Sex
N=14,480,550

Foreign Born Population

In 2009, 19% of people living in Florida were foreign born. Florida’s population consisted of 3,484,141 people born outside of the United States. Of this population, 49% (1,688,819) are naturalized U.S. citizens, compared to 52% (1,795,322) that were not U.S. citizens (Figure 1.4). Among foreign born persons, Latin America was the most common reported place of birth, with 75% of the total foreign born population being born in Latin America (Figure 1.5). Among Floridians 5 years of age and older, 74% speak only English, while 26% speak a language other than English.

Figure 1.4. Place of Birth and Citizenship Status by Race and Ethnicity, Florida, 2009.
Social Characteristics

Racial and ethnic minorities in Florida are disproportionately impacted by HIV/AIDS. Minorities account for 70% of Florida’s HIV epidemic, but only account for 40% of the state’s population. Health disparities in HIV-related morbidity and mortality in Florida occur in the context of several factors, including complacency, fear and stigma, racism, homophobia, and social-sexual mixing of the infected and uninfected. Social and economic factors also play a key role in influencing trends in HIV infection. An individual’s ability to access HIV testing, receive HIV care and treatment, or re-enter care may be influenced by social determinants of health such as poverty, access to healthcare, employment status, and educational attainment. If people are living in poverty, are unemployed, lack health insurance, or are homeless, they may not prioritize HIV as an urgent matter, which may lead to them putting off or being unable to access HIV testing or being linked and retained in care. These underlying factors help contribute to HIV-related disparities among minorities in Florida.

Marital Status

Thirty-four percent (34%) of men in Florida, 15 years of age and older reported never being married, while 50% reported being currently married. For women 15 years of age and older, 26% reported never being married compared to 46% who were currently in a marital relationship. (Figure 1.6)
Employment and Income

Among persons 16 years and older, 61% (9,161,999) were in the civilian labor force. In 2009, 12% of the civilian labor force was unemployed. Unemployment was highest among blacks at 11%; followed by Hispanics at 8%; and whites at 7%

In 2009, the per capita income of Floridians was $24,692. The Median earnings for male full-time workers were $39,122, compared to $32,109 for female workers. When looking at the median earnings for males based on race/ethnicity, white males earned $41,002; black males earned $30,830; and Hispanic males earned $29,236. For females, white females earned $33,808; black females earned $28,113; and Hispanic females earned $26,350. (Figure 1.7)
Poverty

In 2009, 15% of Floridians were living below the poverty level. Persons over the age of 18 accounted for 13% of the population living below the poverty level. Of persons over the age of 18 living below the poverty level, 11% were white; 22% were black; and 17% were Hispanic. Eleven percent (11%) of all families and 21% of children were below the poverty line (Figure 1.8).

Two percent (2%) of households receive public assistance income at an average of $3030 per households, and 10% (667,567) of households received Supplemental Nutrition Assistance Program (SNAP) benefits. Twenty-one (21%) of black households received SNAP benefits in 2009 compared to 16% of Hispanics and 8% of white households.

Figure 1.8. Percentage of Persons Over the Age of 18 by Race and Ethnicity Living Below the Poverty Line, Florida, 2009.

Education

In 2009, 85% of people 25 years and over had at least graduated from high school and 25% had a bachelors degree or higher. Fifteen percent (15%) of people had not graduated high school. For persons not graduating high school, 13% were white, 23% were black; and 26% were Hispanic (Figure 1.9). Overall, 85% of Floridians over the age of 25 completed at least high school education, with 87% being white; compared to 77% of blacks and 74% of Hispanics. In terms of higher education, 17% of whites, 13% of Hispanics, and 11% of blacks in Florida over the age of 25 reported having a bachelor’s degree (Figure 1.10).
Figure 1.9. Percentage of Persons 25 Years of Age and Older With Less Then a High School Diploma by Race and Ethnicity, Florida, 2009.

Percent of Persons Over the Age of 25 With Less Than A High School Diploma
N=12,800,944

![Pie chart showing percentage of persons over age 25 with less than a high school diploma by race and ethnicity in Florida, 2009.]

Figure 1.10. Percentage of Persons 25 Years and Older That Completed High and College by Race and Ethnicity, Florida, 2009.

High School and College Completion of Persons 25 Years of Age and Older by Race
N=12,800,944

![Bar chart showing high school and college completion rates by race and ethnicity in Florida, 2009.]

Health Insurance

In 2009, 79% of Floridians had health insurance, with 61% of those persons having private insurance and 31% having public insurance coverage. Twenty-one percent (21%) of Floridian in 2009 reported being uninsured. Of those Floridians without health insurance, 19% were white; 26% were black; and 34% were Hispanic (Figure 1.11).
Figure 1.11. Health Insurance Coverage by Race and Ethnicity, Florida, 2009.
Section II: The Scope of the HIV/AIDS Epidemic in Florida

Florida ranked second among states in the estimated number of acquired immune deficiency syndrome (AIDS) cases diagnosed in 2009 (most recent year available for US data). That year, a total of 4,799 (14% of total US) AIDS cases were diagnosed in New York, followed by 4,392 (13%) in Florida and 3,760 (11%) in California. Cumulatively, Florida ranks third behind New York and California.

In 2010, at least one AIDS case was reported in all but eight counties (Figure 1.12). Although the AIDS epidemic is widespread throughout Florida, the majority of cases were reported from eight counties: Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, Pinellas and St. Lucie, all reporting 100+ cases in 2010. These eight counties reported a combined total of 2,551 cases, or 74% of Florida’s total reported cases in 2010 (N=3,461). The greatest numbers of AIDS cases were reported from two counties located in the southeastern part of the state, Broward (N=631) & Miami-Dade (728). These two counties reported a combined total of 1,359 cases in 2010, or 39% of the statewide total.

Figure 1.12. AIDS cases and rates per 100,000 population, by county of residence, Florida, 2009, (excluding Department of Corrections).

AIDS Rates per 100,000 Population Reported by County of Residence*
Florida, 2010

N=3,461

Case Rate per 100,000

Based on 2010 statewide population estimates, the 2010 state rate is 21.8 per 100,000 population.

*County totals exclude Department of Corrections cases (N=46). Numbers on counties are cases reported.
Florida ranked first among states in the number of Human Immunodeficiency Virus (HIV) cases reported in 2009 (most recent year available for US data). That year, a total of 5,755 (13% of total US) HIV cases were reported in Florida, followed by 4,886 (11%) in California and 4,291 (10%) in New York.

In 2010, at least one HIV case was reported in all but four counties and eight counties reported 100 or more cases (Figure 1.13). These eight counties included Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, Pinellas and Polk. They reported a combined total of 3,889 cases, or 75% of Florida’s total reported cases in 2010 (N=5,211). The greatest numbers of HIV cases were reported from Miami-Dade (N=1,242), Broward (N=882), and Orange (N=485). These three counties reported a combined total of 2,609 cases in 2010, or 50% of the statewide total.

Generally, HIV cases had an increase in 2002 due to increased HIV testing statewide as part of the “Get to Know Your Status” campaign. Since that time, newly reported HIV cases have decreased each year until 2007. Enhanced reporting laws were implemented in Nov. 2006, leading to an artificial peak in HIV cases in 2007 and 2008, followed by an artificial decrease in 2009 with an expected approach to leveling in 2010 (Figure 1.14).
Figure 1.14. HIV case rates per 100,000 population*, by year of report, Florida, 2001-2010.

HIV/AIDS CASES BY AGE, SEX AND RACE

As in previous years, the greatest proportion of AIDS cases reported in 2010 was among persons 40-49 years old (33%) (Figure 1.15). This year, the 50+ age group was second, with 28% of the reported AIDS cases, followed by the 30-39 age group with 24%.

Compared with AIDS cases, a greater proportion of HIV cases in 2010 were also reported among those aged 40-49 (27%) followed by those aged 20-29 (25%) and aged 30-39 (23%).

Figure 1.15. Age distribution of Florida’s adult AIDS cases compared with the age distribution of Florida’s adult HIV cases, 2010.

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. In 2001, 29% of the AIDS cases reported in Florida were female (Figure 1.16). Over the past ten years, the proportion of AIDS cases among men and women has remained fairly level. The male-to-female ratio declined slightly from 2.4:1 in 2001 to 2.1:1 in 2010. In 2010, the AIDS case rate
per 100,000 population was 30.6 among adult males and 13.5 among adult females, indicating that AIDS cases in this period were still more likely to be reported among males than females in Florida.

*Figure 1.16. Percent of adult AIDS cases by sex and year of report, Florida, 2001-2010.*

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 increase 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. In 2001, 35% of the HIV cases reported in Florida were female (Figure 1.17). Over the past ten years, the proportion of HIV cases among men has increased while the proportion among women has decreased. The result is an increase in the male-to-female ratio, from 1.9:1 in 2001 to 3.0:1 in 2010. This pattern differs from that seen for AIDS cases during the same time period. In 2010, the HIV case rate per 100,000 population was 50.2 among adult males and 16.2 among adult females, higher than the rates seen among AIDS cases.

*Figure 1.17. Percent of adult HIV cases by sex and year of report, Florida, 2001-2010.*
In 2010 a total of 2,362 adult males and 1,097 adult females were reported with AIDS, representing 68% and 32% of cases, respectively (Figure 1.18). Also in 2010, a total of 3,873 adult males and 1,314 adult females were reported with HIV infection, representing 75% and 25% of cases, respectively. Florida’s adult population is 49% male and 51% female; therefore male cases are disproportionately impacted.

**Figure 1.18. Percentage of adult AIDS and HIV cases by sex, Florida, Florida, 2010.**

Historically, blacks account for over 50% of the reported AIDS cases; however, they represent only 15% of the adult population. Numerous disparities can affect the increases of HIV in a given population. Over the past 10 years, the proportion of AIDS cases has decreased among whites by 12% while increasing by 20% among Hispanics (Figure 1.19). The proportion of AIDS cases among blacks has remained fairly constant. Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial.

**Figure 1.19. Percent of adult AIDS cases by race/ethnicity and year of report, Florida, 2001-2010.**
Comment: HIV case reporting, implemented in mid-1997, reflects more recent trends in the epidemic with respect to the distribution of cases by race/ethnicity. The proportion of black HIV cases has decreased by 15% from 2001 to 2010. In contrast, increases were observed among both white (16%) and Hispanic (29%) HIV cases over this same time period (Figure 1.20).

Figure 1.20. Percent of adult HIV cases by race/ethnicity and year of report, Florida, 2001-2010.

In 2010, blacks were over-represented among the AIDS and HIV cases, accounting for 54% of adult AIDS cases and 48% of adult HIV cases, but only 15% of the adult population (Figure 1.21). Hispanics represent 21% of the adult population and account for 19% of the adult AIDS cases and 22% of the adult HIV cases.

Figure 1.21. Percentage of adult AIDS cases and HIV cases by race/ethnicity, Florida, 2010.
Black men and, to an even greater extent, black women are over-represented in the HIV epidemic (Figure 1.22). The HIV case rate for 2010 is 5 times higher among black men than among white men. Among black women, the HIV case rate is 15 times higher than among white women. Hispanic male and Hispanic female rates are 2 times higher than the rates among their white counterparts.

**Figure 1.22. Adult HIV cases and case rates per 100,000 population by sex and race/ethnicity, Florida, 2010.**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Male Rate</th>
<th>Female Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>28.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Black</td>
<td>140.5</td>
<td>74.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12.9</td>
<td>0.1</td>
</tr>
</tbody>
</table>

ADULT (age 13+) HIV/AIDS CASES BY TRANSMISSION CATEGORY

**Males**

Among the male AIDS and HIV cases reported for 2010, men who have sex with men (MSM) was the most common risk factor (61% and 74% respectively) followed by cases with a heterosexual risk (28% for AIDS and 21% for HIV) (Figure 1.23). The recent increase among MSM is indicated by the higher percent of MSM among HIV cases compared to AIDS cases, as HIV cases tend to represent a more recent picture of the epidemic.

**Figure 1.23. Adult male AIDS and HIV cases by mode of exposure, Florida, 2010.**

**Adult Male Cases**

By Mode of Exposure, Florida, 2010

- AIDS N=2,362
- MSM 28%
- IDU 1%
- MSM/IDU 7%
- Hetero 61%
- Other 4%

- HIV N=3,873
- MSM 3%
- IDU <1%
- MSM/IDU 21%
- Hetero 74%
- Other 1%

*Note: NIRs redistributed.*

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2012-2014 Florida Jurisdictional HIV Prevention Plan
Females

Among the female AIDS and HIV cases reported for 2010, heterosexual contact was the highest risk (87% and 89% respectively) (Figure 1.24).

_Figure 1.24. Adult female AIDS and HIV cases by mode of exposure, Florida, 2009._

PERINATAL HIV/AIDS CASES

Of the 1,167 perinatally infected babies born in Florida through 2009 (most complete year), 2 were born as early as 1979 (Figure 1.25). Since that time, the birth of HIV-infected babies continued to rise through 1993. In April 1994, the Public Health Service released guidelines for ZDV use to reduce perinatal HIV transmission, and in 1995 recommendations for HIV counseling and voluntary testing for pregnant women were published. The mandatory offering of HIV testing to pregnant women became law in Florida in October 1996. Since then, the percent of perinatally infected children who received ZDV or whose mothers received ZDV has increased markedly. Through enhanced perinatal surveillance systems, it has been documented that ZDV use among exposed infants and mothers of HIV-infected children has increased at the prenatal, intrapartum, delivery and neonatal stages. In the past few years, the use of other medical therapies, including protease inhibitors has supplemented the use of ZDV for both infected mothers and their babies. The use of these medical therapies has been accompanied by a decrease in the number of perinatally HIV-infected children and is responsible for the dramatic decline in perinatally acquired HIV/AIDS since 1994. Furthermore, numerous initiatives have contributed to the reduction in these cases: provider education, social marketing etc. These initiatives have helped to further educate local providers in the importance of testing pregnant women for HIV and then offering effective treatment during the pregnancy and at delivery to further decrease the chances of vertical transmission. As a result, significant decreases in annual perinatal HIV-infected births have been observed in Florida since 1997, with a leveling trend from 2002 through 2007 followed by another sharp decrease. In summary, these...
successful initiatives have resulted in a 94% decline in HIV-perinatally infected births in Florida from 1993 (N=110) to 2009 (N=8).

*Figure 1.25. Perinatal HIV/AIDS Cases by Year of Birth, born in Florida, 1979-2009 (N=1,167)*

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Number of Cases</th>
<th>% change</th>
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<td></td>
</tr>
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<td>1980</td>
<td>76</td>
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<td>2008</td>
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<td>-35%</td>
</tr>
<tr>
<td>2009</td>
<td>8</td>
<td>-27%</td>
</tr>
</tbody>
</table>

**PREVALENCE ESTIMATE OF HIV INFECTION IN THE U.S. AND FLORIDA**

Assessment of the extent of the HIV epidemic is an important step in community planning for HIV prevention and HIV/AIDS patient care. The HIV prevalence estimate—the estimated number of persons living with HIV infection—includes those living with a diagnosis of HIV or AIDS and those who may be infected but are unaware of their serostatus. Approximately 1,039,000–1,185,000 persons are currently living with HIV infection in the US. Florida has consistently reported 10–12% of the national AIDS morbidity and currently accounts for 11% of all persons living with AIDS in the U.S. The Department of Health now estimates that approximately 135,000 persons, or roughly 11.7% of the national total, are currently living with HIV infection in Florida as of the end of 2009.

There are some small differences and a few substantive differences between the proportional distributions of populations living with HIV Infection in Florida and that in the 40 states in the U.S. as noted in the table below (Figure 1.26). Florida has a slightly higher proportion of women infected with HIV (30%) compared to the US (27%). By race/ethnicity, Florida has similar patterns of HIV infected cases among blacks (49%) compared to the US (48%) and among MSM (44% vs. 46%). However, Florida has a far higher proportion of HIV infected cases among heterosexuals (39% vs. 28%) and a much lower proportion among IDUs (11% vs. 19%) compared to the US.
Figure 1.26. Persons Living with HIV Infection in the U.S. (2008)* and Florida (2009)

Persons Living with HIV Infection

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>U.S.</th>
<th>Florida</th>
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</thead>
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<tr>
<td>N=</td>
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<td>93,053</td>
</tr>
<tr>
<td>Male</td>
<td>73%</td>
<td>70%</td>
</tr>
<tr>
<td>Female</td>
<td>27%</td>
<td>30%</td>
</tr>
<tr>
<td>White</td>
<td>33%</td>
<td>30%</td>
</tr>
<tr>
<td>Black</td>
<td>48%</td>
<td>49%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>17%</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>MSM</td>
<td>46%</td>
<td>44%</td>
</tr>
<tr>
<td>IDU</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>MSM/IDU</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>28%</td>
<td>39%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: U.S. Data: CDC, HIV Surveillance Report, 2009, Vol. 21, Table 15a,
*Estimated for 40 states with confidential name-based HIV infection reporting,
Florida Data: eHARS, alive and reported through 2009, as of 06/03/10.
Note: M:F ratio: U.S., 2.7:1. Fla., 2.3:1, NIRs redistributed for Florida.

IMPACT OF HIV-RELATED DEATHS

As of December 31, 2010 a total of 121,161 AIDS cases were reported in Florida. Of these cumulative cases, 66,848 (55%) were known to have died. HIV/AIDS deaths decreased markedly from 1996-1998, associated with the advent of HAART in 1996. A leveling of the trend during 2000-2006 may reflect factors such as viral resistance, late diagnosis of HIV, adherence problems, and lack of access to or acceptance of care. Yearly declines of 13% in 2007, 7% in 2008 and another 13% in 2009 appear to be promising. Racial/ethnic disparities are evident in the death rate data. Decreases among males and females were observed in all racial/ethnic groups, except white females (where there was no change at all). Racial/ethnic disparities are evident in the death rate data.
Figure 1.27. Resident HIV deaths, by year of death, Florida, 1994–2009.

The peak year for resident HIV deaths was 1995 (Figure 1.28). In 2008 & 2009, HIV was the 6th leading cause of death among persons aged 25-44 as recorded by Florida’s Office of Vital Statistics.

Figure 1.28. Death Rates from Leading Causes of Death Among Persons 25-44 Years of age, by year of death, Florida, 1988-2009.
Section III: Underlying Factors Contributing to HIV/AIDS Trends

Research shows that increased HIV risk and infection are not the result of race and/or ethnicity. Still, people who have specific knowledge, attitudes, beliefs, and behaviors are more (or less) likely to become infected and more (or less) likely to suffer HIV’s effects. Social, psychological, and economic circumstances represent another set of factors influencing trends in HIV infection. HIV/AIDS health disparities tend to disappear when one considers these underlying factors. The following is a discussion of direct and underlying factors associated with the risk of HIV/AIDS.

Unprotected Sex

Risky situations can include unprotected sex with untested sexual partners, higher numbers of partners, or anonymous partners. Simply stated, the odds of being in a situation where HIV infection status (“serostatus”) is unknown or where HIV infection is not disclosed multiplies with higher numbers of partners. And casual sex does not always provide a safe space for men or women to honestly disclose their recent risk history or HIV status. Condoms can protect much more effectively than guesses about a partner's serostatus or honesty.

Condom Usage

Using condoms correctly can significantly reduce chances of acquiring or spreading HIV infection. In real-world studies, condoms rarely break (0.4-2.3% of uses) or slip off (0.6-1.3% of uses), and proper use of condoms reduces HIV risk by 85%.¹

Serosorting

Serosorting refers to trying to limit sex partners to those of the same HIV status, that is, HIV-positive men or women with HIV-positive men or women, or HIV-negative men or women with HIV-negative men or women. This practice might prevent HIV from spreading, even if there is unprotected sex or if a condom breaks. However, serosorting cannot work if one partner is unaware of his infection, does not disclose his HIV-positive status, or has sex with other partners of unknown or negative HIV status. Serosorting does not always protect against other STDs.

Social/Sexual Mixing

Many people choose to have sex with others who are very similar to themselves, while others date or have sex with people from groups that differ in age, race/ethnicity, or other traits. If a person restricts sexual contacts to others in a very specific group (such as those living in the same area of a town), this can affect the risk of acquiring HIV. If the group he or she is selecting
partners from has very few members living with HIV, he or she lowers the chances of becoming infected. However, if the group has very high HIV/AIDS rates, then they unknowingly put themselves at higher risk of acquiring HIV.

Researchers have suggested that when MSM from small towns visit or relocate to "gay meccas", they increase their risk of acquiring HIV. A number of studies specifically note that when gay men take vacations in major gay metropolises, or during gay "circuit party" events, they are more likely to take a "time out" from their safer sex habits, and so take on risky sexual behaviors, and are more likely to have infected partners when they do so.

Within some sexual networks, younger women or MSM might have sexual partners ten years of age or older than themselves. Age mixing in sexual networks potentially exposes younger partners to HIV and other STDs from those with more sexual experience.

**Other Underlying Factors**

**Saturation:** This refers to the number of people who are already living with HIV in the community. If more people have HIV, every instance of an HIV-negative partner having unprotected sexual exposure to an untested or non-disclosing partner is that much riskier. It increases the chances of encountering an HIV-positive partner.

**Late Diagnosis:** If people avoid HIV testing, they may end up getting a late diagnosis when they finally do test. They might find they have already been living with HIV or AIDS for a long time. That means they have less chance to take advantage of life-prolonging medications and more time to spread the infection unknowingly.

**Access:** If people do not have clear access to prevention services and HIV/AIDS counseling and testing, they miss opportunities to learn how to avoid infection (primary prevention). Linkage to treatment must occur, and those in care need counseling about how to protect others from infection (secondary prevention, or “prevention for positives”). If those living with HIV do not have clear access to quality care, they cannot protect their own health. If people do not understand how to take their medicines on time to fight the virus, they cannot live healthier lives with HIV.

**Homophobia:** Verbal and physical abuse of gay and bisexual men of all ages often involves bullying and violence. These can result from attitudes and beliefs that homosexuality and/or effeminate males are not acceptable. This in turn increases the potential for other negative health effects. Common school-day bullying can have harmful effects on the targeted individual in the present, as well as years later. If people have heard peers, co-workers, family, their church, or others make homophobic remarks about gay, bisexual, and other MSM, they may hide their identity. *Men who cannot establish relationships without judgment may be at higher risk for HIV infection through occasional and often anonymous unprotected sexual encounters.*
**HIV Stigma:** This is another type of judgment that people fear will be placed on them. If people feel that others will judge them for having HIV or even for taking an HIV test, they may try to avoid revealing their HIV status to sexual partners. They might also deny to themselves their own risk for infection. Stigma and denial give HIV a hiding place.

**Economic Challenges:** If people are living in poverty, are unemployed, lack health insurance, are homeless, or have difficulty getting basic food and shelter, they could make desperate choices that increase their HIV risk.

**Childhood Abuse:** Men and women who have suffered sexual abuse when they were children often take more sexual risks as adults because of the trauma and confusion of their experiences.

**Incarceration:** People who have been in jail or prison have higher HIV/AIDS rates than the general population for several reasons. A high percentage of new inmates and prisoners may already have HIV. Most prisons forbid condoms to avoid encouraging sex between inmates or prisoners, which is officially prohibited. Injection drug use with smuggled drugs or sharing needles for tattoos might be other issues for some incarcerated people.

**Other STDs:** If many people in a community have other sexually transmitted diseases (STDs), there is a significantly increased chance of being infected with HIV or passing it on to someone else.

**Mental Health Issues:** If people are struggling with any psychosocial health issues, such as depression, partner violence, and low self-esteem, they may feel less worthy and less able to protect themselves and their partners from HIV.

**Drugs:** If people use illicit mood-altering drugs or “recreational” drugs, HIV risks can increase dramatically. “Ecstasy” (also known as X or E) makes many users want to be touched, and they may not be as concerned about risks as long as they get the physical sensation they seek. Crystal methamphetamine (also called “crystal”, “Tina”, or “meth”) is a particularly dangerous threat.

**Treatment Optimism and Illusions of Safety:** Some people might not have the healthy respect for HIV’s threat that they once had. Compared with the 1980s and early 1990s, fewer people now have visible symptoms of HIV/AIDS or are dying with HIV/AIDS. Thus, some people might have less fear of infection. Some people do not understand that HIV still makes life more difficult, since the medicines can cause embarrassing, painful, and even life-threatening side effects. Since HIV can sometimes find its way around the medicines used to fight it, an infected person must structure his or her life very carefully to take pills at the right time every single day.
**Prevention Burnout or Fatigue:** People who have been tested and are in an apparently monogamous relationship, or who grew up before the HIV epidemic, when condoms were not used often, might become tired of taking precautions.

**Mistrust of the Health Care System:** Researchers have found that some people who subscribe to false beliefs such as, “A lot of information about AIDS is being held back from the public,” or “the government deliberately created HIV” tend to use condoms less frequently or not at all.\(^1\)

**Personal Responsibility:** Among HIV-positive and HIV-negative people, those who think it is “the other guy’s job” to protect himself are more likely to have unprotected sex.\(^2,3\) *Those who feel a high sense of community responsibility to protect others from HIV or any other STD are far less likely to have unprotected sex.*

**ENDNOTES**


Chapter 3: Community Needs Assessment
Chapter 3
Overview

The HIV planning process requires the PPG to conduct a community assessment of HIV prevention needs utilizing various assessment strategies. The community assessment serves as the basis for identifying populations at risk for HIV infection in Florida, the prevention needs of those populations, activities/interventions being implemented to address those needs, and service gaps. This chapter provides a description of met and unmet HIV prevention needs among populations at risk for HIV infection in Florida and outlines goals and objectives for conducting Florida’s HIV Prevention activities through 2014.

The following components compose the five sections for this chapter:

Section I: Prioritization of Populations

One of the goals of Florida’s HIV planning process is to identify groups that are disproportionately impacted by HIV/AIDS. Priority populations are identified through the use of HIV/AIDS surveillance data. These groups are found to be the groups that require intensive HIV prevention efforts due to high rates of HIV infection and high incidences of risky behaviors. The prioritization process is carried out based on a logical evidence-based process.

Section II: Assessment of Need

Provider Needs Assessment Survey: Between April 2010 and May 2010, the PPG Community Needs Assessment workgroup conducted a Provider Needs Assessment Survey to offer HIV prevention service providers an opportunity to describe services and unmet needs in their community. The survey identified needs, gaps, and barriers for HIV prevention services.

Statewide Anonymous Ryan White Needs Assessment Survey: The 2010 Anonymous Needs Assessment Survey of persons living with HIV/AIDS (PLWHAs) examines the service needs, gaps in service, and barriers from a consumer perspective. This assessment is part of the Ryan White Treatment Modernization Act comprehensive planning process. Results from the needs assessment are used in setting priorities for the allocation of Ryan White funds, developing the Patient Care Comprehensive Plan, and creating the annual implementation plan.

Section III: Resource Inventory

HIV Prevention Programs and Services at a Glance: This section of the resource inventory provided an overview of current prevention programs and services being provided in Florida.

Funding Snapshot: DOH created the HIV Prevention Funding Snapshot as a tool to help the PPG assess whether the distribution of HIV prevention funding and resources is proportionate to the
distribution of the state’s HIV/AIDS epidemic. It is also used to identify and address HIV prevention service gaps.

**Program Collaborations:** This section details collaborations between the HIV/AIDS and Hepatitis Program and various internal and external partners. The section provides an overview of internal and external collaborative relationships.

**Section IV: Gap Analysis**

The gap analysis looks at met and unmet needs for HIV prevention services among at-risk populations. An unmet need is a requirement for HIV prevention services within a specific target population. These populations are not currently being addressed through existing HIV prevention services and activities. The services are lacking either because services are unavailable, inappropriate, or inaccessible to the target population. The goal of the analysis is to determine whether prevention resources are being directed to high-risk populations.
Section I: Prioritization of Populations

The prioritization process is carried out based on a logical evidence-based process to determine the highest priority-specific prevention needs in Florida. Using epidemiological data and information collected through the needs assessment process, priority populations are identified. This chapter details the prioritization process and identifies priority populations for 2012-2014.

Three-Fold Path Methodology Prioritization Model

The current priority setting methodology was designed and implemented by the PPG in 2010 to ensure that the selection of target populations and the allocation of resources was fair and uniform. Guidelines were developed by the PPG Methodology Work Group. The purpose of these guidelines was to assist local prevention planning Partnerships in assessing a local population’s need for prevention services. All local prevention planning partnerships submitted prioritized populations.

The Three-Fold Path Methodology consists of the following:

**Path 1: HIV Case Data (40% 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 over 10 years.

**Path 2: People living with HIV/AIDS in an area (40% of Weight)**

Rationale: Priority should be given to those populations living with HIV/AIDS in an area. This methodology relies on people living with HIV/AIDS in an area 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.

**Path 3: Planning Partnership Deliberation (20% Weight)**

Rationale: Planning Partnerships consist of people “in the field”—prevention specialists, health planners, community members, behavioral scientists, epidemiologists, and others invested in making a discernible difference in this disease. Their expertise should be utilized in setting priorities.
Each of the priority populations were ranked by placing them in numerical order of HIV case rank, cases of people living with HIV/AIDS, and PPG’s deliberations. The numerical total of the three group rankings by priority population was totaled. The population with the lowest ranking total was the highest priority; the next lowest total was the second highest priority, etc. This methodology was followed at the local and state level.

The calculation of the final ranking is done in the following manner. Forty percent of the final ranking is based on HIV case data 40% is based on people living with HIV/AIDS in an area, and 20% is based the summed rankings of the fourteen prevention partnerships divided by fourteen. The final ranking of priorities for Florida is displayed in Table 2.

### Table 1: Final Rankings of Priority Populations

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<th>40% of weight</th>
<th>20% of weight</th>
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<td>CPP Rank</td>
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</tr>
<tr>
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<tr>
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</tr>
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<tr>
<td>H-IDU</td>
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<tr>
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<td>W-Hetero</td>
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<td>4</td>
<td>7</td>
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<tr>
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</tbody>
</table>

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: 1) HIV-positive persons; 2) black heterosexuals; 3) black MSM; 4) white MSM; 5) Hispanic MSM; 6) Hispanic heterosexuals; 7) white heterosexuals

### 2012-2014 Priority Populations

A priority population is a group that is disproportionately impacted by HIV/AIDS. Priority populations are identified through the use of HIV/AIDS surveillance data and the community services assessment. These groups are found to be the groups that require intensive HIV prevention efforts due to high rates of HIV infection and high incidences of risky behaviors. Individuals within these populations may come from a various socioeconomic and demographic groups backgrounds and engage in behaviors that place them at risk for HIV infection.

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 allows for 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. Table 3 provides the definitions of priority populations and their HIV risk behaviors.

Table 2: Description of Priority Populations

<table>
<thead>
<tr>
<th>Populations</th>
<th>Definition</th>
<th>Risk Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black, Hispanic, and White MSM</td>
<td>Men who report sexual contact with other men or with both men and women.</td>
<td>Unprotected sex between men that results in exposure to semen or blood.</td>
</tr>
<tr>
<td>Black, Hispanic, and White Heterosexuals</td>
<td>Persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., sex with an IDU, a bisexual male, or a person known to be HIV-positive or to have AIDS).</td>
<td>Unprotected vaginal, anal, or oral sex between a man and woman that results in exposure to semen, vaginal fluids, or blood.</td>
</tr>
<tr>
<td>Black, Hispanic, and White Injection Drug User(IDU)</td>
<td>Person who are at risk for HIV infection through the use of equipment to inject drugs (e.g., syringes, needles, cookers, spoons).</td>
<td>Use of needles, syringes, or preparation materials by two or more people that results in exposure to blood.</td>
</tr>
<tr>
<td>HIV-Positive Persons</td>
<td>Persons diagnosed with HIV infection</td>
<td>Unprotected vaginal, anal, or oral sex between a man and woman that results in exposure to semen, vaginal fluids, or blood.</td>
</tr>
</tbody>
</table>
Local partnership conducted their own prioritization process to determine priority populations for their respective areas. Below are the 2012-2014 priority populations for local partnership areas.

**Table 3: 2012-2014 Local Area Priority Populations**

|---------|----------------|--------------|--------------|----------------|-------------------|--------------|-----|----------------|--------------|--------------|----------------|--------------|------------------|
Section II: Assessment of Need

To assess the prevention needs in Florida, the PPG utilized a Provider Needs Assessment Survey to assess what prevention services are being provided in local areas and to also address unmet needs. In addition to utilizing the Provider Needs Assessment Survey, the PPG utilized the results of the Statewide Anonymous Ryan White Needs Assessment Survey to help identify needs and barriers to care and treatment for PLWHAs. Detailed below are summaries of the findings from both surveys.

Provider Needs Assessment Survey Findings

The following is a summary of findings from the community needs assessment conducted by the PPG during April and May of 2010. The purpose of the survey was to offer HIV prevention service providers an opportunity to describe services and unmet needs in their community.

Methods

The survey consisted of 26 questions designed for HIV prevention service providers. Questions assessed a range of variables, including respondent demographics, agency information, delivery of prevention services, and community and agency needs.

The PPG selected an Internet-based survey format 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. Respondents completed the questionnaire on the Survey Monkey website and submitted their responses electronically. Responses were reviewed for geographic representation and duplication. Email reminders to complete the survey were sent to non-responding agencies, and providers with more than one survey submission were asked to select a single submission for inclusion in the analysis.

Responses were maintained and summarized by Survey Monkey. Bureau of HIV/AIDS staff members and PPG members performed a review of significant findings; significant response patterns and relationships are reported below.

Findings

There were 158 agencies who responded to the survey; responses to each question ranged from 136 (86%) to 150 (95%) (excluding questions asked only of subgroups of respondents). Findings are reported based on the number of responses to each survey item. Each area of the
state was represented by at least two agencies serving the area (range of agencies responding per area = two to 23); additionally, four respondents reported a statewide service area. Figure 2.1 shows the distribution of respondents by region (based on agency location).

**Figure 2.1. Percentage of Responses by Region.**

![Distribution of Responses by Region](image)

**Demographics of Respondents**

Respondents included females (57%), males (43%), and female-to-male transgender persons (<1%). Nearly half (49%) of respondents identified as black, over one-third (37%) as white, 11% as Hispanic/Latino, and 3% as multiracial. Approximately three-fourths (76%) identified as heterosexual and one-fourth (24%) as gay, lesbian, or bisexual.

**Agency Information**

The majority (62%) of responding agencies were community-based organizations (CBO); approximately one-third (35%) were county health departments; and 6% were private for-profit agencies or government agencies other than the Florida Department of Health. Nearly three-fourths (71%) of agencies have provided HIV prevention services for at least 10 years, and only 11% have provided prevention services for less than four years. The majority (78%) of agencies provide HIV/AIDS services as part of a larger services program, while 22% provide only HIV/AIDS services. Nearly two-thirds (61%) of agencies have a local service area (city or county), over one-third (38%) have a regional service area (two or more counties), and 1% have a statewide service area (all counties). Agency funding sources for HIV prevention include CDC indirect funding through DOH (49%); other state funding (40%); Ryan White (34%); city or county funding (26%); donations (26%); private grant funds (19%); CDC direct funding (16%); Substance Abuse and Mental Health Services Administration (SAMHSA) (10%); and Health Resources and Services Administration (HRSA) (9%).
**HIV Prevention Service Provision**

Approximately half (51%) of agencies estimated providing HIV prevention services (e.g., interventions, HIV testing, outreach) to at least 1,000 people in the last 12 months; approximately one-fourth estimated serving 250-999 clients (25%), and another one-fourth estimated serving less than 250 clients (23%). The majority of agencies reported providing clients with HIV prevention walk-in services or same-day appointments (85%) and offering services during weekends or evening hours (67%).

Respondents were asked to select from a list which populations their agency primarily targets (i.e., actively markets to or recruits for prevention services). Most agencies reported targeting both males (83%) and females (86%). African Americans/blacks (90%) represent the most targeted racial/ethnic group, followed by Hispanics/Latinos (65%), whites (47%), Haitians (40%), Asians (19%), Native Hawaiian/Pacific Islanders (15%), American Indian/Alaskan Natives (15%), and other racial/ethnic groups (27%). Young adults (18-29) (81%) represent the most targeted age group, followed by persons ages 30-50 (69%), persons over age 50 (55%), and youth (under 18) (53%). Heterosexuals (77%) represent the most targeted group by transmission category, followed by men who have sex with men (71%) and injection drug users (40%). Other targeted populations at risk for HIV infection or transmission include HIV-positive persons (60%), substance abusers (58%), incarcerated persons/ex-offenders (51%), and transgender persons (37%).

As shown in Table 4, the vast majority (86%) of agencies reported providing HIV testing, and over half (59%) reported providing rapid HIV testing (59%). Testing programs include routine HIV testing of pregnant women (35%), routine HIV testing of inmates in correctional facilities (24%), and Social Network Strategy (SNS) HIV testing (18%). Additionally, nearly one-third (30%) reported providing Partner Services and half (51%) reported providing STD testing.

Agencies reported providing a variety of other HIV prevention services (Table 1), including condom distribution (91%); HIV/STD education (90%); community events (80%); linkage to care (75%); community mobilization (39%); group support (39%); media campaigns (33%); Internet-based outreach, interventions, or campaigns (26%); motivational interviewing for HIV prevention (19%); structural interventions (8%); and cell phone-based interventions or campaigns (7%).

Of the agencies currently providing one or more effective behavioral interventions (e.g., DEBI/EBIs) (55%), the most commonly reported interventions were VOICES/VOCES (57%), SISTA (41%), CRCS (25%), Healthy Relationships (23%), RESPECT (13%), Blood Lines (13%), Community PROMISE (13%), Many Men Many Voices (11%), and d-up: Defend Yourself! (10%). Other interventions were reported by less than 10% of respondents.

Respondents were asked to select from a list any significant barriers or difficulties their agency has faced when providing HIV prevention services. Insufficient funding (71%) represents the most reported barrier. Other barriers reported include increasing workloads (44%), inadequate
transportation (43%), mental health issues (35%), substance abuse problems (33%), homelessness issues (31%), the target population being unaware of services available (29%), recruitment/retention (22%), cultural barriers (22%), and recruiting qualified staff (19%). Other barriers were reported by less than 12% of respondents.

**Unmet Prevention Service Needs**

Respondents were asked to select from a list the three most important unmet needs for HIV prevention services in their area (Table 4). The top three prevention needs selected were media campaigns (30%), community mobilization (26%), and group support (25%). Other services include community-level interventions (23%), Internet-based outreach, interventions, or campaigns (23%), rapid HIV testing (20%), HIV/STD education (19%), linkage to care (18%), STD testing (17%), individual- and group-level interventions (16%), and cell phone-based interventions or campaigns (16%). Other services were selected by less than 13% of respondents.

**Table 4 HIV Prevention Services in Florida: Services Provided and Unmet Needs, 2010**

<table>
<thead>
<tr>
<th>HIV Prevention Service</th>
<th>Agencies Providing Service (n=148) n (%)</th>
<th>Agencies Reporting Service as an Unmet Need (n=142) n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective behavioral interventions (n=149)</td>
<td>82 (55%)</td>
<td>NA</td>
</tr>
<tr>
<td>Community-level interventions</td>
<td>NA</td>
<td>33 (23%)</td>
</tr>
<tr>
<td>Individual- or group-level interventions</td>
<td>NA</td>
<td>23 (16%)</td>
</tr>
<tr>
<td>Structural interventions</td>
<td>12 (8%)</td>
<td>12 (9%)</td>
</tr>
<tr>
<td>HIV testing</td>
<td>127 (86%)</td>
<td>9 (6%)</td>
</tr>
<tr>
<td>Rapid HIV testing</td>
<td>87 (59%)</td>
<td>28 (20%)</td>
</tr>
<tr>
<td>Social Network Strategy HIV testing</td>
<td>26 (18%)</td>
<td>15 (11%)</td>
</tr>
<tr>
<td>Routine HIV testing of inmates in correctional facilities</td>
<td>36 (24%)</td>
<td>NA</td>
</tr>
<tr>
<td>Routine HIV testing of pregnant women</td>
<td>51 (35%)</td>
<td>NA</td>
</tr>
<tr>
<td>Partner Services</td>
<td>45 (30%)</td>
<td>14 (10%)</td>
</tr>
<tr>
<td>STD testing</td>
<td>75 (51%)</td>
<td>24 (17%)</td>
</tr>
<tr>
<td>HIV/STD education</td>
<td>133 (90%)</td>
<td>27 (19%)</td>
</tr>
<tr>
<td>Condom distribution</td>
<td>135 (91%)</td>
<td>8 (6%)</td>
</tr>
<tr>
<td>Group support</td>
<td>58 (39%)</td>
<td>36 (25%)</td>
</tr>
<tr>
<td>Media campaigns</td>
<td>49 (33%)</td>
<td>42 (30%)</td>
</tr>
<tr>
<td>Internet-based outreach, interventions, or campaigns</td>
<td>39 (26%)</td>
<td>32 (23%)</td>
</tr>
<tr>
<td>Cell phone-based interventions or campaigns</td>
<td>10 (7%)</td>
<td>22 (16%)</td>
</tr>
<tr>
<td>Motivational interviewing for HIV prevention</td>
<td>28 (19%)</td>
<td>15 (11%)</td>
</tr>
<tr>
<td>Community events</td>
<td>118 (80%)</td>
<td>18 (13%)</td>
</tr>
<tr>
<td>Community mobilization</td>
<td>58 (39%)</td>
<td>37 (26%)</td>
</tr>
<tr>
<td>Linkage to care</td>
<td>111 (75%)</td>
<td>26 (18%)</td>
</tr>
<tr>
<td>HIV prevention services for HIV+ clients in care settings</td>
<td>61 (41%)</td>
<td>NA</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>12 (8%)</td>
<td>9 (6%)</td>
</tr>
</tbody>
</table>
Respondents were asked to provide up to three open-ended responses regarding populations with the “greatest unmet need for HIV prevention services” in their area. Further guidance stated that respondents should “list an existing priority population (such as HIV-positive persons, black MSM, etc.), a subgroup within a priority population (such as Hispanic heterosexual males, older white MSM, etc.), or another group (such as transgender persons, American Indians, etc.).” A total of 381 responses were entered by 136 survey participants. Common response patterns (non-mutually exclusive) are shown in Figure 2.2. Of the 381 responses, the top populations reported were blacks/African Americans (36%), MSM (29%), Hispanics (16%), youth/teens (16%), heterosexuals (14%), females (12%), and HIV-positive persons (9%). Other groups were reported by less than 9% of respondents.

Figure 2.2. Percentage of Populations With the Greatest Unmet Need.

* Categories are non-mutually exclusive; for example, a response specifying “black MSM ages 13-24” would be included in the black, MSM, and youth/teens categories.

As black and MSM populations were reported as having the greatest unmet need, Figures 2.3 and 2.4 provide further detail on these responses. Figure 2.3 shows responses within the black category by risk group, and Figure 2.4 shows responses within the MSM category by race/ethnicity. While other characteristics (e.g., age, substance use) were specified in a number of responses, risk group and race/ethnicity were the most commonly reported characteristics.
**Figure 2.3. Percentage of Black Responses by Risk Group**

Distribution of Black Responses

- Heterosexual: 44%
- Male: 20%
- Other: 36%

**Figure 2.4 Percentage of MSM Responses by Race and Ethnicity.**

Distribution of MSM Responses by Race/Ethnicity  
N=111

- Black: 32%
- White: 39%
- Hispanic: 19%
- Black & White: 4%
- Black & Hispanic: 1%
- Other: 1%
- No Race/Ethnicity Specified: 5%

Documenting Linkage to Services

Of agencies encountering HIV-positive clients (n=148), nearly three-fourths (73%) reported tracking linkages to care; 18% reported sometimes tracking these linkages, and 10% reported not tracking these linkages. Of agencies reporting linking clients to other services (regardless of HIV status) (n=151), over one-third (40%) reported tracking these linkages; 36% reported sometimes tracking these linkages, and 23% reported not tracking these linkages.

Agency Staff Training

Respondents were asked to select from a list the types of trainings their agency’s HIV prevention staff receives. The majority of agencies reported that staff members receive HIV/AIDS 501 (94%), confidentiality (87%), HIV/AIDS 101 (82%), and cultural competency (77%) trainings. Nearly one-fourth (23%) of agencies reported other types of trainings (e.g., interventions, HIV testing).
Technical Assistance Needs

Nearly one-third (30%) of agencies reported needing technical assistance (TA). These agencies reported a wide range of TA needs, including TA on topics such as conducting focus groups (38%), grant writing/proposal development (36%), recruiting hard-to-reach populations (36%), program marketing (36%), outreach and recruitment (34%), program monitoring and evaluation (32%), quality assurance (30%), bridging theory and practice/applying behavioral theory to HIV prevention (30%), public relations (30%), community needs assessment (28%), small group facilitation (28%), cultural competency (28%), motivational interviewing (28%), adaptation and effective interventions (26%), logic model development (26%), resource development (26%), strategic planning (23%), selecting evidence-based interventions (23%), PEMS training (21%), and fiscal management (21%).

Limitations

No probability sampling techniques were used; thus, responses may not be generalized to all HIV prevention service providers in Florida. However, survey responses were obtained from a large number of agencies (N=158) representing each area of the state.

Conclusions

Findings suggest that most providers have expertise and capacity for providing HIV prevention services to Florida’s at-risk populations. While most agencies reported a services program in which HIV/AIDS is not the sole focus, the majority had an established history (≥ 10 years) of providing HIV/AIDS services. Diverse funding sources for HIV prevention were reported, which DOH encourages to support the sustainability of programs. The vast majority of agencies ensure prevention staffs receive important trainings on HIV/AIDS, cultural competency, and confidentiality. Less than one-third of agencies reported needing TA. However, these agencies reported a wide range of TA needs. Free trainings and TA available to providers (e.g., via the Blackmon Roberts Group, CDC-funded capacity building assistance providers, and DOH staff) should be further promoted by DOH and further utilized by providers.

Responses suggest broad implementation and reach of HIV prevention services, including HIV testing, behavioral interventions, and condom distribution. Agencies appear to target a vast range of populations and to implement practices that help increase access to and use of services (e.g., walk-in services, non-traditional hours). Reported barriers to services underscore the need to further explore ways of addressing issues such as transportation, mental health issues, substance abuse, and homelessness. Such barriers may be lessened by linking clients to psychosocial and health services, as well as local efforts to implement structural interventions (e.g., new public transportation routes, policies limiting alcohol advertising). Responses suggest that providers desire more far-reaching initiatives in their areas (e.g., media campaigns, community mobilization initiatives, community-level interventions). A variety of
other prevention service needs were reported (e.g., group support, rapid HIV testing, linkage to care, and individual- and group-level interventions), including an interest in the use of new technologies for HIV prevention (e.g., Internet- and cell phone-based initiatives). Provider responses suggest that numerous populations, particularly blacks and MSM, have unmet service needs. These findings may be used with other data (e.g., epidemiologic and funding data) to help assess and meet the service needs of Florida’s at-risk populations.

Statewide Anonymous Ryan White Needs Assessment Survey

Needs assessment is an interconnected part of other Ryan White Treatment Modernization Act planning tasks. Results from the needs assessment are used in setting priorities for the allocation of funds, developing the comprehensive plan, and creating the annual implementation plan. Needs assessment results can also provide baseline data for evaluation and help providers improve services. The survey of PLWHAs, which is only one component of the needs assessment process, examines the service needs, gaps in service, and barriers from a consumer perspective. The 2010 Anonymous Ryan White Needs Assessment Survey took respondents between 10 and 15 minutes to complete.

Methods

The anonymous needs assessment survey was implemented and administered in a variety of different ways, with some counties using multiple strategies. It was not possible to compute response rates. However, with more than 7,000 completed surveys, it is felt that coverage was adequate for a straightforward descriptive analysis of the data to convey useful information, without applying tests of statistical significance. Major issues that emerged were cautiously assumed to be approximations of trends among the general PLWHA population in the state.

Examples of implementation approaches are as follows. Clients were given paper copies of the survey (if they had not already answered the survey) as they entered the agency to pick up food bags. Case managers completed the survey with clients during appointments or clients completed them while waiting to see the case manager. Case managers called clients in outlying counties and asked if they would complete a survey - if clients agreed a survey was mailed to them, sometimes with postage included. Staff personnel (not an individual's own case manager) also called clients in outlying areas to complete surveys over the phone. Other personnel were used so that clients would feel free to answer the questions honestly. The same staff would meet with a client in an office to help complete the survey if the client needed assistance. Throughout the state, the Internet was used to reach at-large PLWHAs.

Survey items (N=59) and multiple-choice responses were conceptually developed to assess service and other gaps in the HIV/AIDS patient care systems across the state. Selected survey items were analyzed and discussed here, primarily those considered essential for individual
well-being. Demographic, behavioral, and situational characteristics were then described. No tests of statistical significance were applied to the data.

Results

Among 5,049 male survey respondents, non-Hispanic whites predominated with 42% of the completed surveys, followed by non-Hispanic blacks (30%) and Hispanics (21%). Seven percent (7%) were of other race/ethnicity. This contrasts with statewide racial/ethnic surveillance data on all PLWHAs among males through 2009 (N = 60,992), where 38% are white, 38% are black, 23% are Hispanic, and 2% are of other race/ethnicity. Among 2,430 female respondents (and among 27,691 women living with HIV/AIDS), the percentage responding (versus the percentage PLWHAs) was 23% (16%) for whites, 53% (69%) for blacks, 16% (13%) for Hispanics, and 9% (2%) for those of other race/ethnicity.

The distributions of self-reported sexual identification were expectedly very different for males and females. While gays predominate among males, “straight” (heterosexual) females account for virtually all respondents. There were 68 male-to-female transgendered persons and seven female-to-male transgendered persons in the sample. Questions regarding injection drug use were not included in the survey.

According to age (N=7,257 respondents), 55% were 45-64, 38% were 25-44, 3% were 13-24, 4% were >64, and <1% were <13. Of 7,364 clients responding to employment questions, 60% were not working, 17% were working full-time, 10% part-time, 8% “off and on”, and 4% were self-employed.

During the past 12 months, virtually all respondents (93%) were receiving some form of care, including but not limited to having had a CD4 count or viral load test. Among the 7% who did not receive care, 271 offered at least one reason. A variety of reasons were offered, some of which could lend themselves to intervention, such as “I could not pay for services”, “I did not know where to go”, and “I could not get transportation” (Table 1). However, some barriers were less directly or readily amenable to corrective action on the part of the public health system. Examples of these include, “I did not feel sick” (though better education about taking meds could help overcome this barrier), “I did not want people to know I have HIV”, and “I could not get time off work”. Differences according to race/ethnicity were unremarkable (data not shown).
Table 5: Reasons for not receiving medical care in the past 12 months, Florida, 2010.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>I did not feel sick</td>
<td>28%</td>
<td>76</td>
</tr>
<tr>
<td>I could not pay for services</td>
<td>28%</td>
<td>75</td>
</tr>
<tr>
<td>I did not want people to know that I have HIV</td>
<td>24%</td>
<td>64</td>
</tr>
<tr>
<td>I did not know where to go</td>
<td>23%</td>
<td>61</td>
</tr>
<tr>
<td>I was not ready to deal with having HIV</td>
<td>21%</td>
<td>58</td>
</tr>
<tr>
<td>I was depressed</td>
<td>20%</td>
<td>55</td>
</tr>
<tr>
<td>I could not get transportation</td>
<td>12%</td>
<td>32</td>
</tr>
<tr>
<td>I missed my appointment(s)</td>
<td>10%</td>
<td>26</td>
</tr>
<tr>
<td>I had a bad experience with the medical staff</td>
<td>9%</td>
<td>24</td>
</tr>
<tr>
<td>I could not get time off work</td>
<td>6%</td>
<td>17</td>
</tr>
<tr>
<td>I could not get an appointment</td>
<td>6%</td>
<td>15</td>
</tr>
<tr>
<td>I was too busy taking care of my partner</td>
<td>3%</td>
<td>9</td>
</tr>
<tr>
<td>There are not enough doctors in my area</td>
<td>2%</td>
<td>6</td>
</tr>
<tr>
<td>I could not get childcare</td>
<td>2%</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>14%</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total Respondents (N)</strong></td>
<td><strong>271</strong></td>
<td></td>
</tr>
</tbody>
</table>

One-third of respondents received care through a public or health department clinic, another one-third through a doctor’s office, and one-quarter through an HIV specialty clinic. A limitation of these data is that an “HIV specialty clinic” could be one located within a health department.

Complete (100%) adherence was reported by 81% of respondents, while the remainder were less than completely adherent. The five most prevalent reasons (respondents could check multiple reasons) for not taking medications exactly as directed were 1) forgetting (38%), 2) the meds made them “feel really bad” (27%), 3) they do not like taking medications (22%), 4) they feel healthy (10%), and 5) they cannot afford them (9%).
Table 6: Services Received and Service Gaps for Services Needed, Florida, 2010.

<table>
<thead>
<tr>
<th>Service Gap</th>
<th>Service Gap</th>
<th>Received Needed Service</th>
<th>Total (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Support</td>
<td>53%</td>
<td>47%</td>
<td>2,399</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>48%</td>
<td>52%</td>
<td>1,465</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>45%</td>
<td>55%</td>
<td>550</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>42%</td>
<td>58%</td>
<td>1,091</td>
</tr>
<tr>
<td>Outreach</td>
<td>41%</td>
<td>59%</td>
<td>1,826</td>
</tr>
<tr>
<td>Transportation</td>
<td>40%</td>
<td>60%</td>
<td>2,977</td>
</tr>
<tr>
<td>Food Bank or Food Vouchers</td>
<td>37%</td>
<td>63%</td>
<td>4,145</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>34%</td>
<td>66%</td>
<td>4,224</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>32%</td>
<td>68%</td>
<td>2,927</td>
</tr>
<tr>
<td>Dental/Oral Health</td>
<td>31%</td>
<td>69%</td>
<td>5,718</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>31%</td>
<td>69%</td>
<td>1,213</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>27%</td>
<td>73%</td>
<td>3,121</td>
</tr>
<tr>
<td>Health Education/Risk Reduction</td>
<td>20%</td>
<td>80%</td>
<td>2,797</td>
</tr>
<tr>
<td>Early Intervention Services</td>
<td>20%</td>
<td>80%</td>
<td>3,047</td>
</tr>
<tr>
<td>Treatment Adherence</td>
<td>12%</td>
<td>88%</td>
<td>2,990</td>
</tr>
<tr>
<td>Case Management</td>
<td>11%</td>
<td>89%</td>
<td>6,352</td>
</tr>
<tr>
<td>Outpatient Medical Care</td>
<td>5%</td>
<td>95%</td>
<td>6,360</td>
</tr>
<tr>
<td>Medications</td>
<td>5%</td>
<td>95%</td>
<td>6,355</td>
</tr>
<tr>
<td>Other</td>
<td>57%</td>
<td>43%</td>
<td>803</td>
</tr>
</tbody>
</table>

Overall, 72% of respondents indicated they received all needed services that were listed in this survey item. Excluding those who did not need the services, the majority of respondents received needed specific services (except for legal services, where slightly less than half received the service). There were numerous specific gaps (Table 2). The difference between the total 7,000 some odd respondents and the totals shown in the table represent those who did not need the particular service. Of 18 services listed, more than 4,000 respondents needed each of six specific services (service gaps in parentheses): Food bank or food vouchers (37%), health insurance (34%), dental/oral health (31%), case management (11%), outpatient medical care (5%), and medications (5%). The latter two services are considered vital, and fortunately these needs are met for 95% of respondents. Evidently, more than 800 respondents (approximately 10% of all respondents) expressed no need for medications. Differences in service gaps according to race/ethnicity were unremarkable (data not shown).

Nearly 5,000 respondents reported no barrier to services. Of the 2,091 who indicated they experienced one or more barriers, 37% did not know where to receive services (Table 3), a high percentage considering how many service sites there are. This could probably be addressed by public health authorities via education and social marketing. Social marketing could also be effective in reducing stigma, which underlies not wanting others to know the respondent was HIV-positive (a full 11% of those expressing barriers).
### Table 7: Service Barriers, Florida, 2010.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I did not know where to get services</td>
<td>37%</td>
</tr>
<tr>
<td>I could not pay for services</td>
<td>24%</td>
</tr>
<tr>
<td>I was depressed</td>
<td>21%</td>
</tr>
<tr>
<td>I could not get transportation</td>
<td>19%</td>
</tr>
<tr>
<td>I did not qualify for services</td>
<td>14%</td>
</tr>
<tr>
<td>I did not want people to know that I have HIV</td>
<td>11%</td>
</tr>
<tr>
<td>I missed my appointment(s)</td>
<td>10%</td>
</tr>
<tr>
<td>I could not get an appointment</td>
<td>9%</td>
</tr>
<tr>
<td>I was put on the waiting list</td>
<td>8%</td>
</tr>
<tr>
<td>I had a bad experience with the staff</td>
<td>7%</td>
</tr>
<tr>
<td>Services were not in my language</td>
<td>5%</td>
</tr>
<tr>
<td>I was too busy taking care of my partner</td>
<td>2%</td>
</tr>
<tr>
<td>I could not get childcare</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>17%</td>
</tr>
</tbody>
</table>

Total Respondents (N) 2,091

Twenty-one percent (21%) indicated depression as a barrier, and a sizeable proportion of those needing mental health services did not receive them (27%; Table 2). However, the degree of clinical or sub-clinical depression was not determined. Depression was more common among racial/ethnic minorities than among whites.

Among respondents answering the housing questions, 68% lived in an apartment or house that they owned or rented. Another 20% lived in someone else’s apartment or house, including friends and relatives. Three percent lived in a room or boarding house. Only 2% were homeless and 1% lived in a homeless shelter. Another 2% were in jail or prison. Ten respondents lived in a nursing home. Ninety percent of respondents indicated they had a place of their own to sleep every night for the past six months. Of those who did not (N=465), 53% reported not having a place of their own to sleep for one or more months of the last six months. Living situations six months prior to the survey did not substantively differ from present living situations (data not shown).

The majority of respondents had no needs concerning the listed housing services. Of those who did, two-thirds or more experienced service gaps according to the situations listed in Table
4. The most prevalent needs in terms of raw numbers were for money to pay rent or mortgage and money to pay utilities.

Table 8: Housing Services Gaps, Florida, 2010.

<table>
<thead>
<tr>
<th>Service Gap</th>
<th>Service Gap</th>
<th>Received Needed Service</th>
<th>Total (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>House for persons living with HIV/AIDS</td>
<td>76%</td>
<td>24%</td>
<td>1,049</td>
</tr>
<tr>
<td>Temporary short-term housing</td>
<td>73%</td>
<td>27%</td>
<td>907</td>
</tr>
<tr>
<td>Housing where my child(ren) can live with me</td>
<td>73%</td>
<td>27%</td>
<td>546</td>
</tr>
<tr>
<td>Permanent, independent housing</td>
<td>72%</td>
<td>28%</td>
<td>1,691</td>
</tr>
<tr>
<td>Nursing home</td>
<td>72%</td>
<td>28%</td>
<td>317</td>
</tr>
<tr>
<td>Assisted Living facility</td>
<td>71%</td>
<td>29%</td>
<td>547</td>
</tr>
<tr>
<td>Money to pay rent/mortgage</td>
<td>68%</td>
<td>32%</td>
<td>2,830</td>
</tr>
<tr>
<td>Money to pay utilities</td>
<td>68%</td>
<td>32%</td>
<td>2,905</td>
</tr>
<tr>
<td>Help finding a place to live</td>
<td>67%</td>
<td>33%</td>
<td>1,793</td>
</tr>
</tbody>
</table>

Discussion

Although many reasons were offered for not receiving medical care in the past six months (Table 1), a relatively small proportion had need in this regard. Only 4% (N=271) of respondents in the sample gave one or more reasons why they had trouble obtaining medical care. Of these, 20% were depressed. While extent of clinical or sub-clinical depression was not ascertained, a shortage of mental health services could be addressed and resources committed to this need. Six respondents indicated insufficient numbers of doctors in the area to provide HIV care and treatment; however, this number was small, and there is no immediately evident way to impact it. Nearly one-fourth of respondents in need of medical services avoided them because they did not want people to know that they had HIV. Addressing underlying stigma and reality-checking in this group may require effective social marketing, which could address other unmet needs as well, including where to find transportation. In-service cultural sensitivity training could have an impact on reducing bad experiences with staff.

Those respondents in need of a particular service were most numerous for case management (6,352), outpatient medical care (6,360), and medications (6,355) (Table 2). A relatively small proportion of respondents indicated an unmet need for delivery and receipt of these services (respectively, 11%, 5%, and 5%), which is encouraging as the most needed services were also
the most often received. Roughly one-third of respondents did not receive needed food bank or food vouchers, had no health insurance, and needed nutritional counseling, dental/oral health services, and substance abuse treatment. All the above unmet need categories can be addressed to some extent by public health and community-based organizations. The general absence of differences across the racial/ethnic spectrum suggests all demographic groups require similar levels of additional professional attention and intervention.

Limitations of the Data

The demographic profiles of the sample and all PLWHAs differed enough, especially among females, to suggest a non-representative sample of clients had been achieved. Clients were self-selected for survey participation. Next time, efforts will be made to more systematically sample eligible individuals to produce a more representative sample, whose characteristics, knowledge, attitudes, and behaviors could then be reliably compared from one survey cycle to the next. Responses were subjective and subject to respondent biases, including recall and social desirability of answers to sensitive questions. However, this would be the case even if a randomized survey had been conducted. To enable better generalization to the overall PLWHA population will require a different study design and consume more resources, but the cost-effective benefits in achieving the survey goals and objectives should outweigh the drawbacks. Finally, the survey period was January through September, 2010, and thus spanned the time when a funding crisis emerged in the ADAP program statewide; a wait list was started in June and increased through September. PLWHA who responded to the survey after the wait list began in June would very likely have a very different response than if completing the survey before this time and vice versa. Since most planning areas completed the survey process prior to June, this discrepancy probably did not greatly affect the overall results statewide.

Conclusion

This survey provided a snapshot of a cross-section of needs and reasons that some of those needs went unmet. The number of a self-selected group of PLWHAs with actual unmet need is what we obtained, which may be regarded as a minimum estimate. However, the proportions of the sample in need of services likely differ from the proportion of all persons in need, due to the non-representative nature of the sample. Resources could be assigned to improve the situations where the most PLWHAs had specific service needs and where these services were amenable to change. Future surveys will deploy more uniform sampling methodology to achieve a sample from which generalizations can be made, statistical tests of comparison can be conducted, and comparisons over time can be made. A lingering challenge will be including in the survey sufficient numbers of PLWHAs who are not in care nor connected with Ryan White programs, a group that could account for 25%-33% of all PLWHAs, according to CDC.
Section III: Resource Inventory

HIV Prevention Programs and Services at a Glance

HIV Testing

Since 1985, when DOH began collecting data on HIV testing at registered testing sites across the state, over 6 million anonymous and confidential tests have been conducted. Today over 1,600 public and private sites are registered with the DOH to provide HIV counseling, testing, and linkage services. Social and demographic data including risk behaviors, are collected at these sites, and are compiled along with test results by the Prevention Section of the HIV/AIDS and Hepatitis Program. While this database is currently not unduplicated, and as such cannot be used to provide data on the number of individuals tested, it does constitute a record of the number of tests conducted. It is a crucial indicator about the nature and direction of the epidemic, and is used to inform and evaluate HIV prevention activities and policy making at the state and local level.

At least 80% of the estimated 135,000 persons with HIV in Florida know they are infected. Since 1999, DOH has focused on increasing the proportion who know their HIV status. A variety of strategies have been pursued, including: the increased use of OraSure and rapid testing in outreach settings; testing in clinical settings such as emergency rooms; improved risk assessment and targeted testing; increased testing in correctional settings; increased emphasis on partner services; expansion of non-traditional, community-based testing programs; increased use of mobile vans; directly-funded CDC testing programs; a social marketing campaign encouraging persons at risk for HIV to be tested; and expanded testing and outreach focusing on minority populations and men who have sex with men. These strategies undoubtedly have led, at least in part, to the 77.7% increase in testing between 1999 and 2010.

In 2010, 410,678 HIV tests were conducted at Florida’s registered testing sites, representing a 4% increase (approximately 15,000 tests) over the previous year. This marks the 10th consecutive year that the number of HIV tests performed in Florida exceeded 250,000. Increases in testing were recorded among all racial/ethnic groups, but especially in blacks (7.2% or approximately 12,000 tests).

The African American Testing Initiative concluded in 2010 and contributed to the continued increase in testing among blacks. As with previous years, persons who reported heterosexual sex as their highest risk represented the majority of the tests. For the second straight year, rapid testing accounted for the largest number of tests with 49.8%, followed by blood at 40.0% and OraSure at 10.2%.

The number of positive tests decreased by 12.8% (664) and the overall positivity rate decreased from 1.3% in 2009 to 1.1% in 2010. Men who have sex with men (MSM) account for 39.7% of all
positive tests reported in 2010, yielding a positivity rate of 6.0%. Although heterosexuals represent 59.2% of all testing and 23.4% of positive results, the positivity rate for this risk group is only 0.4%. Blacks and adults age 30 and older continue to record higher than average positivity rates.

**Behavioral Interventions**

The majority of HIV prevention behavioral interventions delivered in Florida are evidence based and have been proven to reduce sexual and drug-using risk behaviors in high-risk populations. Most of these interventions are classified as Effective Behavioral Interventions (EBIs) and can be found within the Centers for Disease Control and Prevention’s (CDC) DEBI/REP (Diffusion of Effective Behavioral Interventions/Replicating Effective Programs) project ([www.effectiveinterventions.org](http://www.effectiveinterventions.org)). The Prevention Section of the HIV/AIDS and Hepatitis Program, through funding from the CDC, funds 29 community-based organizations (CBOs) to deliver EBIs to priority populations around the state. Funding for these providers continues until December 31, 2012. The overarching goal of all behavioral interventions implemented in Florida is to reduce HIV/STD incidence or risk behaviors and promote safer behaviors. Interventions are grouped into three categories: individual-level, group-level, and community-level.

Almost 47,000 individuals were enrolled in behavioral interventions delivered by the 12 HIV Prevention (HP) providers, with four interventions having a completion rate greater than 90% (Table 1). Among all interventions, the community-level interventions Community PROMISE and RAPP enrolled the greatest number of participants (44,520, 94.9%). The far reach of these interventions can be partly attributed to the wide dissemination of role model stories via face-to-face outreach encounters or through social networking sites on the Internet. The interventions with the next highest number of participants enrolled include VOICES (943, 2%) and Healthy Relationships (418, 0.9%). The number of outreach contacts far exceeds the number of participants enrolled in interventions, thus demonstrating the need for outreach efforts in order to recruit the necessary number of participants. Community PROMISE and RAPP demonstrate the farthest reach (23,760), accounting for a combined 78.4% of the total outreach contacts. Mpowerment (2,454), VOICES (1,044), Healthy Relationships (405), and POL (641) together accounted for 14.9% of the total outreach contacts.

There are currently over 20 county health departments (CHDs) implementing one or more behavioral interventions; the most widely implemented intervention by CHDs is VOICES/VOCES. In 2010, CHDs enrolled 54,099 participants in programs such as CRCS (65), Partnership for Health (1,342), POL (88), and VOICES (2,216).

There are an additional 17 HIV prevention providers funded through the Closing the Gap (CTG) program that implement one or more behavioral interventions and HIV prevention strategies. Preliminary data for CTG providers indicate they will serve almost 14,500 clients during their second year (2010-2011) of implementation. This is an increase of 32% from year one.
Minority AIDS Initiative

DOH uses the Minority AIDS Initiative-Antiretroviral Treatment and Access to Services (MAI-ARTAS) program to identify HIV-infected persons and link them to medical care. MAI-ARTAS is funded by the Health Resources and Services Administration (HRSA) and efforts are focused on minority populations/communities in order to reduce health disparities. There are nine MAI providers located in the following counties: Broward (2); Hillsborough (6); Miami-Dade (1); Orange (3); and Palm Beach (4). These counties consistently have the highest number of HIV/AIDS cases (rank shown in parenthesis).

The MAI-ARTAS program addresses all three goals of the NHAS: 1) reduce the number of people who become infected with HIV; 2) increase access to care and improve health outcomes for people living with HIV; and, 3) reduce HIV-related health disparities. In 2011, there were 807 blacks, 337 Hispanics, 32 “other”, and 141 whites enrolled in the program. This is a total of 1,317, which is an increase from the 1,103 and 1,123 enrolled in 2010 and 2009, respectively. While efforts and resources are aimed at minority populations most impacted by HIV, no one is denied entry into the program.

MAI-ARTAS tracks clients in defined target populations based on several behavioral components. These behaviors are identified as injection drug use, incarceration, and men who have sex with men (MSM), to name a few. MSM were the largest target population served in 2011 and the previous two years. Some of these populations represent those considered high risk. In this time of limited funding, it is important to focus our efforts and resources on those most impacted by HIV/AIDS.

All providers have entered into a partnership with at least one community agency for client referrals to their program. These include, but are not limited to, county health departments, STD clinics, jails, homeless shelters, and mental health and substance abuse clinics. Most notably, partnering with local hospitals has been very successful. Through this arrangement, care coordinators are able to link clients to medical treatment via the Ryan White system of care. This alleviates some of the financial strain that uninsured clients have placed on hospitals. In this reciprocity, both parties benefit, making the MAI-ARTAS program valuable and cost-effective.

Targeted Outreach For Pregnant Women

The mission of TOPWA is to decrease the number of women and babies who contract HIV. HIV-positive, pregnant women enrolled in the TOPWA program receive encouragement to take medications to prevent transmission of the virus to their baby. In addition, they receive assistance with applying for Medicaid, getting prenatal care, HIV prevention education, condoms, and referrals for family planning services.
Every baby born to an HIV-infected mother is prescribed a six-week course of zidovudine to lower the risk of transmission from mother to baby. Since the prescription is for the baby, the mother’s Medicaid will not cover the cost. The baby is only days old and typically does not have his/her own Medicaid number, and the Ryan White program cannot pay for the medication because the baby does not have a diagnosis of HIV infection. The Baby RxPress Program began in 2008 to provide zidovudine through a voucher system with Walgreens Pharmacy and payment is made through funds from the HIV/AIDS and Hepatitis Program. In 2010, zidovudine was provided to 129 babies for a cost of $3,648.92, or $28.28 per newborn. These figures tell us that approximately 25% of HIV-exposed newborns in Florida had no other way to pay for this medication.

Social Marketing and Media

DOH funded three social marketing campaigns targeting Florida’s priority populations. The programs utilize a variety of media and marketing strategies (e.g., radio, print media, social media, advertising, and hotline) to reach target populations. Campaigns include the Florida HIV/AIDS Hotline, We Make the Change, and the Hispanic AIDS Awareness program.

Florida HIV/AIDS Hotline - The Florida HIV/AIDS Hotline is the statewide resource for HIV/AIDS related information, community referrals, and supportive telephone counseling. The hotline numbers are accessible only from within the state of Florida. There are five lines for English speaking callers, two lines for Spanish, and two lines for Haitian-Creole. In addition there is a separate line providing TTY access for hard-of-hearing and deaf callers.

Hispanic AIDS Awareness Program - The Hispanic AIDS Awareness Program (HAAP) provides educational information to raise awareness about the threat of HIV/AIDS in the Hispanic communities of central and south Florida. The HAAP campaign targets Spanish-speaking persons, with priority to Latino men who have sex with men and Latina women. The campaign disseminates HIV prevention messages that encourage condom use and HIV testing. The program designs innovative educational materials and radio and television programs that incorporate images, languages, and cultural icons relevant to the Hispanic population. Campaign materials are disseminated via radio and TV public service announcements, public appearances, social networking sites, billboards, and training seminars.

We Make the Change - We Make the Change (WMTC) is a statewide media campaign designed to increase the awareness of HIV/AIDS and its impact in Florida’s minority communities. Through this minority media campaign, DOH has been able to effectively market and promote HIV prevention messages and services in African-American, Hispanic and Haitian/Caribbean communities. Major components of the campaign are the “We Make the Change” and “Stop the Spread” websites.
Funding Snapshot

The Funding Snapshot addresses 2010 HIV prevention funding by priority population. The goal of the snapshot is to help assess whether the distribution of HIV prevention funding in Florida is proportionate to the distribution of the state’s HIV/AIDS epidemic. The snapshot looks at the total amount of funding for each priority population and compares that to the proportion of HIV/AIDS cases among the priority population. In addition to outlining funding allocated to priority populations, the snapshot provides an accounting of funds that are not targeted to any specific racial/ethnic and risk group.

Priority Populations

The PPG historically determines the state’s priority populations for HIV prevention. To maximize the efficiency, effectiveness, and allocation of limited HIV prevention resources throughout the state, the PPG decided that HIV prevention efforts should focus on seven priority populations. As listed below, the top priority population is HIV-positive persons, followed by six high-risk negative populations of a specified racial/ethnic and risk group.

Florida’s Priority Populations 2010

1. HIV-Positive Persons
2. Black Heterosexuals
3. Black MSM
4. White MSM
5. Hispanic MSM
6. Hispanic Heterosexuals
7. White Heterosexuals

The PPG designed the 2010 priority setting methodology to ensure the fair and uniform selection of priority populations and allocation of resources throughout the state. The priority population rankings were determined based on HIV case data. For prevention purposes, HIV case data are a stronger indicator than AIDS case data of where new infections (incidence) are occurring and which groups are at highest risk. Florida utilizes a passive and active surveillance system for reporting HIV and AIDS cases. Local county HIV/AIDS surveillance offices report case information through the electronic HIV/AIDS Reporting System (e-HARS), and the state updates e-HARS on a continual basis.

Funding Sources

The State of Florida, CDC), and HRSA allocate approximately $39.2 million dollars to support the HIV prevention efforts of Florida’s CBOs, AIDS service organizations (ASOs), county health departments (CHDs), and DOH.
Below is a list of the HIV prevention activities examined in the snapshot by funding source.

**CDC**

- CDC directly funded 15 contracts with CBOs in 2009-2010 and 10 contracts with CBOs in Florida in 2010-2011. The contract cycle starts July 1 and ends June 30.
- The African American Testing Initiative (AATI) grant from CDC funded DOH and providers to conduct HIV testing among black (non-Hispanic) populations. The funding period ended September 29, 2010.
- The Expanded Testing Initiative (ETI) grant from CDC funds DOH and providers to conduct HIV testing among blacks, Hispanics, men who have sex with men (MSM) of all races/ethnicities, injection drug users (IDUs) of all races/ethnicities, and transgender populations. The funding period is September 30, 2010 through September 29, 2011.
- DOH receives funding from CDC to develop and implement an Enhanced Comprehensive HIV Prevention Plan (ECHPP) in Miami-Dade County. The ECHPP grant supports a contract with the Health Council of South Florida (HCSF). The funding period is September 30, 2010 through September 29, 2011.
- The National HIV Behavioral Surveillance (NHBS) grant from CDC funds DOH and the University of Miami to conduct behavioral research among populations at high risk for HIV infection in Miami-Dade County. The contract cycle starts January 1 and ends December 31.
- DOH uses a prevention grant (PG) from CDC to fund multiple prevention efforts:
  - The Blackmon Roberts Group (BRG) is funded to provide one-on-one capacity building assistance primarily to minority HIV/AIDS organizations (DOH-funded and non-funded) in Florida. The contract cycle starts January 1 and ends December 31.
  - The AIDS Institute is funded to assist with the coordination of community planning meetings to maximize resources and address community needs throughout the state. The contract cycle starts January 1 and ends December 31.
  - Condoms (male and female), educational materials, promotional items, testing supplies, sponsorships, equipment, and personnel are among other categories supported with PG funds.

**DOH General Revenue (GR)**

- The Florida AIDS Hotline is funded to make HIV/AIDS information, referrals, and supportive counseling accessible to the public via telephone and the Internet. The contract cycle starts July 1 and ends June 30.
- EMS Resources is funded to produce and provide HIV prevention public service announcements, public awareness media campaigns, and training activities to Spanish-speaking communities in Florida. The contract cycle starts July 1 and ends June 30.
o GR funding from the Bureau of HIV/AIDS and Office of Minority Health supports 17 Closing the Gap (CTG) contracts with CBOs. CTG is a Florida initiative to reduce racial/ethnic health disparities. The contract cycle starts July 1 and ends June 30.

o Rapid test kits, supplies, forms, sponsorships, and personnel are among other categories supported with GR funds.

HRSA

o Through a Minority AIDS Initiative grant from HRSA, DOH funds seven MAI contracts. This initiative serves to link newly diagnosed minorities and HIV-positive persons who have dropped out of care to medical and support services. The Antiretroviral Treatment Access Study model is used to empower clients to become their own medical advocate. The contract cycle starts April 1 and ends March 31.

o The Department of Corrections (DOC) Pre-Release Planning Program is funded through HRSA’s Ryan White Part B funds to link HIV-positive prison inmates to care as they are released from a correctional facility. The funding period starts July 1 and ends June 30.

o Rapid test kits, supplies, forms, sponsorships, and an AETC contract are among other categories supported with HRSA’s Ryan White funding.

Multiple funding sources

o DOH supports 25 HIV Prevention (HP) contracts with CBOs through PG and GR funding. The contract cycle starts January 1 and ends December 31.

o GR and PG funds support seven contracts with Targeted Outreach for Pregnant Women Act (TOPWA) providers. TOPWA is an initiative to decrease the number of babies born with prenatal drug exposure and HIV infection by connecting high-risk or HIV-infected pregnant women to adequate prenatal care. The contract cycle starts July 1 and ends June 30.

o GR and AATI/ETi funds support a contract with Anson-Stoner to develop and disseminate media messages targeting racial/ethnic minority populations at risk for HIV infection. The contract cycle starts July 1 and ends June 30.

o DOH funds HIV testing programs in 16 jails through PG and AATI/ETi funding.

Methodology

To assess the distribution of HIV/AIDS by priority population, living HIV/AIDS cases diagnosed through 2009 among persons at least 13 years of age (cases with no identified risk were redistributed, data include DOC cases, cases were reported as of 6/3/2010) were examined. Cases were distributed to the appropriate priority population category (populations 2-7) based
on race/ethnicity and mode of transmission. Within each racial/ethnic group, the number of PLWHA with the dual risk of being men who have sex with men and injection drug users (MSM/IDUs) were redistributed equally to the group’s MSM and IDU populations.

To estimate the distribution of contract funding in 2010 by priority population, contract funding amounts, funding periods, and target populations listed in provider contracts, then distributed funding to the appropriate priority population categories were examined. While it is recognized that many prevention programs reach persons outside of their target population(s) incidentally, this snapshot serves to describe the intent of the program funding and activities.

For programs only funded for a portion of the year (i.e., AATI, ETI, ECHPP, and CDC direct-funded programs), the funding amount is represented accordingly (e.g., for a program starting the last quarter of 2010, one-fourth of the annual funding amount is represented in the snapshot). For agencies funded through a single contract to implement two or more programs with different target populations, the total funding amount was distributed to each program accordingly, then to the appropriate priority populations. The program-specific funding amounts were based on program budgets or reports from agencies; when program-specific funding amounts were not available, the total contract amount was distributed equally to each program. For programs targeting two or more high-risk negative priority populations (e.g., black and Hispanic heterosexuals), funding was allocated equally to each priority population. For programs with an HIV-positive target population of a specified racial/ethnic and risk group (e.g., HIV-positive black MSM), funding was allocated to the HIV-positive priority population due to its top ranking.

DOH funds a number of HIV prevention activities targeting a racial/ethnic group, but not a specified risk group. AATI programs target Florida’s black populations and are implemented primarily in venues that do not cater to a single risk group (e.g., emergency departments). Thus, AATI funding was distributed by population proportionate to DOH’s estimated proportions of Florida’s black population in the heterosexual (92.5%), IDU (2%), MSM (3%), and WSW (2.5%) (women who have sex with women) risk groups. As ETI funding is used to target a broad range of populations (i.e., blacks, Hispanics, MSM, and IDUs) and the populations served vary significantly by provider, we allocated each ETI provider’s funding to the appropriate populations based on the agency’s HIV testing data (for previous AATI providers, the demographics of AATI clients tested during the prior three years was examined; for providers not previously funded through AATI, the demographics of clients tested during the first few months of ETI was examined). EMS is funded to develop media and marketing efforts targeting Florida’s Spanish-speaking communities. As EMS marketing efforts are tailored by risk group, DOH staff estimates that 70% of EMS funding targets Hispanic heterosexuals and 30% targets Hispanic MSM. Thus, EMS funding was allocated among these priority populations accordingly. Anson-Stoner is funded to create media messages targeting racial/ethnic minorities. As these media messages are targeted to black and Hispanic heterosexuals and white, black, and Hispanic MSM, funding was distributed equally among these five priority populations. In the few additional cases where a provider was contracted to target a racial/ethnic group, but not a specified risk group, the target population was assumed to be heterosexual.
As TOPWA programs target high-risk and HIV-infected pregnant women, each TOPWA provider’s client data were examined to assess the proportion of women served by HIV status and race/ethnicity. DOH staff estimated that HIV-positive TOPWA clients receive three times the resources received by HIV-negative clients. Thus, the percentage of TOPWA clients served who were HIV-positive was tripled to determine the percentage of funding to be allocated to the HIV-positive category. The remaining TOPWA funding was distributed among the black, Hispanic, and other heterosexual categories proportionate to the percentage of women served in these populations. In the few additional cases where a program targets a risk group, but not a specified racial/ethnic population, funding was distributed equally among the group’s black, white, and Hispanic populations.

A sizeable proportion of the HIV prevention funding in Florida is not targeted to any specific racial/ethnic and risk group (e.g., staff positions, condoms, ECHPP funding for the 2010 planning phase) and could not be allocated by priority population. Thus, such funding was allocated to an “all at-risk populations” category. Funding included in this category may be used to support HIV prevention efforts targeting all at-risk persons, the general public, or local priority populations (which may differ from the statewide priority populations).

Limitations

In using this snapshot to help compare the distribution of Florida’s HIV/AIDS epidemic to the distribution of funding for HIV prevention services among Florida’s priority populations, several important limitations should be noted.

First, a number of assumptions were made to allocate funding to the appropriate priority population categories when such assumptions were deemed reasonable (see methodology section).

Second, the proportion of HIV prevention funding and of PLWHA among each priority population may not be directly compared due to the unequal number of population categories in the analyses and pie charts. HIV-positive persons represent the first priority population and, thus, a category in the analysis of funding by population. However, the analysis of PLWHA by population does not include an HIV-positive category as this population represents the distribution of the epidemic in its totality. The all at-risk population is another category represented in the analysis of funding by population, but not in the analysis of PLWHA by population.

Third, while reported HIV/AIDS cases among living persons (through 2009) were deemed most appropriate to illustrate the distribution of Florida’s HIV/AIDS epidemic, there are several accompanying limitations. These data do not include cases that are undiagnosed or unreported. Therefore, populations with a disproportionately high prevalence of undiagnosed or unreported infections may be underrepresented. Furthermore, in determining the appropriate allocation of HIV prevention funding by population, consideration may also be
given to other data, such as HIV incidence estimates and population size (as priority populations differ in size, differing funding levels may be needed to reach the same proportion of each population).

Findings

Based on the methods described above, Figures 2.5 and 2.6 were produced to compare the distribution of Florida’s HIV/AIDS epidemic to the state’s 2010 HIV prevention funding. Figure 2.5 shows the proportion of adult and adolescent persons living with HIV/AIDS (PLWHA), diagnosed through 2009, by priority population. Figure 2.6 shows the estimated distribution of 2010 HIV prevention funding ($39.2 million) by population. Figure 2.7 shows the distribution of funding targeted to priority populations ($23.8 million).

Figure 2.7. Percentage of Persons Living with HIV/AIDS by Priority Population, Florida, 2009.
Of the $39.2 million in HIV prevention funding in Florida, $23.8 million (60.8%) is used to target the state’s seven priority populations. Figure 4 shows the distribution of funding targeted to the state’s priority populations.
Program Collaborations

A holistic approach must be taken when addressing HIV/AIDS. There are complex behavioral, biological, social, and environmental factors that place persons at risk for acquiring and transmitting HIV. In order to effectively address the complex set of factors associated with HIV, it is essential to develop collaborative partnerships with individuals, organizations, and agencies to plan and coordinate strategies that will reduce new HIV infections. The success of prevention programs is dependent on the coordination, collaboration, and linkages that occur across various programs and stakeholders.

Collaboration requires a commitment from all parties and involves shared responsibilities for planning and implementing programs that increase the efficiency of service delivery, provide opportunities for linkage, and the ability to leverage resources. Program collaboration increases the impact and reach of prevention services. Establishing and maintaining collaborative partnerships is essential to the success of HIV prevention programs. This section details collaborations between the Prevention Section and various internal and external partners.

Internal Collaborations

Linkage-to-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 (Community Linkage Coordinator) was implemented in Broward and Miami-Dade 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.

Sexually Transmitted Diseases Program

The HIV/AIDS and Hepatitis Program and STD program 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 DOH 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 2010, there were 91,000 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 prevention section 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.

In Miami, the TOPWA program offers HIV and pregnancy testing as well as gonorrhea and Chlamydia testing. All TOPWA and 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 Section

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. 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 HIV/HCV co-infection into prevention interventions. Since hepatitis is often linked to injection drug users, the section funds drug treatment centers to implement evidence-based interventions.

Selected Jail Linkage programs have staff supported through prevention funding to conduct hepatitis testing.

**Tuberculosis Program**

HIV testing is 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 HIV and TB programs have integrated quality assurance programs, eliminating the need for both programs to visit the same clinic and look at the same records.

**Family Planning and Women’s Health**

There is a close collaboration between HIV perinatal prevention efforts and family planning services statewide. All women enrolled in TOPWA are offered assistance in obtaining family planning services if they wish to delay a subsequent birth. 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.

DOH 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, MACVIH and AMIGAS.

**External Collaborations**

**CDC Directly funded Community-Based Organizations**

DOH values the collaborative relationships between the HIV/AIDS program, local programs, and CDC directly funded CBOs. One major area of collaboration is in rapid testing. DOH 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, DOH collects and reports HIV testing data on behalf of these organizations. Many of these CBOs implement evidence-based HIV prevention interventions to serve their priority populations. DOH provides them with technical assistance and requests capacity building trainings on their behalf.

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.

DOH staffs participate 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.

State and Local Education Agencies

DOH partners with the Department of Education (DOE) to share information and to collaborate on initiatives. The DOE liaison represents the Department at the bi-annual Department of Education AIDS Advisory Council Meetings. In addition, DOH partnered with DOE to offer its HIV 101: In the News as a web-based curriculum for school nurses and health educators.

DOH has also 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.).

Juvenile and Adult Criminal Justice

Testing and linkage programs are in place at 16 of the largest jails in Florida. In 2010, the Pre-release Planning Program through the Department of Corrections identified 1,002 HIV-infected inmates being released from prison. All of these individuals were provided with 30 days of their medication, a copy of recent laboratory results and an appointment with the medical provider of their choice. The Community Linkage Coordinator in Broward and Miami-Dade counties provides 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. In 2010, jail linkage programs around the state tested 34,824 jail inmates for HIV and provided
8,089 linkages for HIV-infected inmates to various social services upon their return to the community.

DOH has 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.

**Substance Abuse Prevention & Treatment Programs**

The correlation of HIV infection with substance use disorders is high. A variety of factors influence the increased risk of HIV infection and the transmission of the virus when coupled with substance use disorders. 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. 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. In addition, the jail linkage and pre-release planning programs coordinate with substance abuse treatment centers to provide education, treatment, and prevention to recently released ex-offenders.

Conventional and rapid HIV testing continue 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 2010, over 12,000 HIV tests were conducted in substance abuse treatment centers.
Section IV: Gap Analysis

Unmet HIV prevention needs are based on the analysis of the funding snapshot, Provider Needs Assessment Survey, the Ryan White Needs Assessment Survey and key informant interviews with leaders across the state. The following assesses unmet needs around the state and provides PPG recommendations for addressing unmet needs. The unmet needs were divided into four primary categories: 1) distribution of funding; 2) training and continuing education opportunities; and 3) changing priority populations to address those not currently served; 4) barriers to providing care and retaining PLWHA in care.

Distribution of Funding

- Funding targeted to MSM, regardless of race/ethnicity, should be proportionate to the incidence of HIV among this population.

- The funding snapshot states that activities are targeted by racial/ethnic group rather than by risk group. However, a large portion of funding is not specifically allocated and goes to “all at-risk populations”. Several opportunities are available to help address unmet needs for populations that are currently underfunded. A large portion of funding should NOT be targeted toward “all at-risk” but more should be targeted toward specific populations, with the following recommendations:
  - Funding should be targeted based on risk behavior rather than by racial/ethnic group.
  - Funding should address epidemiologically at-risk communities (e.g., transgender, MSM youth, etc).
  - Funding should be allocated to agencies with a proven track record of service delivery to target populations for which funds are applied.

- There should be adequate funding levels for prevention services, such as outreach, media campaigns, community mobilization, condom distribution, social networking programs, and HIV/AIDS support groups.

Training and Continuing Education Opportunities

Training opportunities across the state have continuously increased and have been offered to more trainees more than ever before. However, because of mandated travel restrictions and funding gaps there are barriers to adequately train staff to provide services. There is a need for nontraditional training opportunities.
• Training opportunities for cultural competency for providers and medical professionals should be enhanced and offered on a broader basis.
• Agency sustainability should be prioritized.
• Changing preventing strategies and technologies should be offered.

Priority Populations

• Increase programs and services for black MSM because there are gaps in the provision of services based on geography and/or lack of targeted interventions.
• There is a lack of funding and services for white MSM. Eight areas have white MSM listed as their top priority population, but only 4.5% of 2010 targeted funding supported this population. Services and funding for white MSM should be increased.
• There is not a huge focus on youth nor is there specific funding for youth in the state. Youth should be included as a special population. Although school-based restrictions on HIV/AIDS education are barriers for HIV prevention services and education, efforts should be made to target this population.
• Services for injection drug users are not funded based on the priority population’s ranking. State-prohibited needle exchange programs continue to place injection drug users at an increased risk of transmission. Additionally, services for other drug users are not funded because they aren’t listed as a priority population. Special funding should be allocated towards this population.

Barriers Providing HIV Prevention Care and Treatment for Persons Living with HIV/AIDS

Prevalence of homelessness- In some areas of the state, the percentage of homelessness among those living with HIV/AIDS is almost twice the rate observed in the general population. Bringing homeless PLWHA into care and keeping them in care continues to be a challenge, regardless of rural or urban locations. Being adequately housed is a major determinant for a PLWHA being able to adhere to a medical plan of care. Affordable housing is essential to stabilize those clients who are the poorest and the most fragile.

Uninsured persons- According to data submitted through CAREWare, in 2011 at least 46% of PLWHA accessing Ryan White Part B services are uninsured. This is an increase from 18% in 2010. It should be noted that 44% of CAREWare clients identified did not report insurance status. Additionally, the 2010 number may actually be higher as full implementation of CAREWare for eligibility was not achieved until 2011. As documented in multiple studies nationwide, the uninsured typically do not seek preventive or maintenance medical care because of cost and often delay needed care. These delays adversely influence outcomes and
increase the complexity and cost of care to be delivered. A lack of health insurance can exacerbate many treatable illnesses including HIV disease.

**Persons living at or below 300% Poverty**- The poor have difficulty accessing needed health services, whether they are uninsured or underinsured. Hardships such as paying co-pays as well as maintaining safe housing and purchasing healthy foods are all barriers that prevent the poor from staying in care and adhering to a medical regimen. Ryan White Part B CAREWare utilization data for 2010 indicates that 84% of Ryan White Part B clients are living at or below 300% of FPL. The number of clients living at or below 300% of FPL is expected to increase based on the current economic condition.

**Substance abuse**- Substance abuse, which includes binge drinking and illicit drug use, is also more prevalent among PLWHA than it is among the general population. Data indicate that a significant percentage of PLWHA have reported a history of substance abuse. Active substance abusers are more likely to engage in risky behaviors that can have a negative effect on overall health. The interaction of illegal substances and HIV medications can diminish an individual’s ability to adhere to proper HIV treatment. The relationship between injection drug use (IDU) and HIV/AIDS transmission is well known. IDU is the second most common exposure category for female PLWHA and third most common for male PLWHA in the state.

**Mental health**- According to the American Psychiatric Association, people with HIV are more likely to experience a range of mental health issues, which can often accompany adverse life-events. Additionally, mental health problems usually predate substance use activity, which can interfere with HIV/AIDS treatment adherence. Limited or lack of mental health providers in general, and specifically providers with knowledge of HIV/AIDS, causes additional barriers for clients needing this vital service.
Chapter 4: Interventions and Strategies
Under CDC’s funding announcement for HIV prevention programs for health departments, PS-1201, DOH is required to implement four required program components that include: 1) HIV Testing; 2) Comprehensive Prevention with Positives; 3) Condom Distribution; and 4) Policy Initiatives. In addition to implementing required program components, DOH implements the following two recommended program components under PS-12-1201: 1) HIV Prevention Interventions and 2) Social Marketing, Media, and Mobilization. Over the five-year funding period, DOH will implement prevention activities that support core and recommended program components. This chapter provides an overview of Florida’s approach to implementing prevention programs under PS-12-1201.

The chapter is divided into three sections. Section I outlines the role of high-impact prevention in Florida’s prevention programs. Section II details prevention interventions and strategies currently being implemented in Florida. Lastly, Section III details five-year goals and objectives for Florida’s funded prevention program.
Section I: Florida’s Approach to HIV Prevention

In 2010, the White House released the National HIV/AIDS Strategy (NHAS). This comprehensive strategy provides a roadmap for addressing HIV/AIDS in the United States. The strategy outlines specific goals and measurable targets to be achieved by 2015. The strategy is intended to refocus existing HIV/AIDS prevention, care, and treatment efforts and deliver better results. The strategy outlines three goals: 1) Reducing new HIV infections; 2) Increasing access to care and improving health outcomes for people living with HIV/AIDS; and 3) Reducing HIV-related health disparities. The NHAS provides a framework for implementing HIV prevention activities that will achieve the goals outlined in the strategy.

To advance the prevention goals of the NHAS and to maximize the effectiveness and reach of current HIV prevention efforts, CDC has pursed a High-Impact Prevention approach to address HIV (http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf). The premise of high-impact prevention is that by using combinations of scientifically proven, cost-effective, and scalable interventions targeted to priority populations in targeted areas, HIV prevention will be more impactful and will be more effective at reducing new HIV infections. Five factors guide the high-impact prevention approach:

Effectiveness and cost—While all proven interventions may have a place in HIV prevention programs, High-Impact Prevention prioritizes those that are most cost-effective at reducing overall HIV infections. Available cost-effectiveness data strongly supports interventions such as HIV testing and condom distribution, as well as many others. Programs to help people living with HIV avoid transmitting HIV to others are also cost-effective, since this group can be more efficiently served than the much larger population of people at risk for becoming infected.

Feasibility of full-scale implementation—To make a substantial difference in new infections, priority should be placed on interventions that are practical to implement on a large scale, at reasonable cost. More time- and resource-intensive interventions, such as one-on-one or group counseling, should be reserved for people at the very highest risk of transmitting or becoming infected with HIV.

Coverage in the target populations—Prevention planners should select interventions based in part on how many people can be reached once the intervention is fully implemented. For example, CDC recommends routine, opt-out HIV testing in health care settings for people regardless of risk, as research has shown that this approach can identify many people with undiagnosed HIV infection. Additionally, CDC supports targeted HIV testing in non-health care settings among people at higher risk, as this is a cost-effective tool for helping those individuals learn their HIV status.

Interaction and targeting—It is also important to consider how different interventions interact, and how they can most effectively be combined to reach the most-affected populations in a
given area. For example, expanding HIV testing can amplify the impact of efforts to increase adherence to treatment, particularly in areas where large numbers of people remain undiagnosed.

**Prioritization**-To put the above considerations into practice, prevention planners need to rigorously assess the potential impact on HIV infections of combining different interventions for specific populations. This will allow for prioritizing the interventions that will have the greatest overall potential to reduce infections.

Florida has adopted a high-impact prevention approach that:

- Focuses HIV prevention efforts in communities and areas where HIV is most heavily concentrated to achieve the greatest impact in decreasing the risks of acquiring HIV.
- Increases HIV testing.
- Increases access to care and improve health outcomes for people living with HIV by linking them to continuous and coordinated quality care and needed medical, prevention, and social services.
- Increases awareness and educates communities about the threat of HIV and how to prevent it.
- Expands targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.
- Reduces HIV-related disparities and promotes health equity.

Targeted prevention efforts are needed to address persons at greatest risk for transmitting or acquiring HIV infection. In alignment with the NHAS and high-impact prevention, prevention efforts should be intensified in communities where HIV is most heavily concentrated. Efforts should be taken to ensure that prevention efforts are intensified and targeted to communities with higher rates of HIV infection and populations who have the greatest risk for transmitting or acquiring HIV. Priority should be given to HIV-positive persons. Intensified efforts should be made to ensure all persons living with HIV know their HIV status and are linked to and remain in care. In addition, HIV-positive persons should receive interventions that reduce their risk for transmitting the disease. Uninfected persons whose behaviors, relationships, or social determinants place them at risk for HIV infections should be tested a minimum of twice a year and receive interventions that reduce their risk for acquiring HIV. At a minimum, all persons in Florida should have access to accurate information about HIV transmission and prevention, access to HIV testing and counseling, and access to safer sex tools.
Section II: Interventions and Strategies

CDC has identified the following proven strategies, that when tailored to address social, community, financial, and structural factors that place persons at risk, can reduce the risk of HIV infection: 1) HIV testing and linkage to care; 2) antiretroviral therapy; 3) access to condoms and sterile syringes; 4) prevention programs for people living with HIV and their partners; 5) prevention programs for people at high risk for HIV infection; 6) substance abuse treatment; and 7) screening and treatment for other sexually transmitted infections. Based on the high-impact prevention approach and identified proven HIV prevention interventions, DOH has identified a core set of required and recommended interventions and strategies that are impactful, sustainable, and have successful outcomes for reducing new HIV infections in Florida. Funded HIV prevention programs, regardless of funding source, should implement high-impact prevention programs that include all of the following core program components: 1) HIV counseling and testing; 2) comprehensive prevention with positives programs; 3) condom distribution; and 4) outreach. Programs may also include the following components as recommended program activities to support core program activities: 1) evidence-based interventions for high-risk negatives; and 2) social marketing and community mobilization.

This section provides a description of each intervention or strategy type and an overview of current programs and activities that fall under each type. In planning for prevention activities, a mix of interventions and strategies should be considered for implementation. The information that is provided offers several examples of existing tools and programs that can address the specific needs of various priority populations. However, one should not be discouraged from implementing locally developed evidence-based interventions and strategies. These interventions include a mix of approaches that have the ability to reduce new infections, increase access to care and treatment, and increase health equity; are feasible and sustainable; and scalable and cost efficient. They should be tailored so that they are culturally appropriate for the persons and communities they target. In addition, interventions should be scaled up or down based on what is appropriate for the target population and community.

Core Program Components

HIV Counseling and Testing

Approximately 130,000 Floridians are living with HIV and up to 20% of them don’t know it. HIV testing is a collection of activities designed to increase clients’ knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate medical, prevention, and partner services. HIV testing can be anonymous (client’s name is neither known nor solicited) or confidential (client provides name), and is offered in healthcare and non-healthcare settings.
HIV Testing in Non-Healthcare Settings- HIV counseling and testing programs in non-healthcare settings should identify undiagnosed HIV infection using multiple strategies and the most current recommendations for HIV counseling and testing. HIV testing should take place at venues most likely to reach individuals with undiagnosed infections and be targeted towards populations at highest risk for HIV infections (e.g., MSM, transgender persons, and IDUs, regardless of race or ethnicity; and groups such as black and Hispanic men and women at risk, if this is supported by available data and analysis of service gaps).

HIV Testing in Healthcare Settings- HIV testing in clinical settings provides for routine testing in public and private healthcare settings. Based on CDC’s 2006 Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, the objectives of HIV testing in clinical settings are to increase HIV screening of patients, including pregnant women, in healthcare settings; foster earlier detection of HIV infection; identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and further reduce perinatal transmission of HIV. Healthcare settings include, but are not limited to the following: emergency departments (EDs), urgent care clinics (UCCs), inpatient settings, primary care facilities, community health centers (CHCs), health maintenance organizations (HMOs), family planning and reproductive health clinics, college and university student health clinics, pharmacy-based clinics (i.e., clinics located in pharmacy facilities), retail clinics (i.e., clinics located in retail store facilities), STD clinics, TB clinics, other public health clinics, dental clinics, correctional facility clinics, and substance abuse treatment clinics.

Social Networks Strategy- The Social Networks Strategy (SNS) is implemented as a strategy for reaching and providing HIV counseling and testing to persons with undiagnosed HIV infection. Enlisting HIV-positive or high-risk HIV-negative persons (i.e., recruiters) to encourage people in their network (i.e., network associates) to be tested for HIV may prove an efficient and effective route to accessing individuals who are infected or at very high risk for becoming infected with HIV and linking them to services.

Comprehensive Prevention with Positives

There are approximately 130,000 people infected with HIV in Florida. It is estimated that 53,000 of them are aware of their infection and not receiving adequate care and treatment. A primary goal of the prevention for positives effort is to identify these persons and link them back to medical care. Comprehensive prevention for positives includes linkages to care and treatment, and interventions to improve retention in care and treatment for individuals previously diagnosed with HIV/AIDS; behavioral interventions and other risk-reduction services for HIV-infected individuals and their sexual or needle-sharing partners; interventions to prevent mother-to-child transmission; and referrals to other social services.

Targeted Outreach for Pregnant Women- The Targeted Outreach for Pregnant Women Act (TOPWA) began in 1999. The mission of TOPWA is to decrease the number of women and
babies who contract HIV. HIV-positive, pregnant women enrolled in the TOPWA program receive encouragement to take medications to prevent transmission of the virus to their baby. In addition, they receive assistance with applying for Medicaid, getting prenatal care, and HIV prevention education, condoms, and referrals for family planning services.

**MAI-ARTAS**-Through funding under MAI, Florida has used the Antiretroviral Treatment and Access to Services (ARTAS) intervention as its model for linking newly-diagnosed persons to care. The overarching goal of the MAI-ARTAS program is to identify HIV-infected minorities not accessing medical care and treatment and link them to services. The MAI-ARTAS program coordinates with county health departments, STD clinics, jails, homeless shelters, mental health and substance abuse clinics, and hospitals to receive referrals for individuals recently diagnosed with HIV. There is also coordination between MAI-ARTAS and Ryan White Part C to ensure clients who have fallen out of care are referred to the program. MAI-funded providers coordinate with Ryan White case managers to ensure the client is transferred to a traditional case manager after the client has completed the MAI-ARTAS program, if needed. The MAI-ARTAS program works with many local, state, and federally funded agencies and programs to strengthen the support infrastructure for clients. By working with a variety of partners, MAI-ARTAS ensures an optimal level of care for clients.

**Jail Linkage Program**-Multiple jail linkage projects around the state provide HIV/STD Testing and linkages to inmates in 17 county jails. Persons who test positive for HIV are linked to available medical and support services in their communities upon release. Jails collaborate with community-based organizations in their counties to ensure a link to necessary services for released inmates.

**Peer Programs**-The MAI-TCE program facilitates the development, integration, and expansion of culturally competent and effective behavioral health, substance abuse, and mental health services within racial/ethnic minority communities most impacted by HIV/AIDS. This includes integrating these services with HIV services and medical treatment within a primary care network. The expected outcomes for the program include reducing the impact of behavioral health problems, HIV risk and incidence, and HIV-related health disparities in these communities. The program ensures that individuals who have a mental and/or substance use disorder, and who are most at risk for or are living with HIV/AIDS, have access to and receive appropriate behavioral health services and HIV/AIDS medical treatment. Through increased integration - behavioral health issues and problems will be identified early; individuals will be assessed; and as appropriate, referred to treatment and services.

The Prevention section funds peer programs in the following four counties: Alachua, Duval, Orange, and Palm Beach. The Peer Programs operate within the county health department to work in close association with Ryan White eligibility, ADAP, and case management. The goal of these programs is to improve client outcomes by helping engage and retain persons living with HIV/AIDS (PLWHA) in care and treatment (linkage, adherence, retention). The peer navigator serves as a role model who provides reliable information, steers clients in the proper direction to meet their care needs, and helps them overcome barriers to remaining in care. Peers provide...
HIV-infected clients with guidance and advocacy beyond that which can be provided by case managers and clinicians, through experienced guidance and plain language messages.

Behavioral Prevention Interventions for HIV-Infected Persons

The purpose of behavioral prevention interventions for those living with HIV/AIDS is to address risk behaviors of HIV-infected individuals and their sex or needle-sharing partners, to decrease the likelihood of HIV transmission to uninfected individuals. These interventions also address increasing safer sex behaviors, improving retention in care and treatment, improving medication adherence, and increasing self-efficacy for disclosure of HIV-positive status and condom negotiation. Interventions in this category can be broken up by individual-level (ILI), group-level (GLI), and community-level interventions (CLI). Some examples of ILIs include Partnership for Health and CLEAR (Choosing Life! Empowerment, Action, Results). Examples of GLIs include Healthy Relationships and WILLOW (Women Involved in Life Learning from Other Women). One example of a CLI that could be used with HIV-infected individuals would be an adapted version of Popular Opinion Leader (POL) to address social norms and behaviors among networks of HIV-infected individuals in a given area.

Condom Distribution

Condom distribution (CD) functions as a structural-level intervention by increasing the availability, accessibility, and acceptability of condoms, which leads to increased condom use and potentially, a reduction in HIV/STD acquisition and transmission. Programs should consider integrating CD programs with other HIV prevention strategies and healthcare services as part of a more comprehensive HIV prevention approach.

Outreach

Outreach is defined as an HIV prevention intervention designed to meet potential clients in their own communities and in settings where they live, work, and socialize in order to link them to prevention, testing, and treatment services. One of the primary goals of outreach is to proactively initiate contact with HIV-infected and high-risk populations that are in need of HIV prevention interventions or treatment in order to provide them with health information and increase their awareness of the availability of HIV services within their respective communities.

Active Street Outreach- Active street outreach is usually conducted within a specified area, taking place within a few blocks or in a certain neighborhood or community.

Fixed-Site or Venue-based Outreach- Fixed-site or venue-based outreach activities usually involve setting up a table on a street in front of a frequented corner store, in a well-known bar or hangout, or even working out of a mobile HIV testing unit or storefront. This type of
outreach usually requires one staff person to remain at the fixed site and the other to participate in more of an active street outreach capacity.

**Drop-Off Site Outreach**-Drop-off site outreach usually involves leaving condoms and educational materials with the volunteer distributor. Many outreach workers leave condoms and educational materials with store owners that are partners in HIV prevention; some examples include, barber shops, beauty salons, student organizations on college campuses, corner markets, bookstores, tattoo/piercing parlors, churches, youth recreation centers, gyms, and after-school programs.

**Internet/Phone Outreach**- Internet outreach is defined in the NCSD’s *National Guidelines for Internet Outreach* as, “A virtual interaction between an STD/HIV prevention professional, such as an outreach worker, and a person or persons at risk for STDs or HIV, for the purposes of providing STD/HIV related: health information and education, referrals and access to services, recruitment for testing and treatment, and support for reducing risk behaviors.” Potential venues for Internet outreach include but are not limited to: social networking sites, which include both dating and niche web sites; chat rooms, instant messaging, e-mail, bulletin/message boards and forums; and lastly, via text messaging.

**Recommended Program Components**

**Behavioral Prevention Interventions for High-Risk Negatives**

The purpose of behavioral prevention interventions for high-risk negatives is to reduce risk behaviors that increase the likelihood that someone will become infected with HIV. High-risk behaviors include having unprotected sex and sharing needles used to inject drugs of any kind. These interventions address safer sex skills (condom negotiation, regular use of condoms), social norms and perceptions, behavioral influencing factors, sexual relationship dynamics, the importance of getting tested regularly for HIV, and the acquisition of protective skills. Interventions in this category can be broken up by individual-level (ILI), group-level (GLI), and community-level interventions (CLI). One example of an ILI for high-risk negatives is RESPECT. Some examples of GLIs include VOICES/VOCES and Many Men, Many Voices (3MV). Examples of CLIs include Community PROMISE, Mpowerment, and Real AIDS Prevention Project (RAPP).

**Social Marketing, Media, and Community Mobilization**

Social marketing and community mobilization activities are used to create environments that support high-impact prevention by actively involving community members in efforts to raise HIV awareness, build support for and involvement in HIV prevention efforts, motivate individuals to work to end HIV stigma, and encourage HIV risk reduction where people live, work, play, and worship.

**Sistas Organizing to Survive**-Sistas Organizing to Survive (SOS) is designed to encourage black women to become educated about HIV/AIDS and to be tested. The SOS model was created to
encourage communities to expand and strengthen their response to the HIV/AIDS epidemic among black women; encourage individuals to be tested for HIV; increase access to HIV prevention and care services: reduce barriers to HIV testing, prevention, and care by reducing HIV/AIDS stigma; and stimulate the development of a plan to address the disproportionate impact that HIV/AIDS is having on black women.

L.U.C.E.S-L.U.C.E.S. (Latinas Unidas Contra El SIDA or Latinas United Against AIDS) is designed to address HIV/AIDS among Hispanic/Latina women and to encourage Latina women to get tested. The goals of the initiative are to: raise awareness about the magnitude of HIV/AIDS among Latina women in Florida; offer tools to enable Latina women to educate others about HIV/AIDS and HIV prevention where they live, work, play, learn, and worship; connect Latina women to HIV/AIDS resources; increase the capacity of Latina women to build effective responses to the HIV/AIDS epidemic in local communities; and strengthen Latina women’s ability to take charge and control of their sexual health.

Man-up-The Man-Up Initiative is designed to stimulate the development and implementation of community action plans aimed at preventing the further spread of HIV/AIDS among Florida’s men and their partners. The goals of the initiative are to: encourage men to “man up” and take responsibility for the consequences of their sexual actions and other HIV risk behaviors; create an enabling environment to support awareness of men’s health issues; engage in a dialogue about men’s health, including awareness of HIV and other STDs and the need for testing; create a coalition of providers to address the health needs of men, including health disparities and access to care; engage in a public awareness campaign addressing men’s health issues to promote holistic health strategies; and expand and strengthen responses to the HIV/AIDS epidemic among males.

The Shawl Circle-The Shawl Circle is a collaborative effort between the HIV/AIDS and Hepatitis Program and the Department’s Breast and Cervical Cancer program. The project is designed to be culturally appropriate to the American Indian women, while empowering them to become advocates for their communities. The project has an educational component and a testing component for HIV.

Faith Initiative-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. Currently, the initiative consists of four components: general HIV/AIDS awareness for churches; AME Church Testing Initiative; The National Church Week of Prayer; and The Southern Christian Leadership Ambassador Project.

Business Responds to AIDS: STOP AIDS: It’s Everyone’s Business-BRTA/LRTA programs help businesses and labor organizations respond to AIDS in the workplace and the community. These programs are based on building partnerships among businesses, labor unions, health departments, community-based organizations, and government agencies to promote the development of comprehensive HIV/AIDS programs. The BRTA/LRTA program is comprised of
five components: workplace policy development, supervisor/labor leader training, employee education, family education, and community involvement. STOP AIDS: It's Everyone's Business incorporates all five components to engage businesses across the state to join in the fight to STOP the spread of HIV/AIDS. It is a recognized fact that community business leaders and businesses have tremendous influence within their communities. BRITA/LRTA allows health departments to utilize these relationships in their HIV prevention efforts.

Finding Our Voices: Mobilizing Black Gay Men: This DVD is a community mobilization initiative to stop the spread of HIV and AIDS among black gay men. The purpose of 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, HIV/AIDS and Hepatitis Program 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 Campaign – The “Bodies” campaign was developed to address condom use, sexual risk taking behaviors, stigma, and HIV testing among WMSM. The department sought feedback from the Florida Gay Men's Workgroup on campaign concepts and materials. In addition, the campaign was focus group tested by a group of WMSM to identify messages, social marketing materials and venues that were culturally appropriate for the population. The marketing strategy of the campaign utilizes print media, banner advertisements on high-traffic gay websites, Google Ad Network marketing, search engine marketing, and Facebook ad marketing. Internet-based advertisements and marketing is geo-targeted to Florida.

The “Love Campaign”- The Black MSM Consultation Group worked with the Florida Department of Health, HIV/AIDS and Hepatitis Program to create a social marketing campaign entitled “The Love Campaign.” The group wanted the department to create a campaign that shows black gay men in loving and responsible relationships. The posters and palm cards were distributed statewide.

Silence is Death Mobilization Report- Silence is Death 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 PLWHA data for the top 20 counties are presented in rank order so that the experience of each county can be put in perspective with the others, facilitating the targeting and prioritization of efforts to close the gaps. 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; encouraging local governments and communities to expand and strengthen their responses to the HIV/AIDS epidemic among blacks; encouraging individuals to be tested for HIV/AIDS; increasing access to HIV prevention and care services; reducing barriers to HIV testing, prevention and care by reducing HIV/AIDS stigma; and stimulating the development of a plan to address the disproportionate impact that HIV/AIDS is having on black communities.
Out in The Open: The Continuing Crisis of HIV/AIDS Among Florida’s Men Who Have Sex With Men Mobilization Report—Out in the Open addresses the HIV/AIDS epidemic among men who have sex with men (MSM) in Florida. Throughout the epidemic, HIV/AIDS has been a crisis for communities of MSM. From the mid 1980’s into the early 1990’s, a large number of MSM diligently adopted risk reduction measures in the face of an incurable and unmanageable disease. The current intensity of the epidemic among MSM, coupled with increased HIV/AIDS complacency and sexual risk behavior, calls for renewed emphasis on prevention efforts. The goal of the report is to stimulate the development and implementation of community action plans to prevent the further spread of HIV/AIDS among MSM in Florida.

Organizing to Survive: The HIV/AIDS Crisis Among Florida’s Women Mobilization Report—Organizing to Survive provides an analysis of Florida’s HIV/AIDS data among women by race/ethnicity. The goal of the report is to stimulate the development and implementation of community action plans to prevent the further spread of HIV/AIDS among women living in Florida.
Section III: Goals and Objectives

DOH has established goals and objectives for each required and recommended program component. The goals and objectives establish targets and performance measures for HIV program activities over the five-year project period. The goals that are included are broad aims that define the intended results of prevention activities. SMART (specific, measureable, achievable, realistic, and time-based) objectives are included to measure the overall accomplishments of the program goals over the five-year project period. Two types of objectives are included:

**Outcome objectives:** The overall intended effects of the intervention, specifying its purpose and mission.

**Process objectives:** Process objectives describe the specific intervention activities (activities that will be conducted to meet the goal/objectives), the projected level of effort needed to carry them out, the people responsible for carrying them out, and when they will be completed.

The following tables outline goals, outcome objectives and process objectives for prevention activities funded under PS-12-1201.
## HIV Testing

<table>
<thead>
<tr>
<th>Goal(s):</th>
<th>Through voluntary counseling and testing, increase the proportion of people who know their HIV status.</th>
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</thead>
<tbody>
<tr>
<td>Outcome Objective(s):</td>
<td>Increase the proportion of people who know their HIV status by 25% by 2016.</td>
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<tr>
<td><strong>Process Objective 1:</strong></td>
<td>By the end of the project period, increase the number of community health centers that offer routine HIV testing to their clients by 30%.</td>
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<tr>
<td><strong>Process Objective 2:</strong></td>
<td>Throughout the project period, ensure that at least 90% of statewide social marketing materials developed contain an HIV testing message.</td>
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<tr>
<td><strong>Process Objective 3:</strong></td>
<td>By December 31, 2012, modify administrative rules, policies, and procedures to streamline HIV testing wherever possible.</td>
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<td><strong>Process Objective 4:</strong></td>
<td>By the end of the project period, increase the number of registered HIV test sites by 30% to ensure that testing is readily available.</td>
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<tr>
<td><strong>Process Objective 5:</strong></td>
<td>By the end of the project period, increase the number of faith-based HIV test sites by 20%.</td>
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<tr>
<td><strong>Process Objective 6:</strong></td>
<td>Throughout the project period, maintain the 16 funded HIV testing programs in jails throughout the state.</td>
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<tr>
<td><strong>Process Objective 7:</strong></td>
<td>Throughout the project period, ensure that at least 95% of HIV testing counselors are certified and have completed their annual update certification. Prevention staffs will conduct a face-to-face or web-based meeting to certify all Early Intervention Consultants, as required, so that they can provide this annual update certification for their local areas.</td>
</tr>
<tr>
<td><strong>Process Objective 8:</strong></td>
<td>Throughout the project period, ensure that at least 80% of newly diagnosed persons are linked to medical care and attend their first appointment.</td>
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<tr>
<td><strong>Process Objective 9:</strong></td>
<td>Throughout the project period, ensure that at least 90% of newly diagnosed persons are linked to partner services.</td>
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<tr>
<td><strong>Process Objective 10:</strong></td>
<td>Throughout the project period, evaluate all new testing technologies for possible inclusion in Florida’s testing program as they become available.</td>
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<tr>
<td><strong>Process Objective 11:</strong></td>
<td>Throughout the project period, evaluate HIV testing programs to see if hepatitis and STD testing services can be further integrated into those programs.</td>
</tr>
<tr>
<td><strong>Process Objective 12:</strong></td>
<td>Throughout the project period, ensure that 95% of newly identified positive test results are returned to clients.</td>
</tr>
</tbody>
</table>
## Goal(s):
Increase the proportion of HIV-positive individuals receiving prevention with positives services (e.g., linkage to/retention/re-engagement in care, treatment adherence, partner services, integrated screening, health education/risk reduction interventions) by 2016.

## Outcome Objective(s):
1. Increase the proportion of newly identified HIV-infected persons and infected persons who have fallen out of care that are receiving available care and treatment by 10% by 2016.
2. Increase the proportion of HIV-infected individuals who receive comprehensive prevention services and treatment adherence education by 10% by 2016.

### Process Objective 1.1:  
Annually, provide education on disease transmission and medical adherence to 1,100 HIV-infected persons enrolled in ARTAS.

### Process Objective 1.2:  
Annually, link 1,100 HIV-infected individuals enrolled in ARTAS to medical care and treatment.

### Process Objective 1.3:  
Establish four Peer Navigation Programs to assist newly identified HIV-infected persons in obtaining medical care and treatment by December 31, 2014.

### Process Objective 1.4:  
Offer pre-release planning services to 90% of known HIV-infected inmates in all Department of Corrections (DOC) facilities annually.

### Process Objective 1.5:  
Annually, link 2,800 pregnant women enrolled in TOPWA to prenatal care, including HIV treatment for HIV-infected pregnant women.

### Process Objective 1.6:  
Annually, have a transmission rate of HIV-infected newborns of less than 1%.

### Process Objective 1.7:  
Annually, refer at least 75% of HIV-infected inmates to medical care upon release from the 16 funded jail linkage programs.

### Process Objective 2.1:  
Annually, ensure all funded prevention providers conduct behavioral risk screening for enrolled HIV-infected clients.

### Process Objective 2.2:  
Expand implementation of clinic-based interventions, such as Partnership for Health and/or Interdiction Project to one additional county annually.

### Process Objective 2.3:  
By January 2013, provide two new funding mechanisms to support comprehensive prevention with positives in community-based organizations.

### Process Objective 2.4:  
Annually provide 100% of the health departments and funded community-based organizations with educational materials related to HIV prevention and treatment adherence for HIV-positive persons.

### Process Objective 2.5:  
Maintain at least one prevention representative on the Patient Care Consumer Advisory Group for prevention with positives interventions and activities.

### Process Objective 2.6:  
Annually, at least 90% of HIV-positive persons enrolled in peer navigation programs will receive treatment adherence education.
Condom Distribution

**Goal (s):**
Increase statewide condom distribution to target HIV-positive persons and persons at highest risk of acquiring HIV infection.

**Outcome Objective(s):**
Ensure condom distribution to healthcare and non-healthcare facilities likely to reach HIV-infected and persons at high risk of acquiring HIV infection.

**Process Objective 1:** Conduct ongoing statewide condom distribution evaluation to identify additional settings that serve high-risk populations and target areas with high HIV prevalence in need of increased condom distribution.

**Process Objective 2:** Annually, increase the number and variety of condom distribution sites through recruitment efforts with local businesses, community-based organizations, faith-based organizations, healthcare facilities, colleges/universities, and other community partners.

**Process Objective 3:** In years two and three, develop and disseminate a statewide condom distribution strategy to include population-specific prevention messages for HIV-positive persons and persons at highest risk for acquiring HIV.

**Process Objective 4:** Annually, increase the quantity of male condoms distributed statewide by 5%.

**Process Objective 5:** Annually, increase the quantity of female condoms distributed statewide by 5%.

Policy Initiatives

**Goal (s):**
Develop an HIV prevention policy initiative with efforts to align structures, policies and regulations to promote optimal HIV prevention, care and treatment during the five-year funding period.

**Outcome Objective(s):**
Annually, identify one policy to review and, over subsequent years, develop a process to plan, revise, and evaluate those policies, to better align with High-Impact Prevention and NHAS.

**Process Objective 1:** In Years One and Two, evaluate policies related to routine HIV testing in healthcare settings.

**Process Objective 2:** In Years Two through Five, identify one policy to review annually.

**Process Objective 3:** Annually, implement recommendations from evaluations conducted on policies identified throughout the funding period.
## HIV Prevention Interventions for High-Risk Negatives

**Goal (s):**
Increase the number of risk negative persons who are enrolled in HIV prevention interventions.

**Outcome Objective(s):**
Shift prevention intervention programming for high-risk negatives to better align with High-Impact Prevention.

**Process Objective 1:** Ensure county health department staff’s annual service delivery plan aligns with High-Impact Prevention.

**Process Objective 2:** Increase the number of prevention interventions and activities implemented statewide for gay, bisexual, transgender and other men who have sex with men, with an emphasis on young transgender individuals and MSM of color by 20%.

**Process Objective 3:** Annually, evaluate whether funded prevention interventions for high-risk negatives are aligned with HIP and appropriately targeted in ways consistent with local epidemics.

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## Social Marketing, Media, and Mobilization

**Goal (s):**
1. Increase the reach and scope of social marketing and media campaigns to ensure that they result in communities receiving messages.
2. Mobilize community partners and stakeholders to actively involve them in efforts to raise HIV awareness, build support for and involvement in HIV prevention efforts, motivate individual to work to end HIV stigma, and encourage HIV risk reduction.

**Outcome Objective(s):**
Increase the reach and scope of social marketing and media campaigns by 10% over the five-year period.

**Process Objective 1:** Increase the number of unique visitors to the We Make the Change website by 25%.

**Process Objective 2:** Increase the number of unique visitors to the Stop the Spread website by 25%.

**Process Objective 3:** Increase the number of callers to the Florida HIV/AIDS Hotline by 25%.

**Process Objective 4:** Increase the number of users of HIV/AIDS and Hepatitis Program social media sites by 25%.

**Process Objective 5:** Increase by 10% the number of participants completing community mobilization capacity building trainings.

**Process Objective 6:** Increase the number of county health departments implementing community mobilization initiatives and activities by 20%.
Conclusion
Conclusion

For over 17 years, Florida’s PPG has played an integral role in identifying HIV prevention priorities and needs. Community planning helps to identify the groups at highest risk for HIV infection. Within Florida, fifteen people per day become infected with HIV and in the U.S, a new HIV infection occurs every 9.5 minutes. This compounded with data showing consistently high rates of infection, especially among MSM, black and Hispanic communities make for a daunting task of preventing and treating HIV. Therefore, the role of community planning remains critical to addressing HIV in Florida.

The 2012-2014 State of Florida Jurisdictional HIV Prevention Plan was produced by the PPG to provide guidance for HIV prevention activities in Florida. Each section is written to stand alone or as an integral part of the whole. The plan is written for federal, state, and local utilization. It can also be used as a quality improvement tool allowing one area to compare itself to another, study community efforts in some other area to implement in their area, and/or as a resource for local grant writing efforts. The goal of writing this plan is to provide state and local resources for grant writing purposes, involve community members in local AIDS efforts, and to inform interested parties such as planners, media, and local and state legislative bodies of local and statewide HIV prevention efforts and direction.
2012-2014
Florida Jurisdictional HIV Prevention Plan
Florida HIV/AIDS Prevention Planning Group (PPG)