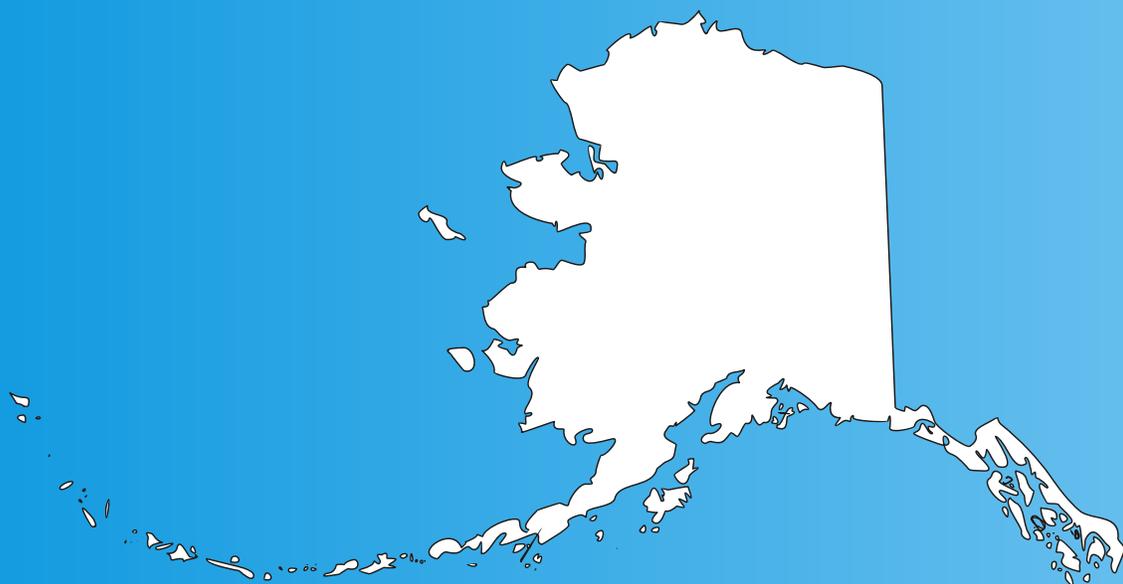


The 2001 - 2003 Alaska HIV Prevention Plan



Alaska HIV Prevention Planning Group
and
State of Alaska HIV/STD Program
Section of Epidemiology
Division of Public Health
Dept. of Health & Social Services

Acknowledgements

The 2001 - 2003 Alaska HIV Prevention Plan reflects the contributions of many individuals involved in the on-going community planning process. A draft copy was widely distributed for comment in October, 2000 to a number of state agencies, public libraries, and community based organizations to encourage input. In addition, the draft was posted on the Section of Epidemiology website.

The following individuals and agencies submitted comments on the *Draft 2001-2003 Alaska HIV Prevention Plan* in time to be considered by the HIV Prevention Planning Group before they finalized this document and we would like to thank them for taking the time to do so:

- Robert Buttane, Administrative Juvenile Probation Officer, Division of Juvenile Justice
- Robert Miller, University of Alaska Fairbanks, Director of Public Affairs for the University of Alaska
- Cathy Feaster, Municipality of Anchorage, MOA/DHHS/CHS/ Reproductive Health Clinic Program Manager

The HIV Prevention Planning Group reviewed all public comments received on the *Draft 2001-2003 Alaska HIV Prevention Plan* at its November, 2000 meeting. After consideration, and with some modifications to reflect the comments received, the Planning Group adopted *The 2001-2003 Alaska HIV Prevention Plan* as a working document. Strategies for HIV prevention activities and priorities will be reviewed annually. Comments on the HIV Prevention Plan are welcomed at any time.

The 2001-2003 Alaska HIV Prevention Plan has been developed by the Alaska HIV Prevention Planning Group with support from the State of Alaska HIV/STD Program and funding from the federal Centers for Disease Control and Prevention. If you would like additional information please call the HIV/STD Program (907) 269-8000 or visit the website at <http://www.epi.hss.state.ak.us/programs/aids&std/hppg/default.htm>

Table of Contents

Executive Summary	i
List of Acronyms	iii
Section I: Overview of the Community Planning Process	I-1
List of HIV Prevention Planning Group Members	I-2
Section II: Epidemiologic Profile of HIV and AIDS in Alaska	II-1
Sociodemographics of Alaska	II-1
HIV and AIDS in Alaska - Overview (AIDS Case Data)	II-6
Characteristics of Persons with AIDS in Alaska	II-7
Characteristics of Populations at Risk for HIV Infection	II-18
Geographic Distribution of HIV Infection in Alaska	II-39
Conclusions	II-43
Section III: Needs Assessment and Needs Prioritization	III-1
Identification of Priority Populations	III-1
A Theory-Based Approach to Needs Assessment	III-2
Empirical Data on Prevention Needs	III-3
HIV Prevention Resources	III-7
Identifying Met and Unmet Needs	III-8
Prioritizing Unmet Needs	III-9
Section IV: Interventions	IV-1
Characteristics of Effective Interventions	IV-3
Intervention Types	IV-6
Prioritizing Interventions	IV-14
Section V: Recommendations	V-1
Statewide HIV Counseling, Testing, Referral and Partner Notification	V-1
The Strategy for HIV Prevention in Urban Alaska	V-2
The Strategy for HIV Prevention in Rural Alaska	V-3
Prevention Goals and Objectives	V-6
Recommendations for Program Coordination	V-28
Tables	
Table 1 Estimated 1999 Alaska population by race/ethnicity	II-1
Table 2 1999 Population estimates	II-4
Table 3 HIV and AIDS cases reported to the Alaska Division of Public Health	II-6
through December 31, 1999	
Table 4 Alaska AIDS cases and known deaths by year of first AIDS diagnosis through	II-8
December 31, 1999	
Table 5 Alaska AIDS cases in adults/adolescents by race/ethnicity and date of first	II-10
AIDS diagnosis	
Table 6 Comparison of estimated adult/adolescent male population to Alaska AIDS	II-10
cases in adult/adolescent males by race/ethnicity and date of first AIDS diagnosis	

Table of Contents (continued)

Table 7	Comparison of estimated adult/adolescent female population to Alaska AIDS cases in adult/adolescent females by race/ethnicity and date of first AIDS diagnosis	II-11
Table 8	Alaska adult/adolescent AIDS cases by exposure category and date of first AIDS diagnosis	II-13
Table 9	Alaska AIDS cases in adult/adolescent males by exposure category and date of first AIDS diagnosis	II-14
Table 10	Alaska AIDS cases in adult/adolescent females by exposure category and date of first AIDS diagnosis	II-15
Table 11	Alaska resident deaths with an underlying cause of HIV infection by year of death, 1982-1999, Section of Vital Statistics	II-16
Table 12	HIV without AIDS in Alaska	II-17
Table 13	Adult/adolescent cases of HIV and AIDS not known to have died, by race/ethnicity and sex, reported in Alaska through December 31, 1999	II-19
Table 14	Adult/adolescent cases of HIV and AIDS not known to have died, by exposure and sex, reported in Alaska through December 31, 1999	II-19
Table 15	Partner notification activity, 1999 (contacts and results by case)	II-21
Table 16	Partner notification activity, 1999 (contacts by race/ethnicity and age)	II-21
Table 17	Adult/adolescent HIV and AIDS cases with exposure of male-male sex by race/ethnicity, persons not known to have died through December 31, 1999	II-23
Table 18	Adult/adolescent HIV and AIDS cases with risk of injecting drug use by race/ethnicity, persons not known to have died through December 31, 1999	II-24
Table 19	Participants in DARFS Projects in Anchorage	II-26
Table 20	Percent of women giving birth to live infants whose prenatal health care providers counseled them about HIV prevention	II-33
Table 21	Percent of women giving birth to live infants whose prenatal health care provider discussed HIV testing with them	II-33
Table 22	Adolescent cases of HIV and AIDS not known to have died, by race/ethnicity, reported in Alaska through December 31, 1999	II-34
Table 23	Adolescent cases of HIV and AIDS not known to have died, by exposure category, reported in Alaska through December 31, 1999	II-35
Table 24	HIV and AIDS cases reported in Alaska in persons not known to have died, number and prevalence rate through December 31, 1999	II-40
Table 25	HIV and AIDS cases in persons not known to have died, by gender by geographic category, through December 31, 1999	II-40
Table 26	HIV and AIDS cases in persons not known to have died, urban centers by race/ethnicity, through December 31, 1999	II-41
Table 27	Exposure category of adult/adolescent cases of HIV and AIDS not known to have died, 1982 through December 31, 1999, by geographic category	II-42
Table 28	Race/ethnicity of HIV/AIDS cases not known to have died, by geographic category 1982 through December 31, 1999	II-42
Table 29	Results from decision tree worksheets for prioritizing populations with unmet needs	III-12

Table of Contents (continued)

Maps

Map 1	Map of Alaska Census Areas	II-3
--------------	----------------------------------	------

Figures

Figure 1	AIDS rates (cases reported per 100,000 population), 1999 - United States	II-7
Figure 2	Alaska AIDS cases and known deaths by year of first AIDS diagnosis through December 31, 1999	II-9
Figure 3	Alaska AIDS cases in adult/adolescent males first diagnosed with AIDS from 1995-1999, by race/ethnicity	II-11
Figure 4	Alaska AIDS cases in adult/adolescent females first diagnosed with AIDS from 1995-1999, by race/ethnicity	II-12
Figure 5	Alaska AIDS cases by exposure category for adult/adolescent males first diagnosed with AIDS from 1995-1999	II-14
Figure 6	Alaska AIDS cases by exposure category for adult/adolescent females first diagnosed with AIDS from 1995-1999	II-15
Figure 7	Gonorrhea Rates by gender and age, Alaska, 1999	II-28
Figure 8	Gonorrhea rates by race, Alaska, 1995-1999	II-28
Figure 9	Chlamydia rates by gender and age, Alaska, 1999	II-29
Figure 10	Chlamydia rates by race, Alaska, 1996 -1999	II-29
Figure 11	Percentage of high school and middle school students who report ever having sexual intercourse	II-36
Figure 12	Percentage of high school students who report having sexual intercourse within the past three months	II-36
Figure 13	Percentage of high school students who report having intercourse prior to age 13	II-37
Figure 14	Percentage of high school students who report having four or more sexual partners	II-37
Figure 15	HIV/AIDS in persons not known to have died, by gender by geographic category	II-41
Figure 16	Needs assessment worksheet	III-10
Figure 17	Example of prioritized unmet needs scores	III-11
Figure 18	Prevention interventions included in the compendium of HIV prevention interventions with evidence of effectiveness	IV-2
Figure 19	Center for AIDS Prevention Studies (CAPS), UCSF “Fact Sheets” Summary of what works for HIV Prevention	IV-4
Figure 20	Example of interventions matched to prioritized needs for behavioral risk population and location	IV-15
Figure 21	Blueprint for a Sero-status approach to fighting the HIV/AIDS epidemic	V-1

References

Appendices

Appendix 1	The Process of Formal Consensus	1-1
Appendix 2	The Alaska HIV Prevention Resource Inventory, 2000	2-1
Appendix 3	Decision Tree for Prioritizing Populations with Unmet HIV Prevention Needs	3-1

Executive Summary

The 2001-2003 Alaska HIV Prevention Plan describes the HIV epidemic in Alaska, provides information on populations at increased risk of infection, and recommends strategies to prevent further spread of HIV in Alaska. The HIV Prevention Plan also serves to guide uses of HIV prevention funds from the Centers for Disease Control and Prevention (CDC) within our state. This plan differs from previous plans developed by the Alaska HIV Prevention Planning Group in that it is more geographically specific, it strongly emphasizes populations at high risk, and it recommends specific interventions to reduce the spread of HIV/AIDS in Alaska. Following are key points from the plan:

- Alaska is a low prevalence state for HIV infection and AIDS. This presents us with special opportunities and challenges in preventing new HIV infections and also in helping individuals with HIV remain healthy. Alaska communities have important roles and responsibilities for educating their members about and supporting safer behaviors as well as in providing safe and supportive environments for individuals and families with HIV. This is especially important as more individuals are infected with HIV and more are living longer, healthier lives than ever before.
- Persons who are at greatest risk for HIV infection in Alaska are sexual and needle sharing partners to individuals with HIV infection. In our state these are most likely to be men who have sex with men and the sexual and needle sharing partners of injection drug users. Financial resources specifically for HIV prevention are limited. For greatest effect, these resources should be targeted first to activities reaching those at highest risk of infection.
- The low prevalence of HIV in Alaska sometimes leads to a low perception of risk, even among those with high risk behaviors and exposure to HIV. This situation makes public health activities to advise infected people's sexual and needle sharing partners of their HIV exposure essential. Partner notification coupled with onsite testing and counseling helps previously undiagnosed individuals learn of their HIV infection and facilitates their access to care. Partner notification activities also offer important opportunities for HIV prevention counseling for infected and uninfected partners with referrals for support services.
- An increasing proportion of HIV/AIDS cases is among ethnic minority males and females, and these populations are disproportionately represented in the epidemic in Alaska. The majority of cases of HIV/AIDS in Alaska remain among White males, but the proportion of cases among women, especially Alaska Native women, is growing.
- Adolescents and young adults account for a small proportion of HIV/AIDS cases in Alaska, but other sexually transmitted diseases are prevalent in the population of 13 to 24 year olds.
- Prevention activities should be targeted based on the epidemiology of HIV/AIDS in Alaska, and designed based on the science of prevention, evidence of effectiveness, and cost effectiveness. Prevention interventions and information should be culturally and linguistically appropriate for the intended audience and involve members of the intended population in their design and implementation. Prevention interventions should focus on awareness of risk and risk behaviors, access to condoms and sterile injection equipment, skills to initiate and maintain risk reduction and, for those at increased risk, knowing one's HIV status.

- Urban and rural medical providers, mental health counselors, educators, substance abuse counselors, and medical providers and public health providers all have important roles to play in HIV prevention and care, in both correctional and community settings. Many providers already have a history of involvement with populations at increased risk of infection and those who are infected in their communities. Initiating and strengthening HIV prevention messages and support for risk reduction will assist the entire community in Alaska in the goal of preventing HIV transmission.

List of Acronyms

ADA	Alaska Division of Alcoholism and Drug Abuse
AESOP	AIDS Evaluation of Street Outreach Projects
AIDS	Acquired Immune Deficiency Syndrome
ANHC	Anchorage Neighborhood Health Center
ANHB	Alaska Native Health Board
ASO	AIDS Service Organization
BART	Becoming a Responsible Teen
CAIR	Center for AIDS Intervention Research
CAPS	Center for AIDS Prevention Studies
CARE	Comprehensive AIDS Resources Emergency
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
COM	Compendium of HIV Prevention Interventions with Evidence of Effectiveness
CY	Calendar Year
DARFS	Drug Abuse Research Field Station
DOC	Department of Corrections
FPL	Federal Poverty Level
HCV	Hepatitis C Virus
HE/RR	Health Education and Risk Reduction
HIV	Human Immunodeficiency Virus
HPPG	Alaska HIV Prevention Planning Group
HIVCT	HIV Counseling and Testing
IDU	Injecting Drug User
MSM	Men Who Have Sex With Men
ORW	Outreach Worker
PRAMS	Pregnancy Risk Assessment Monitoring Survey
POL	Peer Opinion Leader (a.k.a. Popular Opinion Leader)
PTW	Programs That Work
RARE-T	Reducing AIDS Risk Effectively in Teens
REP	Replicating Effective Programs
ROTC	Reserve Office Training Corps
RWCA	Ryan White CARE Act
SAFE	Sero-status Approach to Fighting the HIV/AIDS Virus
SEP	Syringe Exchange Program
STD	Sexually Transmitted Disease
YRBS	Youth Risk Behavior Survey

Section I. Overview of the Community Planning Process

Since January 1994, state, territorial and local health departments receiving HIV prevention funds through the Centers for Disease Control and Prevention (CDC) have conducted community planning activities to develop a comprehensive HIV prevention plan. In Alaska, the planning process is guided by a statewide group, the Alaska HIV Prevention Planning Group (HPPG), which was organized in 1994.

The five nationally defined core objectives of HIV Prevention Community Planning are to:

1. Foster the open and participatory nature of the community planning process.
2. Ensure that the community planning group reflects the diversity of the epidemic in the jurisdiction, and that experts in epidemiology, behavioral science, health planning, and evaluation are included in the process.
3. Ensure that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment.
4. Ensure that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values.
5. Foster strong, logical linkages between the community planning process, plans, applications for funding, and allocation of CDC HIV prevention resources.

Members of the Alaska HPPG are volunteers, selected for their knowledge and personal experience related to HIV and risk behaviors, as well as their technical expertise in program planning, evaluation, epidemiology, behavioral science, and other fields related to prevention. Members are diverse in race/ethnicity, serostatus, socioeconomic level, sexual orientation, education, and areas of expertise. Members are appointed by the State Epidemiologist, Division of Public Health, Department of Health and Social Services, on the Planning Group's recommendation and following an open recruitment and nomination process. The HPPG's Membership Workgroup reviews HPPG composition and membership needs, and presents criteria to the HPPG for new members' characteristics to address those needs. Recruitment activities identify the criteria being sought in new members. HPPG member nominations are solicited from consumers and HIV prevention providers throughout the state representing both governmental and non-governmental agencies. HPPG members also recruit prospective members from affected communities through their social and professional networks. Membership nominations are first reviewed by the HPPG's Membership Workgroup. Recommended nominees are presented by the Membership Workgroup to the entire HPPG for discussion and approval. Prospective members are invited to a Planning Group meeting to provide an opportunity for current members to meet them and for prospective members to gain an understanding about how the HPPG functions and what it does. After this step, the HPPG makes a final recommendation to the Chief of the Section of Epidemiology for official appointment.

The Chair of the Alaska HPPG is shared by three HPPG members, two of whom are “community” members and one of whom is from the Alaska Department of Health and Social Services. Facilitation of meetings is rotated among the three co-chairs. In 1999 and 2000, during the development of the 2001-2003 Plan, the HPPG was composed of the following members:

Clarence Smelcer, Community Co-chair, Alaska Native Health Board, Anchorage
Eddie Singleton, Community Co-chair, private sector health care provider, Juneau
Wendy Craytor, Health Department Co-chair, Section of Epidemiology, Anchorage
Victor Carlson, Anchorage
Diana Cunnea, Anchorage
Mary Lee, Anchorage
CarmenRosa Mallipudi, Anchorage
Mike Mtika*, Anchorage,
Rena Mulcahy*, Anchorage
Rebecca Tonsgard-Gibson, Anchorage
Nancy Rollins*, Soldotna and Anchorage
Steve Cady, Fairbanks
Nkenge Williams, Fairbanks
Barbara Wilson, Barrow
Margaret Wilson, Fairbanks
*Members retiring from the HPPG in 2000.

(HPPG members often have lived and worked in areas of the state other than their current place of residence.)

There are liaisons to the HPPG from three state agencies with important roles in HIV prevention in Alaska. They are regularly invited to attend meetings and they receive upcoming meeting dates, agendas and minutes of completed meetings. Liaisons to the HPPG in 1999 – 2000 are:

Viki Wells, Division of Alcoholism and Drug Abuse
Beth Shober, Department of Education and Early Development
Sara Williams (1999), Mel Henry (2000), Department of Corrections

The Alaska Native Health Board (ANHB) also has been asked to name a liaison in the past. One of the Co-chairs is now an ANHB staff member, and currently fills that role. The State Epidemiologist, Dr. John Middaugh, provides technical assistance to the Planning Group, as needed.

In addition to the HPPG’s broad-based membership, the prevention planning process includes multiple activities to seek input from populations at increased risk, service providers to these populations, experts in related fields, and interested others. HPPG meetings are open to the public and each full meeting includes a public comment period. All meetings are advertised in at least the *Anchorage Daily News*, *Fairbanks News Miner*, and *Juneau Empire*. Aside from the state agencies with liaisons to the HPPG, the Deputy Director of the Department of Health and Social Services (which houses the Divisions of Public Health, Alcoholism and Drug Abuse, Mental Health, and Juvenile Justice) is invited to each HPPG meeting. Other specific individuals and agency representatives are specially invited to participate in HPPG meetings where their expertise or interest is particularly relevant. Prevention provider teleconference participants, which include over 50 providers statewide, and other individuals or agencies known to be interested and involved in HIV prevention are regularly advised of the

HPPG's meeting dates and are provided with reports on HPPG activities. Most meetings are held in Anchorage because it is the largest population center, but meetings are periodically held in other communities to encourage participation.

In 2000, HPPG information and activities were made available on the Internet through the Section of Epidemiology web site at www.epi.hss.state.ak.us. Approved meeting minutes, upcoming meeting dates and agendas, a list of HPPG members and their current areas of residence, and applications for HPPG membership are posted on the web site. The draft *2001-2003 Alaska HIV Prevention Plan* was posted on the web site for the public comment period, and the final plan is posted. In addition, comments and questions can be e-mailed directly to the HIV Prevention Group through this web site.

The Alaska HPPG and the two Alaska Ryan White HIV Care Consortia share information and mutual participation in their respective activities through several mechanisms. Since both groups are supported by the Alaska HIV/STD Program, communication about prevention and care activities is easily facilitated by and between HIV/STD Program staff. Generally there is some overlapping membership between the HPPG and one or both Care consortia. Data from Ryan White grant activities are shared with the HPPG and included in the needs assessment process. Reciprocally, the comprehensive Plan is sent to each Care consortium for participants' review of recommended prevention activities. Prevention and Care providers and HPPG members receive epidemiologic data in Section of Epidemiology Reports and Recommendations and Epidemiology Bulletins. In 2001, with the implementation of more prevention activities specifically focused on HIV positive persons, there will be increased interaction between the HPPG and the Ryan White Care consortia.

The Alaska HPPG has adopted a formal consensus decision-making model (Butler et al 1991). All group decision-making processes, including conflict resolution, are addressed following the formal consensus model (Appendix 1). Regular HPPG meetings are held at least quarterly. Additional meetings and/or teleconferences for the full HPPG may be scheduled if deemed necessary by the Co-Chairs. Workgroups schedule additional meetings or teleconferences, as needed.

The 2001-2003 Alaska HIV Prevention Plan

The Alaska HPPG is charged with the responsibility of developing a comprehensive HIV prevention plan. The process for developing the Plan is to identify priority populations based on an assessment of Alaska-specific epidemiologic data, identify unmet HIV prevention needs and available resources, prioritize among unmet needs, and recommend priority interventions to address these needs. *The 2001-2003 Alaska HIV Prevention Plan* is the fourth comprehensive plan produced by the Alaska HPPG. It describes the epidemiology of HIV and AIDS in Alaska, the populations at greatest need for HIV prevention interventions, and recommendations for interventions that are most appropriate to meet these needs.

The 2001-2003 Plan has a number of changes from previous comprehensive plans. In February of 1999, HIV became a reportable disease in Alaska, thereby requiring health care providers and laboratories to report to the Section of Epidemiology suspected and confirmed cases of HIV infection. Previously, only AIDS was reportable. Data now available from HIV reporting provide a more current view of the epidemic. The increase in reported cases due to HIV reporting also enables a closer examination of the epidemiological data by geographic regions, demographic characteristics, and exposure (risk) category. Hence the "Epidemiologic Profile" in the 2001-2003 Plan gives more detailed information than previous versions.

Medical advances in anti-retroviral therapy in the past four years have resulted in people with HIV infection living longer and healthier lives. The effectiveness of therapy in delaying the onset of AIDS gives new impetus to linking HIV positive persons to care and supporting them to use these therapies to prevent progression to AIDS (secondary prevention). It also puts new emphasis on providing primary prevention interventions to help HIV positive persons adopt and maintain safer behaviors to prevent transmission of HIV to others. Recommendations in the 2001-2003 Plan reflect this emphasis on primary and secondary prevention for persons with HIV.

Currently, additional and enhanced research on the effectiveness of prevention interventions is available nationally. The Alaska HPPG was able to draw upon published results of HIV prevention projects that have been scientifically evaluated and shown to be effective. Interventions recommended in the 2001-2003 Plan are exclusively those interventions which have a sound basis in social and behavioral science theory and demonstrated effectiveness in influencing behavior change or are recommended by CDC as an essential component of a comprehensive HIV prevention strategy.

The 2001-2003 Alaska HIV Prevention Plan places more emphasis on high risk populations, is more geographically specific, and makes more specific recommendations for interventions than previous plans. The Plan is designed to provide guidance for HIV prevention activities in all sectors and areas of Alaska for the next three years. It is intended to guide specific interventions for those at greatest risk of HIV infection; to generate community discussion and input; to encourage collaboration among individuals, organizations, and community groups providing HIV prevention and care; and to encourage integration of HIV prevention interventions into services for people likely to engage in risk behaviors – all activities focused toward the goal of preventing HIV and AIDS in Alaska.

Organization of the Plan

The 2001-2003 Alaska HIV Prevention Plan is arranged in order of the essential elements of a comprehensive HIV prevention plan specified by CDC. Each of the Sections II through V of the Plan describe one of the essential elements of the planning process.

Section II contains the **Epidemiologic Profile** which outlines the data on HIV and AIDS in Alaska and other surrogate markers for HIV risk behaviors, e.g., sexually transmitted disease, teen pregnancy rates, information on drug use, and results of behavioral risk factors surveys in Alaska. From an examination of these data the HPPG identified priority populations for HIV prevention activities.

Section III describes the **Needs Assessment and Needs Prioritizing Process** that results in the identification of priority unmet needs for each of the populations identified through the examination of the epidemiologic data. Appendix 2 contains the **Resource Inventory** that summarizes information on Alaska HIV prevention resources and funding sources that helped inform the HPPG's assessment of met and unmet needs.

Section IV describes the process the HPPG used for **Intervention Assessment and Prioritization**. The section includes information on interventions that have undergone scientific evaluation and have demonstrated effectiveness in helping people make behavior changes to reduce their risk of HIV infection. The HPPG drew upon the behavioral science and evaluation literature to select and prioritize interventions to best meet the HIV prevention needs of each of the priority populations in specific geographic locations.

Section V presents the **Recommendations** of the HPPG for prevention goals and objectives for Alaska. Recommendations are presented for prioritized interventions for defined populations, according to behavioral risk factors, in specific geographic areas of the state. This section also describes mechanisms for program coordination, program assistance and support, and evaluation of the planning process.

Section II. Epidemiologic Profile

This epidemiologic profile presents data on the sociodemographics of Alaska and on HIV and AIDS in Alaska (overview, characteristics of persons with AIDS, characteristics of populations at risk for HIV infection, and geographic distribution of HIV infection in Alaska). The Profile also includes information about the strengths and limitations of the data presented as well as conclusions drawn from these data in the context of program experience, national trends, and cumulative scientific knowledge about HIV infection. The Section of Epidemiology updates HIV and AIDS data regularly to reflect information on new cases and supplemental information on known cases, and this Profile should be considered a standalone document as of August 2000.

SOCIODEMOGRAPHICS OF ALASKA

Population. The estimated 1999 population of Alaska is 622,000.* The state's population is relatively young and culturally diverse. The median age for Alaska is 32.9 years compared to 35.6 for the US, making it the second youngest U.S. population after Utah. The age structure of the population varies considerably by race/ethnicity: the median age for Whites is 35.4; for Alaska Natives it is 23.3 due to the large cohort of young children; for Blacks, many of whom come to Alaska as young adults with the military, the median age is 27; for Alaskans of Asian and Pacific Island descent the median age is 31.4; and for Hispanics the median age is 27.8. The 1999 estimates of the race/ethnicity distribution of the population are provided in Table 1.

Table 1. Estimated 1999 Alaska population by race/ethnicity

Racial/Ethnic Category	1999 Estimated Population					
	Male		Female		Total	
	Number	% of Male total	Number	% of Female total	Number	%
White	240,936	74%	217,726	73%	458,662	74%
Black	15,498	4.8%	12,119	4.1%	27,617	4%
Asian/Pacific Islander	14,833	4.6%	16,143	5.4%	30,976	5%
Alaska Native/ American Indian	52,419	16.2%	52,326	17.5%	104,085	17%
Total	323,687		298,313		622,000	100%
Of those in above categories, those of Hispanic Ethnicity	15,582	4.8%	13,962	4.7%	29,544	5%

* Unless otherwise specified, all of the population figures below are the 1999 population estimates for Alaska prepared by the Alaska Department of Labor and Workforce Development. Since these are the most current population figures available, the populations are referred to in the present tense for ease of presentation.

There is considerable geographic variation in the race/ethnicity composition of the population. Two boroughs (Lake and Peninsula and Northwest Arctic) and four census areas (Bethel, Dillingham, Nome, and Wade Hampton) are more than 75% Alaska Native. Conversely, eight boroughs (Denali, Fairbanks North Star, Haines, Juneau, Kenai Peninsula, Ketchikan Gateway, Matanuska-Susitna, and the Municipality of Anchorage) and three census areas (Southeast Fairbanks, Valdez-Cordova, and Wrangell-Petersburg) are more than 75% non-Native. There are 226 federally recognized tribes in Alaska.

The Municipality of Anchorage has the largest population with 259,391 residents and it reflects some of the diversity of the state: Whites make up 77% of the Anchorage population; Alaska Natives 8%; Blacks 7.3%, Asian and Pacific Islanders 7.3%. Of these, approximately 6% are of Hispanic ethnicity.

Populations of Blacks and Asian/Pacific Islanders are concentrated in the two largest urban centers. Of the 27,617 Blacks in Alaska, 69% reside in the Municipality of Anchorage and 23% reside within the Fairbanks North Star Borough. Of the 30,976 Asian and Pacific Islanders, 61% reside in the Municipality of Anchorage and 7% in the Fairbanks North Star Borough, while another 9% reside in Kodiak. The largest concentration of Alaska Natives is in Anchorage where 20% of the Alaska Native population resides.

The armed forces are an influential part of the Alaska population. The number of military personnel in the state has declined since 1990 due to military cutbacks, yet the armed forces remain the largest employer in Alaska. In 1999, the number of full time military, plus their dependents stationed in Alaska totaled 44,557.

The US Census Bureau defines an urban place as an incorporated or unincorporated area with 2,500 persons or more. By the Census Bureau definition there are 26 urban places in Alaska (in 1999) with a total population of 437,586 comprising 70.4% of the total population of the state. This “urban” designation obscures the geographic remoteness of so many Alaska communities with populations over 2,500.

In developing the 2001 - 2003 HIV Prevention Plan, it proved more useful to examine data grouped in several geographic categories based on population distribution and infrastructure rather than to separate areas according to the Census definition of urban. This approach allowed the Planning Group to more closely examine and take into consideration differences in population size, the distribution of cases of HIV and AIDS, health and social service infrastructure, and community norms and dynamics as they pertain to HIV prevention. The Planning Group considered separately the HIV prevention needs and resources, and appropriate prevention interventions for each of the three urban population centers – Anchorage, Fairbanks, and Juneau, - and for two other geographic categories - Urban Satellites and Rural Hubs, and Rural Areas.

For purposes of characterizing the epidemic, data on HIV and AIDS were examined for four geographic categories: (1) Urban Centers – combining Anchorage, Fairbanks, and Juneau; (2) Urban Satellites; (3) Rural Hubs; and (4) Rural Areas. The following section describes these geographic categories used for the planning process.

Map of Alaska Census Areas



Urban Centers

Almost two thirds of the population of Alaska [373,353 (60%)] live within three urban census areas: the Municipality of Anchorage (population 259,391), Fairbanks North Star Borough (83,773); and the Juneau Borough (30,189).

Urban Satellites and Rural Hubs

Urban satellites and rural hubs have a combined population of 164,188 making up 26.4% of the total population of the state. Urban satellites refer to the communities of the Matanuska-Susitna Borough (population 55,694) and the Kenai Peninsula Borough (population 47,270) excluding villages that are not on the road system connected to Anchorage. While there are other communities on the road system north of the Mat-Su Borough and north and southeast of Fairbanks, these are small and widely separated communities that are more similar to rural villages and are thus included in the Rural Areas category.

Table 2. 1999 Population estimates

Urban Centers			373,353	60%
Municipality of Anchorage	259,391			
Fairbanks North Star Borough	83,773			
Juneau	30,189			
Urban Satellites and Rural Hubs			164,188	26.4%
Matanuska-Susitna and Kenai Peninsula Subtotal		102,964		(16.5%)
Matanuska-Susitna Borough	55,694			
Kenai Peninsula Borough less villages off the road system	47,270			
Rural Hubs Subtotal		61,224		(9.8%)
Kodiak city and Kodiak Station	8,724			
Sitka city/Borough	8,681			
Ketchikan city	8,320			
Bethel city	5,471			
Barrow city	4,438			
Unalaska city	4,178			
Valdez city	4,164			
Nome city	3,615			
Petersburg city	3,415			
Kotzebue city	2,932			
Wrangell city	2,549			
Cordova city	2,435			
Dillingham city	2,302			
Rural Areas			84,459	13.6%
Aleutians East Borough	2,151			
Aleutians West Census Area less Unalaska	1,107			
Bethel Census Area less Bethel	10,696			
Bristol Bay Borough	1,258			
Denali Borough	1,871			
Dillingham Census Area less Dillingham city	2,429			
Haines Borough	2,475			
Kenai Peninsula Borough communities not on road system- Nanwalek, Port Graham, Seldovia, Tyonek, Halibut Cove, Grouse Creek, Jakolof Bay	1,682			
Ketchikan Gateway Boro. less Ketchikan city	5,641			
Kodiak Is. Boro. less Kodiak city, Kodiak Stn.	5,265			
Lake and Peninsula Borough	1,791			
Nome Census Area less Nome city	5,696			
North Slope Borough less Barrow	2,975			
Northwest Arctic Borough less Kotzebue	3,941			
Prince of Wales/ Outer Ketchikan	6,589			
Skagway-Hoonah-Angoon Census Area	3,541			
Southeast Fairbanks Census Area	6,283			
Valdez-Cordova Census Area less Valdez and Cordova cities	3,734			
Wade Hampton Census Area	7,060			
Wrangell-Petersburg Census Area less Wrangell and Petersburg cities	1,173			
Yakutat City/Borough	729			
Yukon-Koyukuk Census Area	6,372			
TOTAL			622,000	100%

Rural hubs refer to thirteen economic and transportation centers in the rural regions of Alaska and several other communities in Southeast Alaska, all of which have populations over 2,000 and health and social service infrastructure not found in smaller rural communities.

Rural Areas

The category Rural Areas includes the populations of 260 incorporated and unincorporated cities, census designated places, and Alaska Native Villages outside of the Urban Satellites and Rural Hubs, and persons living outside of any community. Communities in this designation have fewer than 2,000 residents. The combined population of these rural areas is 84,459 making up 13.6% of the state total. Population figures are listed in Table 2 (above) by Census Area less the population of the rural hub of that census area.

Income. Per capita income in Alaska in 1998, the latest year for which data are available, was \$25,462. Nationally, the US per capita income in 1998 was \$26,482. Alaska has fallen from first place in per capita income in the early 1980s to 21st place by 1998 and the average annual rate of growth in per capita income was the least of any state and the District of Columbia in 1998. These changes in the Alaska economy reflect downturns in resource extraction industries – oil, timber, and fishing – and military base closures.

Despite the lower per capita income of Alaska relative to the nation, there is a lower percentage of Alaskans living in poverty compared to the US as a whole. Alaska's federal poverty level (FPL) for 1998 was \$10,070 for an individual; \$20,570 for a family of four. According to the 1999 HRSA State Profile for Alaska, the percentage of Alaskans below 100% of federal poverty level was 7.8% in 1998 compared to 13.1% for the US; the percentage of Alaskans below 200% of poverty level in 1998 was 22.6% compared to 31.1% nationally. The percentage of the population in poverty varies considerably by census area. In general, urban areas like the Municipality of Anchorage, Fairbanks North Star Borough and Juneau have a lower percentage of the population in poverty (7.5 – 11.5%) compared to the most rural census areas like Bethel, Wade Hampton, Dillingham, Lake and Peninsula, and Yukon-Koyukuk Census Areas where the percent living in poverty ranges from 22 to 43%. However, there are exceptions to the rural-urban dichotomy, notably the North Slope Borough and Aleutians West Census Area where the percent living in poverty is less than in the urban census areas.

Income level has a bearing on access to medical care, but there is not a direct correlation between income and access because of federal and state supports for health care for lower income persons and because of federal funding of Alaska Native tribal health services. Alaska has a higher percentage of persons below 200% of poverty level enrolled in Medicaid than nationally. In 1998, 44.8% of Alaskans at 200% of FPL were Medicaid beneficiaries compared to 37% nationally. Over 104,000 Alaska Native residents are eligible for health care through Indian Health Service funded facilities. The Alaska Area Native Health Service reports that in a 36 month period between 1995 and 1998, 113,885 Alaska Native individuals utilized IHS or tribal health facilities at least once.

HIV AND AIDS IN ALASKA — OVERVIEW

AIDS became a condition reportable to the Alaska Division of Public Health in 1985; HIV became reportable in February 1999. Through December 31, 1999, a total of 712 cases of HIV and AIDS were reported to the Alaska Division of Public Health, as shown in Table 3.

Table 3: HIV and AIDS cases reported to the Alaska Division of Public Health through December 31, 1999*

	Total HIV & AIDS Case Reported	HIV & AIDS Cases Not Known to Have Died	HIV & AIDS Cases Known to Have Died
HIV Cases with AIDS	511	273	238
Alaska Residents at First Diagnosis	449	215	234
Not Alaska Residents at First Diagnosis	62	58	4
HIV Cases without AIDS	201	198	3
Total	712*	471*	241*

* Case numbers presented in this Profile differ slightly from data presented in the Section of Epidemiology's May 9, 2000 Reports and Recommendations on "HIV Infection in Alaska" because HIV and AIDS case data are continually updated as new information becomes available.

Medical providers and laboratories are required under Alaska Administrative Code (7 AAC 27.005. and 7 AAC 27.007.) to report suspected and diagnosed cases of HIV and AIDS to the Division of Public Health. Validation studies in Alaska have indicated that Alaska AIDS case data have been quite complete over time. Nationally, AIDS case data are considered among the most complete of all disease surveillance data. An Alaska study also documented that, unlike the situation reported in some other areas of the U.S., Alaska data did not undercount AIDS cases in Alaska Natives/American Indians due to racial misclassification.

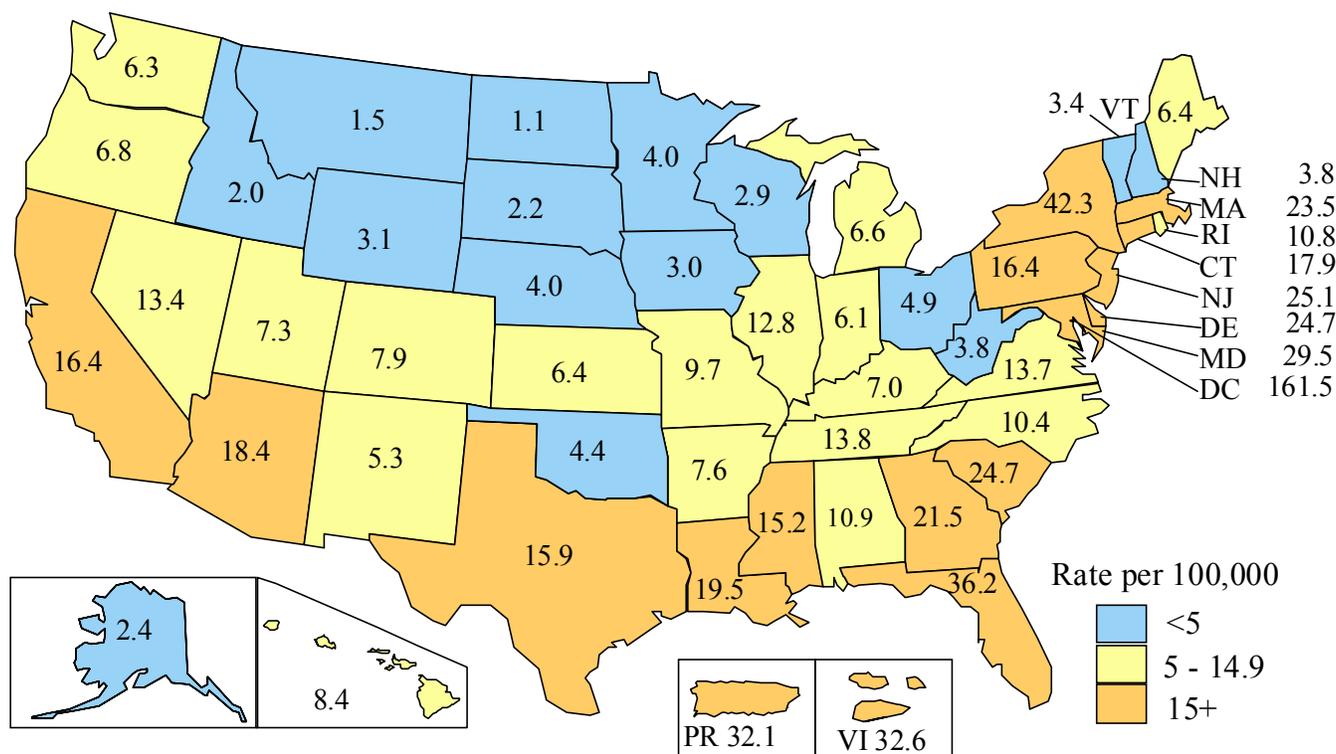
After HIV reporting was introduced in February 1999, the cases reported included persons diagnosed years ago as well as persons recently infected or recently diagnosed for the first time. Reports of older HIV cases were more likely to have incomplete data than reports on more recently diagnosed cases.

CHARACTERISTICS OF PERSONS WITH AIDS IN ALASKA

This section of the Epidemiologic Profile presents information on the 449 cases of AIDS among individuals who were Alaska residents at the time of their first AIDS diagnosis, regardless of where that diagnosis was made. These cases are also referenced in the text and tables that follow as “Alaska AIDS cases.”

Alaska had a relatively low rate of AIDS cases reported to CDC in 1999 (2.4 per 100,000 population), as compared to most other states. Figure 1 depicts the number of AIDS cases reported to CDC across the United States in 1999, expressed as a rate per 100,000 population for each state/area.

Figure 1: AIDS rates (cases reported per 100,000 population), 1999 – United States



Source: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Update. 2000; 1(No. 1:10): [Page 12]

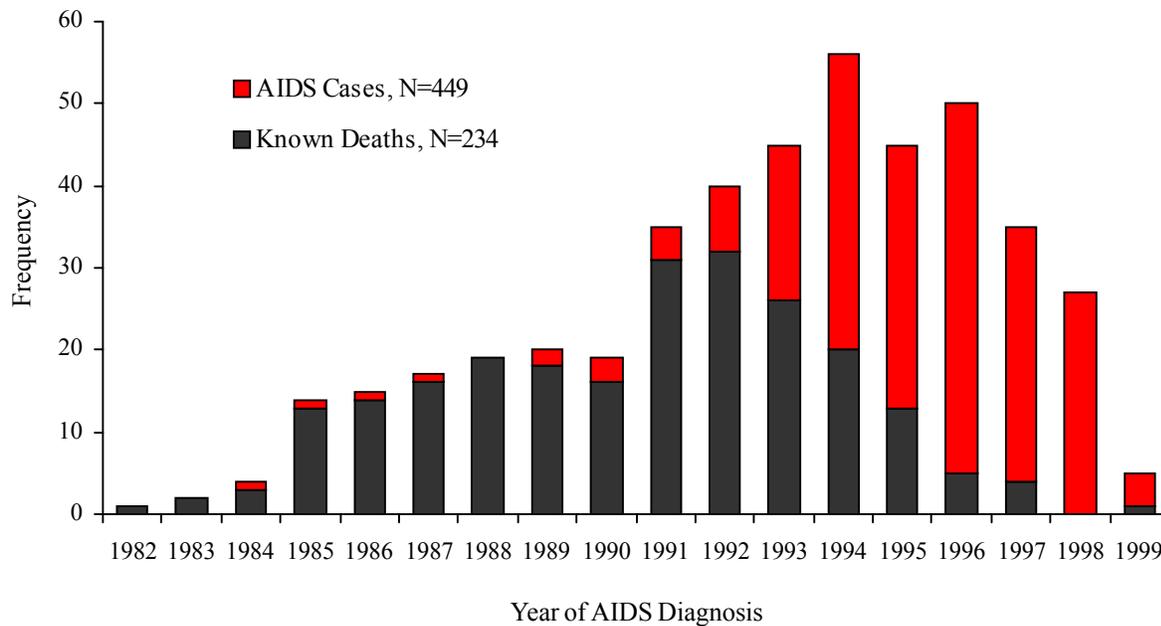
The first case of AIDS was diagnosed in Alaska in 1982. Of 449 Alaska residents diagnosed with AIDS from 1982 through December 31, 1999, 234 (52%) are known to have died (see Table 4 and Figure 2). The highest number of cases diagnosed in a single year was 56 in 1994. The number of diagnosed AIDS cases per year declined from the high of 56 in 1994 to 4 in 1999. The average annual rate of new AIDS cases diagnosed (average AIDS incidence rate) in Alaska from 1995 to 1999 is 5.3 per 100,000 population. (Although CDC calculated a rate for AIDS cases reported in 1999 to create the map in Figure 1, above, single year and age-sex-race-specific case rates are not otherwise calculated for Alaska AIDS case data because the small case numbers make such rates unreliable and unstable over time.)

Table 4 and Figure 2 also show the numbers of individuals diagnosed with AIDS in each year who are known to have died. (Deaths among persons with HIV are discussed further, below.) These data depict (1) the decline in deaths among individuals diagnosed with AIDS in recent years and (2) the decline in the number of new AIDS cases seen in Alaska since 1996. These recent changes are attributed primarily to effects of new treatments for HIV infection. Nationally, declines in deaths and incidence appear to be leveling after 1998.

Table 4: Alaska AIDS cases and known deaths by year of first AIDS diagnosis through December 31, 1999, (N=449)

Year	Cases by Year of First AIDS Diagnosis	Known Deaths Among Persons Diagnosed with AIDS in that Year
1982	1	1
1983	2	2
1984	4	3
1985	14	13
1986	15	14
1987	17	16
1988	19	19
1989	20	18
1990	19	16
1991	35	31
1992	40	32
1993	45	26
1994	56	20
1995	45	13
1996	50	5
1997	35	4
1998	27	0
1999	5	1
Unknown	0	0
Total	449	234

Figure 2: Alaska AIDS cases and known deaths by year of first AIDS diagnosis through December 31, 1999, N=449



It should be noted throughout this Profile that the number of Alaska AIDS cases is small and, in many of the analyses, a difference of one or two cases can change the overall proportion of cases in a particular category considerably.

Of the 449 cases of AIDS first diagnosed in Alaska residents, 444 were diagnosed in individuals ages 13 years and older (adult/adolescent cases) and 5 in infants and children younger than 13 years. Data on race/ethnicity, gender, and exposure for persons ages 13 years and older (adults/adolescents) are presented below. HIV infection in children and in individuals 13-24 years are discussed in more detail later in this document.

Males constituted 85% of adult/adolescent AIDS cases diagnosed from 1995-1999 as compared to 88% of cases diagnosed from 1982-1994. Females constituted 15% of adult/adolescent AIDS cases diagnosed from 1995-1999 as compared to 12% of Alaska AIDS cases diagnosed from 1982-1994.

In order to examine changes over time, the data below on 444 adult/adolescent Alaska AIDS cases are separately presented for the 283 cases of AIDS diagnosed from 1982-1994 and the 161 cases diagnosed from 1995 to 1999. Data on recent AIDS cases are likely to more nearly reflect current HIV infection trends than are data on cases diagnosed earlier in the epidemic. Data on cases diagnosed from 1995-1999 (recently diagnosed AIDS cases) are also presented in graphic format. Data on AIDS cases diagnosed from 1995-1999 have been separately analyzed to see if there are significant differences in the characteristics of the 23 (14%) cases known to have died and the 138 (86%) cases not known to have died. No such differences were observed.

Race/ethnicity of persons with AIDS. Table 5 presents data on the 444 Alaska adult/adolescent AIDS cases by race/ethnicity and date of first AIDS diagnosis. These data are further broken down by sex and date of first AIDS diagnosis, with cases in males presented in Table 6 and for females in Table 7. Alaska population data for 1999 are also included in Tables 6 and 7 for adult/adolescent males by race/ethnicity and adult/adolescent females by race/ethnicity for comparison to the 1995-1999 AIDS case data.

Table 5: Alaska AIDS cases in adults/adolescents by race/ethnicity and date of first AIDS diagnosis, N=444

Race/Ethnicity	Alaska AIDS Cases Diagnosed from 1995-1999 in Persons ≥13 Years	Alaska AIDS Cases Diagnosed from 1982-1994 in Persons ≥13 Years
White	86 (53%)	194 (69%)
Black	15 (9%)	22 (8%)
Hispanic	18 (11%)	17 (6%)
Asian/Pacific Islander	4 (3%)	2 (1%)
Alaska Native/ American Indian	38 (24%)	48 (17%)
Unknown	0 (0%)	0 (0%)
Total	161 (100%)	283 (100%)

Table 6: Comparison of estimated adult/adolescent male population to Alaska AIDS cases in adult/adolescent males by race/ethnicity and date of first AIDS diagnosis

Race/Ethnicity	Estimated Number and Percent of Males ≥15 Years, 1999 Alaska Population**	Alaska AIDS Cases Diagnosed in Males ≥13 Years from 1995-1999	Alaska AIDS Cases Diagnosed in Males ≥13 Years from 1982-1994
White	184,341 (77%)	78 (57%)	177 (71%)
Black	11,813 (5%)	14 (10%)	16 (6%)
Hispanic Ethnicity*	* (4%)	17 (12%)	15 (6%)
Asian/ Pacific Islander	10,530 (4%)	2 (1%)	2 (1%)
Alaska Native/ American Indian	33,609 (14%)	26 (19%)	40 (16%)
Total	240,293	137 (100%)	250 (100%)

*Estimated male Hispanic population = 10,348 or 4% of the total 1999 Alaska male population. Males of Hispanic ethnicity are included in the numbers and percents shown for the racial categories, above.

**Population estimates are for Alaskan males age 15 and older since estimates for males 13 and older are unavailable.

The proportion of Alaska AIDS cases among White males declined in cases diagnosed from 1995-1999 as compared to cases diagnosed from 1982-1994. The proportions of cases among Black, Hispanic, and Alaska Native males increased in the period from 1995-1999 as compared to 1982-1994. The representation of Black, Hispanic, and Alaska Native males among Alaska AIDS cases was greater during the period from 1995-1999 than their representation in the 1999 male population. Figure 3 presents data by race/ethnicity for AIDS cases diagnosed in adult/adolescent males from 1995-1999.

Figure 3: Alaska AIDS cases in adult/adolescent males first diagnosed with AIDS from 1995-1999, by race/ethnicity, N=137

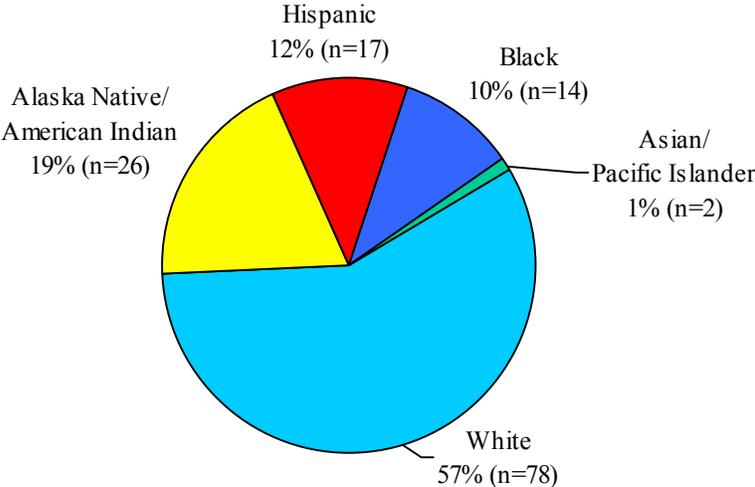


Table 7: Comparison of estimated adult/adolescent female population to Alaska AIDS cases in adult/adolescent females by race/ethnicity and date of first AIDS diagnosis

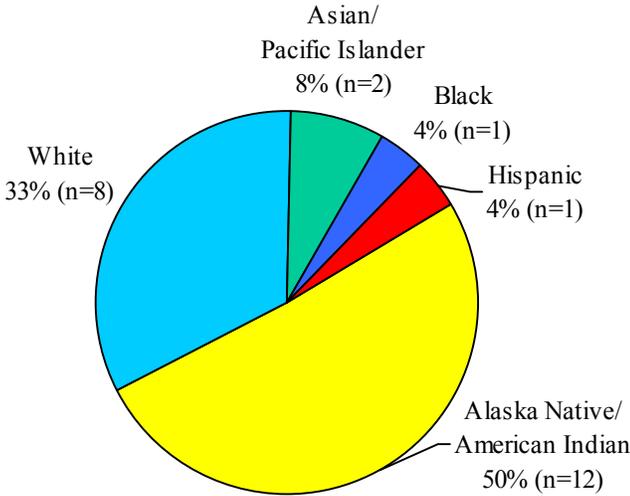
Race/Ethnicity	Estimated Number and Percent of Females ≥15 Years, 1999 Alaska Population**	Alaska AIDS Cases Diagnosed in Females ≥13 Years From 1995-1999	Alaska AIDS Cases Diagnosed in Females ≥13 Years from 1982-1994
White	164,202 (75%)	8 (33%)	17 (52%)
Black	8,486 (4%)	1 (4%)	6 (18%)
Hispanic Ethnicity*	* (5%)	1 (4%)	2 (6%)
Asian/ Pacific Islander	11,910 (5%)	2 (8%)	0 (0%)
Alaska Native/ American Indian	34,418 (16%)	12 (50%)	8 (24%)
Total	219,016	24 (100%)	33 (100%)

*Estimated female Hispanic population = 9,858 or 5% of the total 1999 Alaska female population. Females of Hispanic ethnicity are included in the numbers and percents shown for the racial categories, above.

**Population estimates are for Alaskan females age 15 and older since estimates for females 13 and older are unavailable.

The proportion of Alaska AIDS cases among White, Black, and Hispanic females decreased in cases diagnosed from 1995-1999 as compared to cases diagnosed from 1982-1994. The proportions of AIDS cases among Asian and Alaska Native females increased in the period from 1995-1999 as compared to 1982-1994. Alaska Native females were disproportionately represented among Alaska AIDS cases in the period from 1995-1999 as compared to their representation in the 1999 female population: Alaska Native females constituted 50% of AIDS cases in adult/adolescent females diagnosed from 1995-1999 as compared to 16% of the female population. Asian/Pacific Islander females were slightly over represented among Alaska AIDS cases in the period from 1995-1999 as compared to their representation in the 1999 female population, although case numbers are small. Figure 4 presents data by race/ethnicity for AIDS cases diagnosed in adult/adolescent females from 1995-1999.

Figure 4: Alaska AIDS cases in adult/adolescent females first diagnosed with AIDS from 1995-1999, by race/ethnicity, N=24



Exposure risk among persons with AIDS. Data on adult/adolescent Alaska AIDS cases by exposure category are shown in Table 8. These data are further broken down by sex and date of diagnosis, with cases in adult/adolescent males presented in Table 9 and cases in adult/adolescent females in Table 10.

Overall, the proportion of Alaska AIDS cases among males and females with IDU exposure increased considerably in the period from 1995-1999 (20%) as compared to the period from 1982-1994 (9%). Cases in which the mode of exposure was not identified as one of the other listed categories increased to 26% from 9%. The proportion of cases in which exposure risk was male to male sex plus injecting drug use remained constant (5%), the proportion with hemophilia risk was constant (2%), and the proportion of cases with exposure risk of heterosexual sex with a known HIV positive or person at high risk of HIV was essentially constant across the two time periods (7% and 8%). The proportion of cases in which exposure risk was male to male sex decreased considerably (from 63% to 40%). It is also notable that the number of AIDS cases related to transfusions or transplants was reduced to zero in the more recent period.

Table 8: Alaska adult/adolescent AIDS cases by exposure category and date of first AIDS diagnosis

Exposure Category	Alaska AIDS Cases Diagnosed from 1995-1999 in Persons ≥13 Years	Alaska AIDS Cases Diagnosed from 1982-1994 in Persons ≥13 Years
MSM	65 (40%)	177 (63%)
Injecting Drug Use (IDU)	32 (20%)	26 (9%)
Male-Male Sex (MSM) & IDU	8 (5%)	14 (5%)
Heterosexual contact to HIV+ or person at high risk	11 (7%)	23(8%)
Transfusion/Transplant	0 (0%)	12 (4%)
Hemophilia	3 (2%)	6 (2%)
Other/Unknown/ Unspecified	42 (26%)	25 (9%)
Total	161 (100%)	283 (100%)

Males and females do not both share all of the same exposure categories and exposure risk is therefore distributed differently among male and female AIDS cases. Exposure categories are shown in Table 9 and Figure 5 for adult/adolescent males and in Table 10 and Figure 6 for adult/adolescent females.

Table 9: Alaska AIDS cases in adult/adolescent males by exposure category and date of first AIDS diagnosis

Exposure Category	Alaska AIDS Cases Diagnosed from 1995-1999 in Males ≥13 Years	Alaska AIDS Cases Diagnosed from 1982-1994 in Males ≥13 Years
MSM	65 (47%)	177 (71%)
Injecting Drug Use (IDU)	21 (15%)	19 (8%)
Male-Male Sex (MSM) & IDU	8 (6%)	14 (6%)
Heterosexual contact to HIV+ or person at high risk	5 (4%)	4 (2%)
Transfusion/Transplant	0 (0%)	9 (4%)
Hemophilia	3 (2%)	6 (2%)
Other/Unknown/ Unspecified	35 (26%)	21 (8%)
Total	137 (100%)	250 (100%)

Proportions of Alaska AIDS cases among adult/adolescent males changes as followed in the period from 1995-1999 as compared to 1982-1994: the proportion of cases among males with IDU exposure risk, other/unknown/unspecified risk, or heterosexual contact to a person with/at high risk of HIV increased; the proportions with MSM/IDU or hemophilia exposure risks remained constant; and the proportions with MSM or transfusion/transplant exposure risk decreased.

Figure 5: Alaska AIDS cases by exposure category for adult/adolescent males first diagnosed with AIDS from 1995-1999, N=137

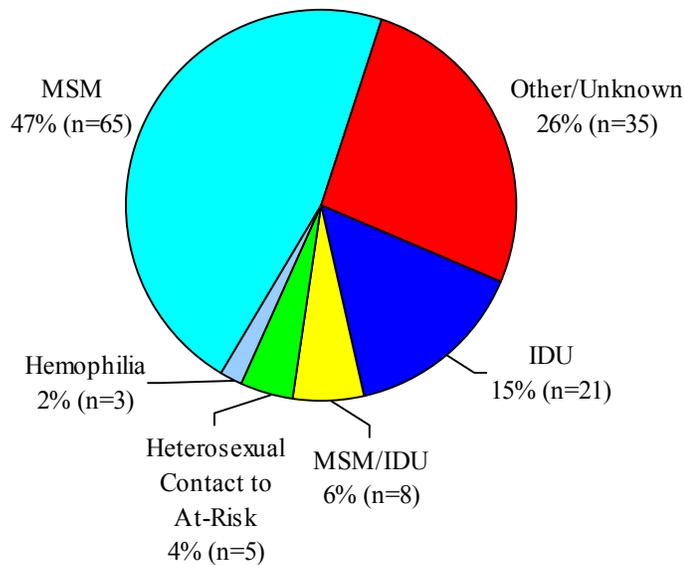
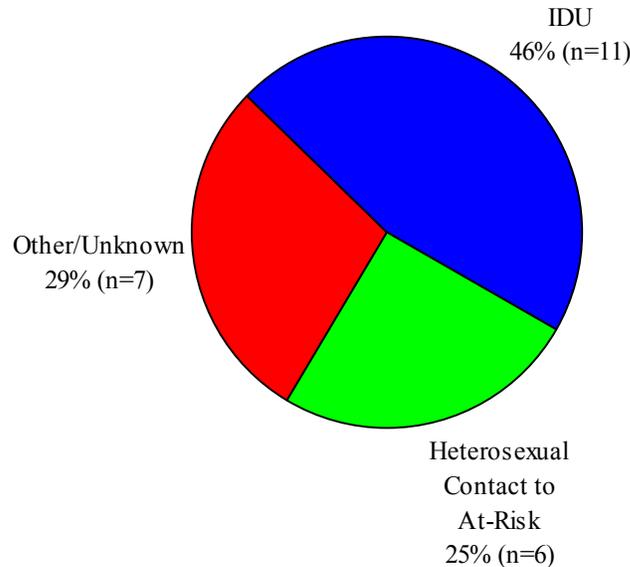


Table 10: Alaska AIDS cases in adult/adolescent females by exposure category and date of first AIDS diagnosis

Exposure Category	Alaska AIDS Cases Diagnosed from 1995-1999 in Females ≥ 13 Years	Alaska AIDS Cases Diagnosed from 1982-1994 in Females ≥ 13 Years
Injecting Drug Use (IDU)	11 (46%)	7 (21%)
Heterosexual Contact to HIV+ or Person at High Risk	6 (25%)	19 (58%)
Transfusion/Transplant	0 (0%)	3 (9%)
Other/Unknown/Unspecified	7 (29%)	4 (12%)
Total	24 (100%)	33 (100%)

The proportion of Alaska AIDS cases among adult/adolescent females in which exposure was injecting drug use increased considerably in the period from 1995-1999 as compared to the period from 1982-1994, as did the proportion with other/unknown/unspecified exposure. The proportion in which exposure was heterosexual contact to a person with/at high risk for HIV or transfusion/transplant decreased in the more recent as compared to the earlier period.

Figure 6: Alaska AIDS cases by exposure category for adult/adolescent females first diagnosed with AIDS from 1995-1999, N=24



Deaths among persons with HIV/AIDS. Data on deaths in Alaska with an underlying cause of HIV infection are shown in Table 11. These data are drawn from death certificates recorded with the Alaska Section of Vital Statistics. All Alaska residents who die, regardless of where they die, should have an Alaska death certificate, as the Alaska Section of Vital Statistics has reciprocal reporting arrangements with other states.

Table 11: Alaska resident deaths with an underlying cause of HIV infection by year of death, 1982-1999, Section of Vital Statistics, N=198

Year	Deaths with Underlying Cause of HIV Infection in that Year (ICD codes 042-044)
1982-1985	0
1986	7
1987	7
1988	7
1989	8
1990	11
1991	16
1992	20
1993	26
1994	21
1995	30
1996	16
1997	10
1998	6
1999*	13*
Total	198

*provisional data

HIV/AIDS first ranked within the top 15 leading causes of death in Alaska in 1991, and remained in the top 15 through 1995. HIV/AIDS has not ranked within the top 15 causes of death since 1995. For the population of Alaskans 25-44 years of age, HIV/AIDS was among the top 10 causes of death in 1996 but not in 1997 or 1998 (ranked data are not yet available for 1999).

Unlike the Vital Statistics data in Table 11 above, data on deaths among Alaska AIDS cases shown earlier in this Profile in Tables 3 and 4 and Figure 2 include information on deaths due to any cause in persons with HIV/AIDS. This information is drawn from Alaska death certificates as well as information from newspaper obituaries and care providers, and from other states for individuals who were not Alaska residents at the time of death. Table 4 and Figure 2 also differ from Table 11 in that for those cases known to have died, the death is shown in the year the case was first diagnosed (rather than in the year the death occurred) in order to reflect case mortality.

Estimated numbers of individuals with HIV. The State of Alaska does not produce estimates of the total number of HIV-infected persons in the state since recommended statistical estimation methods require much larger case numbers than occur in Alaska as well as other data that are not available locally. Based on national data, CDC has prepared 1998 estimates of the number of HIV-infected persons without AIDS in each state. Table 12 presents CDC's estimates of persons living with HIV (without AIDS) in Alaska in 1998. Alaska data from disease reporting through 12/31/99 for cases of HIV (without AIDS) among persons not known to have died are also presented in Table 12 for comparison.

Table 12: HIV without AIDS in Alaska

	CDC Case Estimates for HIV without AIDS, Alaska 1998	HIV Cases without AIDS Reported in Alaska through 12/31/99, Persons not Known to have Died
Sex: Female	76 (21.7%)	42 (21.2%)
Sex: Male	272 (78.3%)	156 (78.8%)
Unknown Sex		0 (0%)
Total by Sex	348 (100.0%)	198 (100.0%)
<hr/>		
Race: White	175 (50.3%)	86 (43.4%)
Race: Black	63 (18.0%)	12 (6.1%)
Ethnicity: Hispanic	41 (11.7%)	9 (4.5%)
Race: Asian	18 (5.3%)	2 (1.0%)
Race: Alaska Native	51 (14.8%)	39 (19.7%)
Unknown Race		50 (25.3%)
Total by Race	348 (100.0%)	198 (100%)
<hr/>		
	Age categories as shown:	Age at first HIV diagnosis:
		Age 0-14: 1 (0.5%)
	Age 13-19: 0 (0%)	Age 15-19: 7 (3.5%)
	Age 20-29: 44 (12.5%)	Age 20-29: 48 (24.2%)
	Age 30-36: 107 (30.9%)	Age 30-39: 66 (33.3%)
	Age 37-44: 125 (35.8%)	Age 40-44: 16 (8.1%)
	Age 45+: 72 (20.8%)	Age 45+: 17 (8.6%)
	Unknown:	Unknown: 43 (21.7%)
	Total: 348 (100.0%)	Total: 198 (100.0%)
<hr/>		
Exposure: MSM	136 (39.0%)	76 (38.4%)
Exposure: IDU	81 (23.4%)	22 (11.1%)
Exposure: MSM/IDU	29 (8.4%)	9 (4.5%)
Exposure: blood/blood products	25 (7.3%)	0 (0.0%)
Exposure: heterosexual contact to HIV+/at-risk	76 (22.0)	15 (7.6%)
Unknown Exposure Category		76 (38.4%)
Total by Exposure Category	348 (100.0%)	198 (100.0%)

Summary. The number of newly diagnosed AIDS cases per year in Alaska declined steadily after 1996. Deaths among AIDS cases also declined and HIV was not among the top 15 causes of death in Alaska from 1996-1998. New cases of HIV and AIDS continued to occur.

The proportion of Alaska AIDS cases in adult/adolescent females and in racial/ethnic minority adult/adolescents increased in the period from 1995-1999 as compared to the period from 1982-1994. Among adult/adolescent males, Hispanic, Black, and Alaska Native males are over-represented in cases of AIDS diagnosed from 1995-1999 as compared to their representation in the 1999 male population of Alaska. Among adult/adolescent females, Alaska Native females are considerably over-represented in cases of AIDS diagnosed from 1995-1999 as compared to their representation in the 1999 female population of Alaska. Asian/Pacific Islander females are slightly over represented in adult/adolescent female AIDS cases diagnosed from 1995-1999 as compared to the female Asian/pacific Islander population, although case numbers are small.

For adult/adolescent AIDS cases diagnosed in the period from 1995-1999 as compared to 1982-1994, the proportion of male and female cases with IDU exposure risk, the proportion of male and female cases with other/unknown/unspecified exposure, and the proportion of male cases with heterosexual exposure risk increased; the proportion of male cases with MSM exposure and female cases with heterosexual exposure decreased; the proportion of male cases with MSM/IDU exposure risk was unchanged, and the proportion of male and female cases with transfusion/transplant exposure declined to zero.

CHARACTERISTICS OF POPULATIONS AT RISK FOR HIV INFECTION

Overall Information on Persons with and at High Risk for HIV and AIDS

Data on all cases of AIDS first diagnosed among Alaska residents are presented in the sections above (including both those not known to have died and those known to have died). Data on prevalent HIV and AIDS cases (cases of HIV and AIDS reported in Alaska and not known to have died) are presented in the sections below. These data provide information on the characteristics of more recently infected individuals as well as the overall population of persons living with HIV and AIDS in Alaska. These data are less complete than the Alaska AIDS case data, particularly with regard to exposure category. Additionally, some of the cases included in the figures below may have moved out of state and some cases lost to follow up are no longer likely to be living.

Of the 471 HIV and AIDS cases reported in Alaska through December 31, 1999 and not known to have died, 468 were adults/adolescents (13 years of age or older) and 3 were pediatric cases (12 years of age or younger). Of the 468 adult/adolescent cases, 389 (83%) were males and 79 (17%) were females. Data on the 468 adult/adolescent cases are shown below by sex and race/ethnicity (Table 13) and sex and exposure category (Table 14).

Table 13: Adult/adolescent cases of HIV and AIDS not known to have died, by race/ethnicity and sex, reported in Alaska through December 31, 1999, N=468

Race/ Ethnicity	Males		Females		Total
	Est. # (%) Males ≥15 Years, 1999 Alaska Population**	HIV and AIDS Cases in Males ≥13 Years	Est. # (%) Females ≥15 Years, 1999 Alaska Population**	HIV and AIDS Cases in Females ≥13 Years	
White	184,341 (77%)	206 (53%)	164,202 (75%)	23 (29%)	229 (49%)
Black	11,813 (5%)	30 (8%)	8,486 (4%)	6 (8%)	36 (8%)
Hispanic Ethnicity	* (4%)	33 (8%)	* (5%)	3 (4%)	36 (8%)
Asian/Pacific Islander	10,530 (4%)	4 (1%)	11,910 (5%)	2 (3%)	6 (1%)
Alaska Native/ American Indian	33,609 (14%)	62 (16%)	34,418 (16%)	30 (38%)	92 (20%)
Unknown		54 (14%)		15 (19%)	69 (15%)
Total	240,293 (100%)	389 (100%)	219,016 (100%)	79 (100%)	468 (100%)

*Estimated male Hispanic population = 10,348 or 4% of the total 1999 Alaska male population. Males of Hispanic ethnicity are included in the numbers and percents shown for the racial categories, above.

**Population estimates are for Alaskan males age 15 and older since estimates for males 13 and older are unavailable.

Table 14: Adult/adolescent cases of HIV and AIDS not known to have died, by exposure and sex, reported in Alaska through December 31, 1999, N=468

Exposure Category	HIV and AIDS Cases in Males ≥13 Years	HIV and AIDS Cases in Females ≥13 Years	Total
MSM	188 (48%)	0 (0%)	188 (40%)
Injecting Drug Use (IDU)	45 (12%)	19 (24%)	64 (14%)
Male-Male Sex (MSM) & IDU	22 (6%)	0 (0%)	22 (5%)
Heterosexual contact to HIV+ or person at high risk	12 (3%)	23 (29%)	35 (7%)
Transfusion/Transplant	0 (0%)	0 (0%)	0 (0%)
Hemophilia	4 (1%)	0 (0%)	4 (1%)
Other/Unknown/ Unspecified	118 (30%)	37 (47%)	155 (33%)
Total	389 (100%)	79 (100%)	468 (100%)

Partner notification activities. Data from partner notification activities offer information about risk-taking behaviors among persons at greatest risk of infection (those with HIV exposure) and on individuals diagnosed with HIV. Data on 1999 partner notification activities coordinated through or conducted by the Alaska Division of Public Health's HIV/STD Program follow.

Total HIV cases diagnosed in 1999 =	29
Source of diagnosis/report:	
Provider:	24
Partner notification activity:	5

Total HIV cases participating in partner notification activities through HIV/STD Program:	14
Of 24 provider reported cases:	9
Of 5 cases newly identified through partner notification:	5

Characteristics of 14 participating infected individuals:

8 males

6 females

Risk-related information:

3 history of IDU

3 history of prostitution

1 male-male sex

2 pregnant

1 incarcerated

Characteristics of 15 nonparticipating infected individuals:

15 males

Risk-related information:

5 male-male sex

10 risks not identified

Reasons for nonparticipation:

8 declined

3 said they were notifying partners themselves

2 had moved

2 had died

The nine original infected patients participating in partner notification activities plus the five contacts newly found to be HIV infected named a total of 78 sexual and/or injecting contacts, 67 of whom were located and provided with counseling and HIV testing in 1999. Three of the contacts had been previously identified as HIV infected through activities independent of these partner notification activities. Overall characteristics of the infected individuals and their contacts are described below and in Tables 15 and 16.

Characteristics of infected individuals and their contacts:

- Without steady employment and/or living situations;
- Living in Anchorage as well as in rural areas;
- Not part of a structured environment (agency, school, treatment facility);
- Those engaging in male-male sex generally did not self identify as gay;
- Did not perceive themselves to be at risk for HIV.

The 67 exposed individuals who received risk reduction counseling and HIV testing through partner notification activities were unlikely to have been reached through any other HIV prevention services.

Table 15: Partner notification activity, 1999 (contacts and results by case)

Case	# Contacts	# Notified/Tested	# Newly Identified HIV Infected	# Previously Identified HIV infected
1	16	16	1	0
2	12	10	1	0
3	3	3	0	0
4	10	6	0	0
5	1	1	1	0
6	1	1	0	0
7	8	6	1	2
8	1	1	0	1
9	2	2	1	0
10	9	9	0	0
11	4	3	0	0
12	7	7	0	0
13	3	1	0	0
14	1	1	0	0
Total	78	67	5	3

Table 16: Partner notification activity, 1999 (contacts by race/ethnicity and age)

Age	White	Alaska Native	Black	Asian/P.I.	Hispanic	Total
13-19						0
20-24	2	2	2	1		7
25-29	13	10	1			24
30-34	11	16	2		2	31
35-39	4	7				11
40-44		3				3
45-49					1	1
50+		1				1
Total	30	39	5	1	3	78

Ryan White CARE Act services. The State of Alaska receives federal funding under Title II of the Ryan White CARE Act (RWCA) to support outpatient medical and supportive services for low income individuals with HIV infection, and supportive services for their families. RWCA service providers funded by the State (the Alaskan AIDS Assistance Association, Interior AIDS Association, and Shanti of Southeast Alaska) served 319 HIV positive clients with the following characteristics during 1999:

Sex:		
	Male:	80%
	Female:	20%
Race/ethnicity:		
	White:	59%
	Black:	10%
	Hispanic:	10%
	Asian/Pacific Is.:	1%
	Alaska Native:	20%
Enrollment:		
	New during the year:	14%
Age:		
	20 years and older:	99%
Risk:		
	MSM:	51%
	IDU:	5%
	MSM/IDU:	1%
	Heterosexual:	40%
	Other/Undetermined:	2%
HIV/AIDS status:		
	HIV without AIDS:	55%
	AIDS diagnosis:	45%

Men who have Sex with Men

Among Alaska AIDS cases in adult/adolescent males, the proportion with MSM exposure risk decreased from 71% in the period from 1982 to 1994 to 47% in the period from 1995-1999. Even with this decline, MSM remained the greatest exposure risk for males, and the proportion of AIDS cases with MSM/IDU exposure risk did not decline. As shown in Table 14, MSM exposure risk accounted for 48% (188 of 389) of all HIV and AIDS cases in adult/adolescent males not known to have died through 12/31/99. When the combined risks of MSM and MSM/IDU are considered, MSM was a risk factor in 54% (210 of 389) of HIV and AIDS cases in adult/adolescent males not known to have died through 12/31/99.

Table 17 presents data by race/ethnicity for all reported cases of HIV and AIDS with MSM exposure risk in Alaska among adult/adolescent males not known to have died through 12/31/99.

Table 17: Adult/adolescent HIV and AIDS cases with exposure of male-male sex by race/ethnicity, persons not known to have died through December 31, 1999, Alaska, N = 188

Race/Ethnicity	Total Number of Cases in Males not Known to Have Died	Number of Male Cases with MSM Risk	Percent of Male Cases in each Racial/Ethnic Category with MSM Risk
White	206	118	57%
Black	30	11	37%
Hispanic	33	19	58%
Asian/Pacific Islander	4	0	0%
Alaska Native/ American Indian	62	31	50%
Unknown Race/Ethnicity	54	9	17%
Total	389	188	48%

More than 50% of HIV and AIDS cases in White, Hispanic, and Alaska Native males not known to have died through 12/31/99 had MSM exposure risk. When MSM and combined MSM/IDU exposure risk are both considered, the proportion of cases with MSM exposure risk increases to 66% in White males and 58% in Alaska Native males (and does not change in males of other races/ethnicities).

Among reported cases of HIV without AIDS (Table 12), MSM account for 38% and MSM/IDU for an additional 5% (combined total of 43%) of all HIV cases not known to have died through 12/31/99.

Data from HIV testing activities provide additional indicator information. From 1985 through 1999, 315 of 3,092 (10.2%) men who identified their risk as MSM tested HIV positive through sites using the State Laboratory. This compares to a positivity rate of 0.5% for all individuals tested through sites using the State Laboratory. Of those males tested who identified their risk as MSM, 10.5% of White MSM, 7.0% of Alaska Native MSM, 14.3% of Black MSM, and 16.0% of Hispanic MSM were HIV infected.

The 1999 partner notification data above indicate that participating HIV positive MSM and contacts with MSM exposure to HIV did not generally self-identify as gay, and that most exposed individuals did not consider themselves to be at risk of HIV infection.

Summary. Men who have sex with men remain the Alaska population with greatest risk of HIV infection. The burden of the HIV and AIDS epidemic has shifted more heavily in recent years from White to racial/ethnic minority MSM. Some MSM engaging in high risk behavior, particularly MSM who do not self-identify as gay, do not perceive themselves to be at risk for HIV infection.

Injecting Drug Users

The proportion of Alaska adult/adolescent AIDS cases with IDU exposure risk increased from 9% in the period from 1982-1994 to 20% from 1995-1999, and the proportion of cases increased among both males and females. Among Alaska AIDS cases in adult/adolescent males, the proportion of cases with IDU exposure risk increased from 8% in the period from 1982-1994 to 15% from 1995-1999, and an additional 6% of AIDS cases in males diagnosed from 1995-1999 had combined MSM/IDU risk. Among adult/adolescent females, the proportion of AIDS cases with IDU exposure increased from 21% in the period from 1982-1994 to 46% from 1995-1999.

As presented in Table 14, a total of 14% (64) of 468 reported adult/adolescent HIV and AIDS cases in persons not known to have died through 12/31/99 had IDU exposure risk. An additional 5% (22) of the 468 adult/adolescent HIV and AIDS cases had combined MSM/IDU risk, totaling 19% of adult/adolescent cases with IDU exposure risk. Table 18 presents data by race/ethnicity on all cases of HIV and AIDS with IDU risk reported in Alaska through 12/31/99 among adults/adolescents not known to have died.

Table 18: Adult/adolescent HIV and AIDS cases with risk of injecting drug use by race/ethnicity, persons not known to have died through December 31, 1999, Alaska, N = 64

Race/Ethnicity	Total Number of HIV and AIDS Cases not Known to Have Died	Number of HIV and AIDS Cases with IDU Risk	Percent of HIV and AIDS Cases in each Racial/Ethnic Category with IDU Risk
White	229	34	15%
Black	36	4	11%
Hispanic	36	4	11%
Asian/ Pacific Islander	6	0	0%
Alaska Native/ American Indian	92	19	21%
Unknown Race/Ethnicity	69	3	4%
Total	468	64	14%

Whites accounted for the largest number of HIV and AIDS cases with IDU exposure risk, although the proportion of cases within each racial/ethnic category with IDU exposure risk was greatest among Alaska Natives. Blacks and Hispanics were also represented among cases with IDU exposure risk. When combined MSM/IDU risk is additionally considered, the proportion of total reported cases with IDU exposure risk increases to 24% in Alaska Native and 22% in White adults/adolescents not known to have died through 12/31/99 (percentages for other races/ethnicities do not change).

Among reported cases of HIV infection (without AIDS) through 12/31/99, 16% had a risk of IDU or combined MSM/IDU risk (Table 12).

Cases with IDU risk comprise 18% of adult/adolescent males with HIV and AIDS (considering both IDU and MSM/IDU) as well as 24% of cases in adult/adolescent females not known to have died (Table 14).

Data from HIV testing activities provide additional indicator information. From 1985 through 1999, 49 (1.2%) of 4,238 individuals who identified their risk as IDU tested HIV positive through sites using the State Laboratory. This compares to a positivity rate of 0.5% for all individuals tested through sites using the State Laboratory. Of those seeking testing who stated their risk as IDU, 0.9% of White IDU, 0.3% of Alaska Native IDU, 5.2% of Black IDU, and 6.0% of Hispanic IDU were HIV infected.

The 1999 partner notification data presented above indicate that most participating infected individuals and contacts with exposure to HIV did not consider themselves to be at risk of HIV infection, including those who were IDU. Participating individuals with IDU exposure risk were located in rural as well as urban areas.

HIV and Hepatitis C infection. Recent cases of hepatitis C infection in the U.S. are increasingly related to injecting drug use. All cases of hepatitis C (3,073) ever reported in Alaska were compared to all HIV cases ever reported (717 at the time this comparison was conducted). Sixty-two (62) individuals reported with hepatitis C were also reported with HIV.

University of Alaska Anchorage Drug Abuse Research Field Station (DARFS): DARFS has conducted federally funded research among IDU in Anchorage since 1991. The original 5-year+ project (“Cooperative”) enrolled 1,428 drug users, including IDU (20–30%) and non-injecting drug users (70–80%). A Needle Exchange Project (“Intervention” or NEP) begun in 1996 included only injecting drug users. Enrollment in the Intervention Project was 609 IDU, most of whom were also in the earlier Cooperative project.

There is no reliable estimate of the size of the IDU population of Anchorage. DARFS staff believed they had recruited into their studies most of the total population of IDUs in Anchorage in the lower socio-economic ranks. This was based on their seeing the same people over the years and not enrolling any new participants.

Incentive fees paid by both projects attracted individuals who needed the money (and not others) and therefore selected for lower socio-economic status. The highest proportions of DARFS participants resided in the Anchorage census areas including Mountain View, Fairview and Spenard neighborhoods. Through January 2000, approximately 60 to 70 participants in the “Interventions” Project (NEP) used the Needle Exchange site in mid-town Anchorage. (DARFS staff was unable to establish a NEP site in Mountain View.) Participants in the DARFS projects are characterized in Table 19.

Table 19: Participants in DARFS Projects in Anchorage

	Co-op #	Co-op %	NEP #	NEP %
Male	984	68.9%	468	76.8%
Female	444	31.1%	141	23.2%
Mean Age	34 years		38 years	
Black	443	31%	118	19.4%
White	619	43.4%	333	54.7%
Hispanic	36	2.5%	19	3.1%
Asian/Pacific Islander	15	1.1%	6	1.0%
Native American	280	19.6%	131	21.5%
Other	1	0.1%	2	0.3%
Refused	1	0.1%		
Never in Detox or Treatment.			233	38.3%
Yes, Detox or Treatment			376	61.7%
TOTAL	1,428		609	

Source: Personal interviews with DARFS staff, Spring 2000

HIV testing data from DARFS participants: Between 8/91 and 4/30/98, 34 (2%) of 1,794 individuals tested HIV positive. Of those, 28 (82%) were male and 6 (18%) were female. HIV positive participants included 20 Whites, 9 African Americans, 4 Alaska Natives, and 1 Hispanic. In the “Interventions” Project (needle exchange) there were no incident (newly diagnosed) cases of HIV. The 609 participants had a 70% return for follow-up. The few positives in this NEP cohort were already identified as positive during the Co-op study, or they seroconverted during the time gap between the two projects (ca. 1 year).

Alaska Division of Alcoholism and Drug Abuse (ADA) substance abuse treatment program clients with IDU history. Of 7,151 admissions to ADA funded programs in 1998, 297 (4%) used an injected drug as their primary, secondary, or tertiary drug. Of these 297 clients, 216 (73%) were admissions to facilities in the Anchorage/Mat-Su area; 44 clients (15%) were admissions to facilities in Southeast Alaska.

Summary. The proportion of Alaska AIDS cases with IDU exposure risk increased substantially among adult/adolescent males and females diagnosed in recent as compared to earlier years. IDU exposure risk was also prominent among cases of HIV and AIDS, as well as the smaller subpopulation of cases of HIV without AIDS, among persons not known to have died through 12/31/99. Numbers and proportions of HIV and AIDS cases with IDU exposure risk are greatest among Whites and Alaska Natives, although case numbers and HIV testing data substantiate risk behavior among Black and Hispanic IDU. Although the number of HIV and AIDS cases in females is smaller than in males in Alaska, IDU is a more prominent risk factor for females than males. There are IDU in rural as well as in urban areas of Alaska and even IDU with high-risk behaviors and HIV exposure may have low perception of HIV risk.

Persons at risk for HIV infection through heterosexual contact with HIV infected individuals or other individuals at high risk for infection

According to CDC's national definition, classification of exposure risk as heterosexual contact specifically requires heterosexual contact with a person known to have or be at high risk for HIV infection (for example, an injecting drug user). Among Alaska AIDS cases in adults/adolescents with an exposure risk of heterosexual contact, the proportion in males increased from 2% of cases diagnosed from 1982-1994 to 4% diagnosed from 1995-1999, and the proportion in females declined from 58% of cases diagnosed from 1982-1994 to 25% diagnosed from 1995-1999. The relatively small change in heterosexual transmission in both populations may be due, in part, to an increase in the proportion of cases classified as other/unknown/unspecified risk in the more recent as compared to the earlier time period (from 8% to 26% for males and from 12% to 29% for females).

Among reported adult/adolescent HIV and AIDS cases in Alaska not known to have died through 12/31/99, 7% of all cases (3% of male cases and 29% of all female cases) reported heterosexual exposure to a partner at high risk of HIV infection. Among all reported cases of HIV infection without AIDS in persons not known to have died through 12/31/99, 8% reported a risk of heterosexual exposure to a partner at high risk of HIV infection (Table 12).

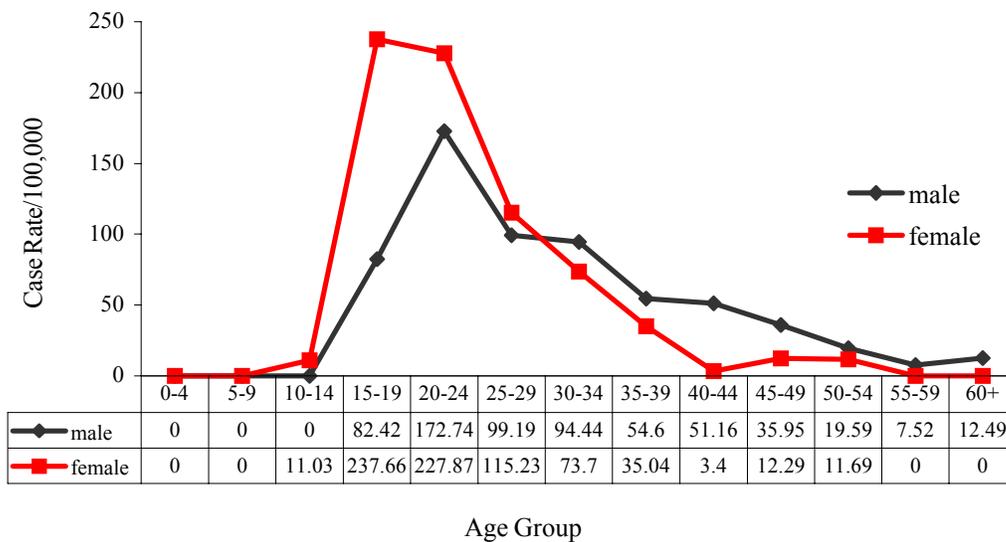
Data from voluntary HIV testing conducted in facilities using the State Laboratory provide additional indicator information. From 1985 through 1999, 1.3% (47 of 3,536) of females identifying their risk as sexual contact with a bisexual male, males and females identifying their risk as heterosexual contact with an injecting drug user, and males and females identifying their risk as heterosexual contact with an HIV positive person tested HIV positive. This compares to a positivity rate of 0.5% for all individuals tested through sites using the State Laboratory.

Sexually Transmitted Diseases. Infection with a sexually transmitted disease indicates sexual risk behavior, although the data do not show a high degree of overlap between populations with gonorrhea, chlamydia, or syphilis infections and populations with HIV infection in Alaska at this time (see data below).

Syphilis. Syphilis, and especially infectious syphilis, is relatively rare in Alaska. In 1999, 13 syphilis cases were reported in Alaska including one case of infectious syphilis. All cases were reported in individuals older than 35 years.

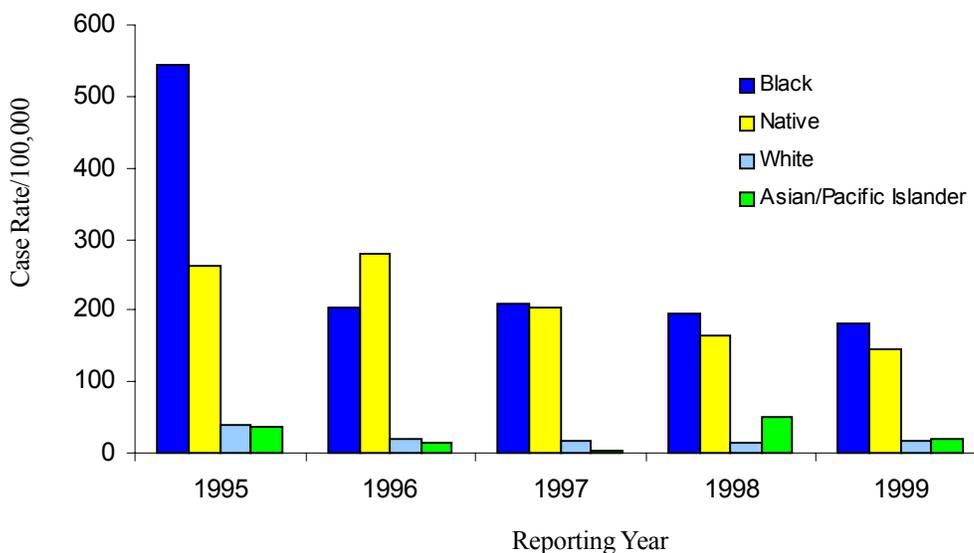
Gonorrhea. In 1999, 302 cases of gonorrhea were reported in Alaska, with 153 (51%) cases reported in females and 149 (49%) in males. Highest case rates were in males 20-24 years and females 15-19 years of age. Gonorrhea rates by gender and age are shown in Figure 7.

Figure 7: Gonorrhea Rates by Gender and Age, Alaska, 1999, N=302



In Alaska as in the U.S. as a whole, gonorrhea disproportionately affected minority populations in 1999. Gonorrhea rates by race for the period 1995-1999 are shown in Figure 8. The 1999 rates of gonorrhea among Blacks (181/100,000) and Alaska Natives (145/100,000) were over 9 times higher than in Whites (16/100,000). The gonorrhea rate for Alaska Natives decreased from 521/100,000 in 1990 to 145/100,000 in 1999. Alaska Natives comprised 17% of the state's population but accounted for 50% (n=151) of the 1999 reported cases of gonorrhea. Blacks comprised 4% of the state's 1999 population but accounted for 17% (n=50) of the reported 1999 cases of gonorrhea. Highest rates of gonorrhea occurred in Black males age 20-24 years and Alaska Native females age 15-34 years.

Figure 8: Gonorrhea Rates by Race, Alaska, 1995-1999



Chlamydia. In 1999, 1,888 cases of chlamydia were reported in Alaska for a rate of 304/100,000, ranking Alaska the 8th highest state in the U.S. Highest case rates were in males age 20-24 years and females age 15-19 years and 20-24 years. Chlamydia rates by age and gender are shown in Figure 9.

As with gonorrhea, chlamydia was reported disproportionately among racial minorities, women, and adolescents. In 1999, chlamydia rates were 7 times higher in Alaska Natives (872/100,000) and 6 times higher in Blacks (683/100,000) as compared to Whites (116/100,000). Chlamydia rates by race are shown for years 1995-1999 in Figure 10. Alaska Natives comprised 17% of the state's 1999 population but accounted for 48% (n=908) of 1999 reported cases of chlamydia. Blacks comprised 4% of the state's 1999 population but accounted for 10% (n=189) of 1999 reported cases of chlamydia. Highest rates of chlamydia occurred in Alaska Native females age 15-24 years.

Figure 9: Chlamydia rates by gender and age, Alaska, 1999
n=1,888

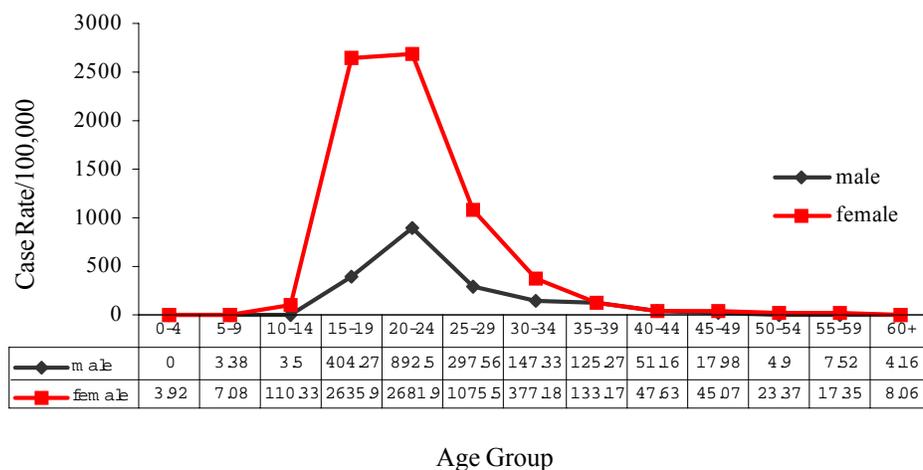
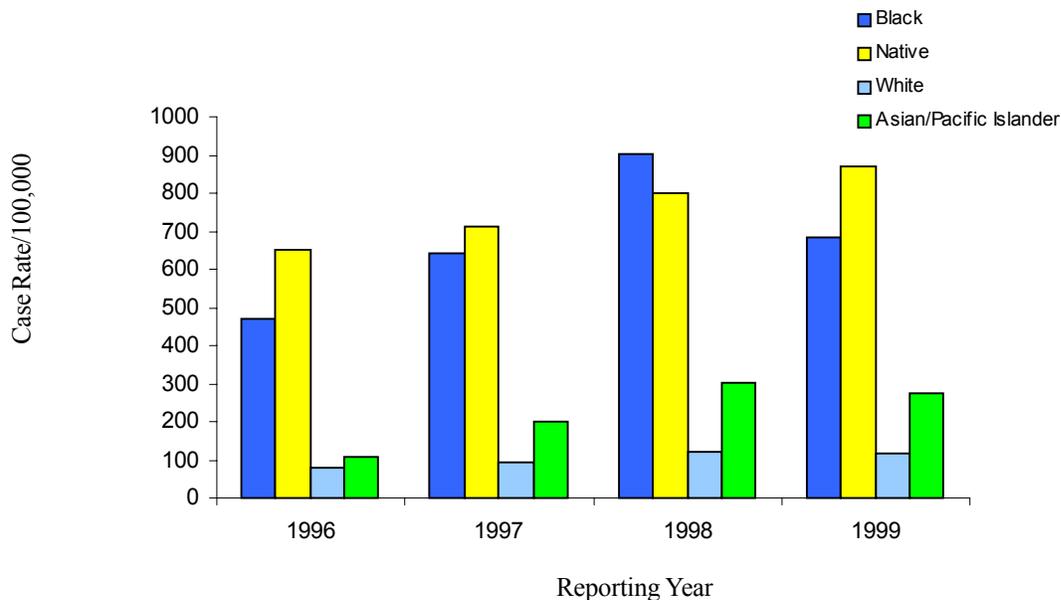


Figure 10: Chlamydia Rates by Race, Alaska, 1996-1999



HIV and STD coinfection. While persons with gonorrhea or chlamydia have engaged in unsafe sexual behavior, having these STD does not now correlate closely in Alaska with exposure to HIV or HIV infection. All cases of chlamydia (6,726 cases) and gonorrhea (7,600 cases) reported in Alaska from 1/1/89 through 12/31/99 were compared to all cases of HIV ever reported (717). Four (4) individuals ever reported with HIV had 5 cases of chlamydia reported since 1/1/89. No individual was reported with chlamydia after the reported date of HIV onset. Thirteen (13) individuals ever reported with HIV had 18 cases of gonorrhea reported since 1/1/89. Three (3) of these 13 individuals were reported with one case (each) of gonorrhea after their reported dates of HIV onset.

Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a nationally designed survey regularly conducted by the Alaska Department of Health & Social Services to gather information about the health related lifestyle choices of Alaskan adults. Over 100 health interviews are conducted each month using a standardized BRFSS questionnaire. Interviews are conducted over the telephone using randomly selected telephone numbers. Respondents are selected from among the adult members of the household (18 years of age and older). Data are statistically weighted to represent the state's population. In 1997, with additional funding from the HIV/STD Program, the BRFSS included a Sexual Behavior Module to gain additional information about sexual activity and perception of risk for HIV. The following sections summarize results of selected questions from the 1994 to 1998 Alaska BRFSS and the 1997 BRFSS Sexual Behavior Module.

Support for AIDS education in the schools. From 1995 to 1998, the majority of Alaskans (72%) consistently supported beginning AIDS education in elementary school. Less than 4% opposed AIDS education in the school.

Condom Effectiveness. The number of Alaskans who think that a properly used condom is "very effective" for preventing HIV infection has increased each year: 29.3% in 1994, 36.1% in 1995, and 47% in 1997 (not asked on the BRFSS in 1998). In 1996, a higher percent of Alaskans thought condoms were "very effective" for preventing HIV compared to the nation (Alaska 38.7%, nationwide 37.5%). The number of Alaskans who think that a properly used condom is "not at all effective" has decreased each year.

Consistent with national opinion, the majority of Alaskans would encourage a sexually active teenager to use condoms. In 1998, 89.9% Alaskans said they would encourage condom use; nationwide, 89.7% would similarly endorse condom use for sexually active teenagers. Endorsement for condom use for sexually active teenagers was slightly higher in Alaska in 1995 (91.1%).

HIV Testing Experience. The percentage of Alaskans who reported that they have had an HIV test:

- has increased over time (from 47% in 1994 to 52.8% in 1998);
- has been consistently higher than the national median (40% in 1998); and
- is higher for females (55.1% in 1998) than males (50.4% in 1998).

In 1998, a higher percentage of Alaskans of non-White and Hispanic origin report having been tested for HIV than Whites. Of those reporting ever having been tested for HIV, 50.4% of Whites, 88.4% of Blacks, 56.5% of Alaska Natives/American Indians, 56.3% of Hispanics, and 42.9% of others. Nationally also, a higher percentage of Blacks (55.8%) and Hispanics (46.4%) report ever being tested than Whites (38.4%).

Note: Alaska HIV testing data confirm that a higher percentage of the state's population of Alaska Natives and Blacks have been tested for HIV as compared to Whites.

Risk Perception. The majority of Alaskans do not consider themselves at risk for HIV infection. Between 1995 and 1998 the percentage of Alaskans reporting no chance of getting infected with HIV has been between 60 and 66%. In 1998, the percentage of Alaskans with a perception of no risk was 62.6% compared to the nationwide median of 66.8%.

A higher percentage of Alaska Natives (67.5%) rated their risk of HIV as none compared to White (62.6%), Black (55.8%), Hispanic (57%) and Other (63.4%).

Comparing responses from Alaskan men and women shows that a higher percentage of women (65.4%) perceive themselves at no risk for HIV infection than do men (60.2%). However, 2.8% of women assess their risk as high compared to 1.1% of men who perceive themselves to be at high risk.

Risk Behavior. (Source: 1997 BRFSS Sexual Behavior Module [N = 784]) Consistent with low perception of risk (see above), 90.4% of Alaskans reported that none of a list of specific HIV-related risk behaviors applied to them. Only 4% said that any of the stated risk situations applied to themselves. A risk situation applied to slightly more males (4.5%) than females (3.5%); and to more 18 to 35 year olds than older respondents. The numbers are too small and non-responses too great to say anything about similarities or differences by race/ethnicity.

Again consistent with low perception of risk, 91.1% responded that they had not been treated for an STD in the past year. 3.5% of males and 4.0% of females reported being treated for an STD. More 18 to 35 year olds were treated for STD than older respondents. More Alaska Natives (9.1%) reported being treated for STD in the preceding year than Whites (2.4%) and persons of other races/ethnicities (5.2%).

Condoms were used at last intercourse by 20.7% of respondents. Condoms were used at last intercourse by a slightly higher percentage of males (22.2%) than females (19%). More Alaska Natives (28.7%) reported using a condom at last intercourse than did Whites (18.7%) and persons of other race/ethnicity (20.6%).

The youngest age group of both adult males and adult females reported the highest percentage of condom use at last intercourse (18-24 year old males 39%; 18-24 year old females 40.1%).

The same categories of persons who reported more condom use at last intercourse (males, 18-24 year olds, and Alaska Natives) are the same categories who reported a higher percentage of multiple sex partners in the previous 12 months: 10.3% of males compared to 8.2% females; 19.0% of 18 to 24 year olds compared to 14.4% of 25 to 34 year olds, and lower with increasing age; and 16.8% of Alaska Natives compared to 8.3% of Whites and 3.9% of all others.

Comparing responses about condom use at last intercourse with number of sex partners in the past 12 months shows that persons at higher risk due to multiple sex partners are much more likely to use condoms. Sixty-five to 91.9% of the persons with multiple partners over the year used condoms at last intercourse compared to only 15.9% persons with only one partner during the previous year.

Reporting no sex partners in the previous 12 months were an equal percentage of men and women (11%); a higher percentage of 18 to 24 year olds (18.9%) than for other age categories; and a higher percentage of Alaska Natives (15.7%) than Whites (9.9%) and others (3.9%).

Summary. Although many individuals in Alaska may engage in unprotected heterosexual sex, most currently have low risk of HIV exposure during sexual contact. Males and females who have unprotected sex with partners who are HIV positive or who are current/former injecting drug users, and females who have unprotected sex with bisexual males, are at increased risk of HIV exposure in Alaska. Perception of risk is low. Because of the low prevalence of HIV in the population and because partners' risk behaviors may be unknown, partner notification services play a key role in alerting persons with heterosexual HIV exposure of their risk and offering them HIV counseling, testing, and, if infected, early access to care.

Risk of HIV infection among women in Alaska

The proportion of AIDS and HIV cases among females has increased over time, although the number and proportion of cases remain considerably smaller than in males. In the period from 1982-1994, 12% of Alaska AIDS cases were in adult/adolescent females. Among Alaska AIDS cases diagnosed from 1995-1999, 15% of cases were in adult/adolescent females. Of all reported HIV and AIDS cases among adults/adolescents not known to have died through 12/31/99, 17% were in females. Of all reported HIV cases without AIDS through 12/31/99, 21% were in females.

Data provided above indicate that most individuals exposed to HIV who participated in partner notification activities in 1999 did not consider themselves to be at risk of HIV infection. Many of these individuals were female. Low perception of risk among most females is also noted in BRFSS data (65.4% reported no risk for HIV infection), although 2.8% of females assessed their risk as high (as compared to 1.1% of males).

HIV seroprevalence in childbearing women. From 1990 through 1996, Alaska participated in the national Survey of Childbearing Women. Blood samples drawn from all Alaska newborns for metabolic screening were, after the required tests had been completed, stripped of identifiers and anonymously tested for HIV. The resulting data provided population based information about the prevalence of HIV infection among childbearing women in Alaska. From 1990 to 1996, the number of HIV positive women delivering live infants in Alaska ranged from 0 to 4 women per year (positivity range of 0.0% to 0.3% per year).

Pregnancy Risk Assessment Monitoring Survey (PRAMS). PRAMS is an ongoing national surveillance study conducted by states to collect information on maternal behaviors, attitudes, and experiences. The PRAMS includes a systematic, stratified random sample of mothers who have given birth to live infants. Response data are statistically weighted to represent the state's population of women with live births.

Beginning in 1996, surveyed mothers were asked if their prenatal health care providers had (1) counseled them about HIV prevention and (2) discussed HIV testing with them. National PRAMS data indicate that discussion of HIV testing is highly correlated with testing. In 1996, 8,198 Alaska-resident women participated in the PRAMS, 9,820 in 1997, and 9,793 in 1998. Survey results for the two HIV-related questions follow in Tables 20 and 21:

Table 20: Percent of women giving birth to live infants whose prenatal health care providers counseled them about HIV prevention

	1998	1997	1996
Yes	46.7%	42.9%	43.9%
No	50.3%	54.0%	52.4%
Skipped (no prenatal care)	0.8%	1.7%	1.4%
No response	2.2%	1.3%	2.3%

Table 21: Percent of women giving birth to live infants whose prenatal health care providers discussed HIV testing with them

	1998	1997	1996
Yes	73.7%	74.5%	76.6%
No	23.6%	22.3%	20.0%
Skipped (no prenatal care)	0.8%	1.7%	1.4%
No response	1.9%	1.5%	2.0%

Civilian Applicants for Military Service and Job Corps participants. Since October 1985, all persons applying for active duty or reserve military service (including the National Guard), the service academies, and the Reserve Office Training Corps (ROTC) in the U.S. have been screened for HIV infection as part of their entrance medical evaluation. From October 1985 through March 2000, 19,542 such individuals were tested in Alaska. Of these 3 of 16,120 males (0.02%) were HIV positive and none (0) of 3,422 women tested were HIV positive. Of the three males, one was 20-24 years and two were 30 years or older, one was White, one was Black, and one was of unspecified race.

The Job Corps is a U.S. Department of Labor occupational training program for socially and economically disadvantaged youth aged 16-25 years. The Job Corps recruits high school drop outs or high school graduates from rural and urban areas of all 50 states and U.S. territories to provide them with additional training to assist them to obtain and hold meaningful jobs. The 2,118 Alaska residents entering the Job Corps from 1990 through 1997 included 1,304 males and 814 females; 904 Whites, 141 Blacks, 972 Alaska Natives/American Indians, and 101 individuals of other races/ethnicity; and 701 individuals from Anchorage and 1,417 individuals from other areas of the state. Of the 2,118 Alaska Job Corps participants, none tested HIV positive.

Summary. The proportion of Alaska AIDS cases in adult/adolescent females has increased in recent (1995-1999) as compared to earlier (1982-1994) years, and females comprise 17% of all reported HIV and AIDS cases in Alaska among persons not known to have died through December 31, 1999. Injecting drug use is the most prominent risk for adult/adolescent females in Alaska, followed by heterosexual contact to a partner at increased risk of HIV. Perception of HIV risk is generally low and partner notification services play a key role in advising women with HIV exposure of their risk and in offering them HIV counseling and testing services to help prevent infection or identify infection early and facilitate access to care. Of all pregnant women, a relatively large proportion is likely to be screened for HIV as part of prenatal care.

Risk of HIV infection in Alaska children

Of all Alaska AIDS cases diagnosed from 1982 through 1999, 5 were in individuals younger than 13 years at diagnosis. Perinatal transmission was the mode of HIV exposure in four cases and blood products in one. Among all cases of HIV and AIDS reported in Alaska and not known to have died through 12/31/99, 3 were 12 years of age or younger.

HIV infection related to transfusion, transplantation, or blood products (clotting factor for hemophilia), historically the other major risk for children, was essentially eliminated as a risk for new infections when effective screening tests were introduced in the mid-1980s.

Summary. HIV infection is rare among children in Alaska. The greatest HIV risk for children is being born to an HIV-infected mother (perinatal transmission). The availability of antiretroviral medications effective in reducing transmission during pregnancy has helped reduce perinatal infection rates nationwide. HIV infection can be most effectively prevented in Alaska children by increasing the proportion of pregnant women who receive good prenatal care early and throughout their pregnancies, and by providing case management and ongoing prevention services for HIV positive women.

Risk of HIV infection among Alaska adolescents

From 1982 through 1999, 23 cases of AIDS were diagnosed among Alaskans 13-24 years of age. Of these, 87% (20 of 23 cases) were diagnosed in the period from 1982-1994 and 3% (3 of 23 cases) in the period from 1995-1999.

Among reported cases of HIV and AIDS in Alaska among individuals not known to have died through December 31, 1999, 8% (39 of 468) of total adult/adolescent cases were in individuals 13-24 years of age. Of these, 77% (30 of 39 cases) were in males and 23% (9 of 39 cases) were in females. Table 22 presents case data by race/ethnicity and Table 23 by exposure category.

Table 22: Adolescent cases of HIV and AIDS not known to have died, by race/ethnicity, reported in Alaska through December 31, 1999, N=39

Race/Ethnicity	HIV & AIDS Cases 13-24 Years at Diagnosis, Persons not Known to have Died
White	19 (49%)
Black	4 (10%)
Hispanic	2 (5%)
Asian/Pacific Islander	1 (3%)
Alaska Native/ American Indian	9 (23%)
Unknown	4 (10%)
Total	39 (100%)

Table 23: Adolescent cases of HIV and AIDS not known to have died, by exposure category, reported in Alaska through December 31, 1999, N=39

Exposure Category	HIV & AIDS Cases 13-24 Years at Diagnosis, Persons not Known to have Died
Perinatal	0 (0%)
MSM	17 (44%)
Injecting Drug Use (IDU)	6 (15%)
Male-Male Sex (MSM) & IDU	4 (10%)
Heterosexual contact to HIV+ or person at high risk	4 (10%)
Transfusion/Transplant	0 (0%)
Hemophilia	1 (3%)
Other/Unknown/ Unspecified	7 (18%)
Total	39 (100%)

As presented in Table 23, MSM was the exposure risk for the largest proportion of cases (17 of 39 cases or 44%) of HIV and AIDS cases among persons 13-24 years of age at diagnosis and not known to have died through 12/31/99. When combined MSM/IDU exposure risk is additionally considered, MSM was an exposure risk in 54% of cases. IDU was the exposure risk for 15% of cases. MSM, IDU, or both combined were exposure risks in 69% of cases of HIV and AIDS in persons age 13-24 not known to have died through 12/31/99.

Civilian Applicants for Military Service and Job Corps participants. (These data are also cited in the section on women, above.) From October 1985 through March 2000, 19,542 individuals applying for active duty or reserve military service (including the National Guard), the service academies, and the Reserve Office Training Corps (ROTC) were tested for HIV in Alaska. Of these 3 of 16,120 males (0.02%) were HIV positive and none of 3,422 women tested were HIV positive. Of the three males, one was 20-24 years and two were 30 years or older, one was White, one was Black, and one was of unspecified race.

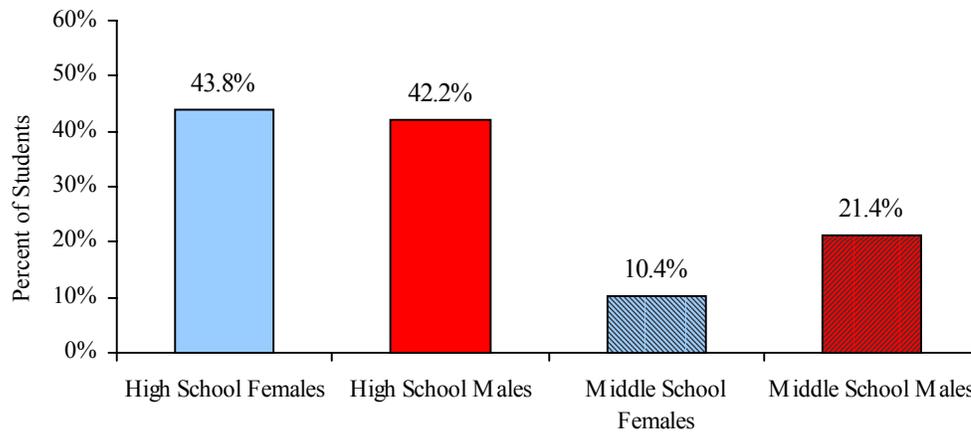
The Job Corps is a U.S. Department of Labor occupational training program for socially and economically disadvantaged youth aged 16-25 years. The Job Corps recruits high school drop outs or high school graduates from rural and urban areas of all 50 states and U.S. territories to provide them with additional training to assist them to obtain and hold meaningful jobs. The 2,118 Alaska residents entering the Job Corps from 1990 through 1997 included 1,304 males and 814 females; 904 Whites, 141 Blacks, 972 Alaska Natives/American Indians, and 101 individuals of other races/ethnicities; and 701 individuals from Anchorage and 1,417 individuals from other areas of the state. Of the 2,118 Alaska Job Corps participants, none tested HIV positive.

Sexually Transmitted Diseases. Sexually active adolescents in Alaska are at risk for STD. As discussed in the section of this Profile on heterosexual transmission, highest rates of gonorrhea in Alaska in 1999 occurred in Black males age 20-24 years and Alaska Native females age 15-34 years. Highest rates of chlamydia in 1999 occurred in Alaska Native females age 15-24 years. Infection with gonorrhea or chlamydia in Alaska is not highly correlated with exposure to HIV at this time.

Youth Risk Behavior Survey. The Youth Risk Behavior Survey (YRBS) is part of a national surveillance system implemented in 1988 by the Centers for Disease Control and Prevention (CDC). The YRBS is intended to monitor the prevalence of behaviors that influence adolescent health and also put youth at risk for the most significant health and social problems that can occur in adolescence and adulthood. Several categories included in the YRBS address sexual behaviors that can result in HIV infection, other STD, and unintended pregnancy. Data below are from the 1999 Alaska YRBS, which included 254 schools in 55 school districts statewide. (The Anchorage School District did not participate in the 1999 YRBS.)

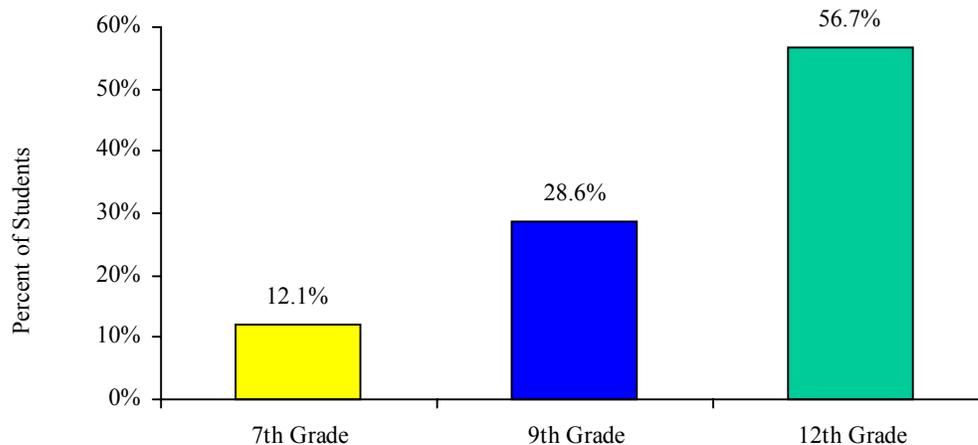
Among high school students, 42.2% of boys and 43.8% of girls report ever having sexual intercourse. Among middle school students (7th and 8th graders), 21.4% of boys and 10.4% of girls report ever having sexual intercourse (Figure 11).

Figure 11: Percentage of high school and middle school students who report ever having sexual intercourse



The rate of ever having sexual intercourse increases with increasing age, for example 12.1% of 7th graders, 28.6% of 9th graders, and 56.7% of 12th graders report ever having sexual intercourse (Figure 12). These rates are slightly lower than U.S. rates overall.

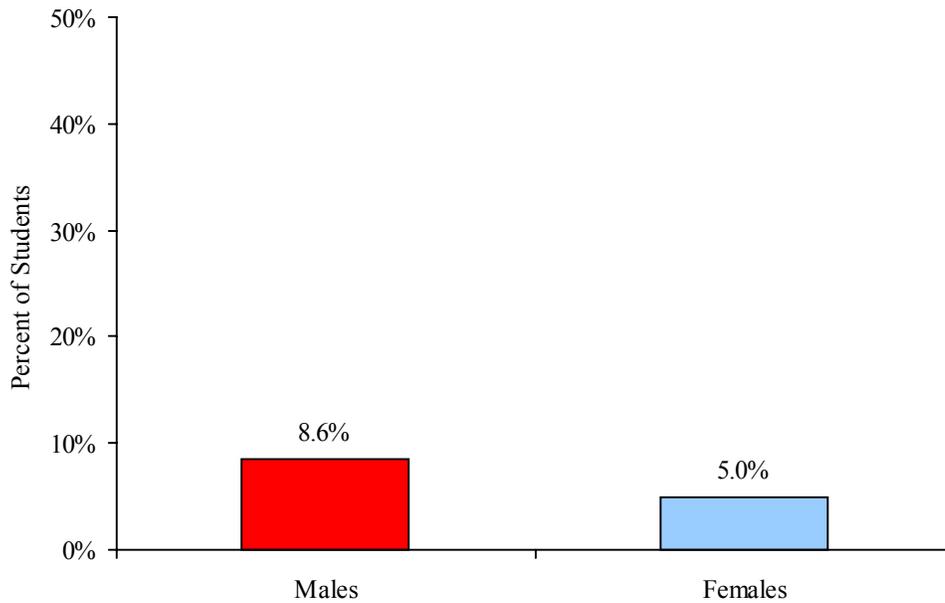
Figure 12: Percentage of high school students who report having sexual intercourse within the past three months



Among Alaska high school students, 24.0% of boys and 29.3% of girls report having sexual intercourse within the past three months.

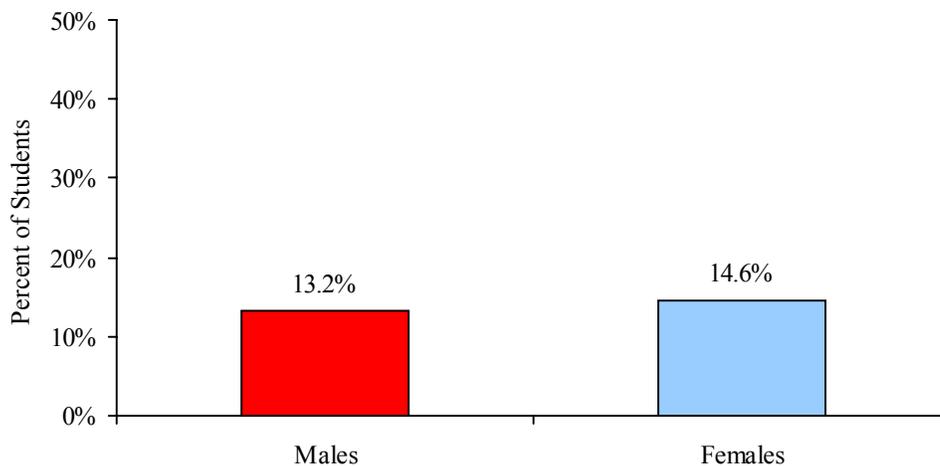
First sexual intercourse prior to age 13 was reported by 8.6% of high school boys and 5.0% of high school girls (Figure 13).

Figure 13: Percentage of high school students who report having intercourse prior to age 13



In addition, 13.2% of high school boys and 14.6% of high school girls report having four or more sexual partners (Figure 14).

Figure 14: Percentage of high school students who report having four or more sexual partners



With regard to condom use, 62.8% of high school boys and 50.0% of high school girls report using a condom during their last sexual intercourse. These rates are similar to U.S. rates overall.

The most common illegal drugs used by high school students in Alaska are marijuana, inhalants (glues, paints, and sprays), and methamphetamines (speed, crystal, crank, or ice). Heroin use is reported by 3.9% of Alaska high school students, crack use by 4.6%, cocaine use by 8.8%, and current cocaine use by 4.1%. A total of 3.5% report ever using a needle to inject an illegal drug.

Births to teens in Alaska. Birth rates among teens declined nationally and in Alaska in the 1990s, and Alaska had one of the largest percent declines in teen births of any state in the U.S. In 1997, 389 females age 18 years and younger gave birth in Alaska. Females age 15-17 years had a birth rate of 26/1,000, slightly lower than the U.S. rate in the same age group (33/1,000). Females age 18-19 years in Alaska had a birth rate of 94/1,000, slightly higher than the U.S. rate for the same age group (84/1,000).

Alaska birth rates by race for teens in the combined age group from 15-19 years were as follows in 1997:

White:	37.5/1,000 (579 births)
Alaska Native:	83.5/1,000 (380 births)
Black:	68.8 (68 births)
Asian/Pacific Islander:	63.3/1,000 (58 births)
Unknown:	(15 births)
Total:	50.2/1,000 (1,100 births)

The Alaska live birth rate for teens aged 15-19 has nearly reached the Healthy Alaskans 2000 goal of 50 per 1,000 aged 15-19. Data from the CDC indicate that the decline in births is not due to an increase in abortion, as abortion rates have also declined.

Summary. HIV infection is uncommon in young people in Alaska at this time, although sexual risk behavior is relatively common. Overall, exposure risks are similar to those in all adults/adolescents with HIV and AIDS in Alaska, and males account for 77% of cases among persons aged 13-24 years at diagnosis. Exposure risks of MSM, IDU, or combined MSM/IDU account for 69% of HIV and AIDS cases in persons aged 13-24 years at diagnosis. Risks due to blood transfusion/blood products, formerly an important risk for young males with hemophilia, have essentially been eliminated in Alaska and nationwide.

HIV risk among racial/ethnic minorities in Alaska

Among adult/adolescent females living with HIV and AIDS, Alaska Native and Black females are disproportionately affected in comparison to their representation in the state's 1999 population. Asian/Pacific Islander females are slightly over-represented in Alaska AIDS cases diagnosed in adult/adolescent females from 1995-1999 as compared to their representation in the 1999 Alaska population, although the number of AIDS cases in adult/adolescent Asian/Pacific Islander females is small. Hispanic females are represented in HIV and AIDS cases roughly in proportion, and White females are under-represented relative to their representations in the state's 1999 population.

Hispanic, Black, and Alaska Native males are over-represented among adult/adolescent AIDS cases diagnosed from 1995-1999 in comparison to their representation in the 1999 Alaska population. White and Asian/Pacific Islander males are under-represented among adult/adolescent AIDS cases diagnosed from 1995-1999 as compared to their representation in the state's 1999 population.

Partner notification data for 1999 indicated that most participating infected individuals and contacts with exposure to HIV did not consider themselves to be at risk of HIV infection. Males and females and all races/ethnicities participated in these activities in 1999. This low perception of risk is supported by BRFSS data.

Summary: As the epidemic has progressed, the proportion of AIDS cases among racial/ethnic minority persons has increased. Alaska Native and Black females and Hispanic, Black, and Alaska Native males are over-represented among persons with HIV and AIDS in Alaska in comparison to their proportionate representations in the 1999 Alaska population.

GEOGRAPHIC DISTRIBUTION OF HIV INFECTION IN ALASKA

For purposes of planning for prevention and care services, data on *prevalent* cases provide the most current picture of the distribution of HIV infection. Prevalence refers to active cases or persons living with an illness. The closest measure of prevalence for HIV infection in Alaska is the total number of reported cases of HIV and AIDS minus those who are known to have died.

Geographic location refers to the place of residence at the time of first diagnosis of AIDS for persons with AIDS, the time of first HIV diagnosis for persons with HIV and not AIDS, or, lacking that information, the place of residence subsequent to diagnosis.

The following description of the geographic distribution of HIV infection in Alaska uses data on place of residence at diagnosis of persons who have been reported with HIV or AIDS and who are not known to have died. Persons included in these figures could have moved out of state or moved within the state and the data may include deceased persons whose death has not been ascertained. With these limitations, the following description of 471 cases is the best approximation of the current distribution of persons with HIV in Alaska.

As would be expected, the majority (81%) of these cases of HIV and AIDS are in persons who resided in one of the three most populous urban centers (Anchorage, Fairbanks, and Juneau) at the time of diagnosis. The three urban centers combined also have the highest prevalence of HIV at 101.8 per 100,000 population. Table 24 shows the number, percent and prevalence per 100,000 for the cases of HIV and AIDS not known to have died.

Table 24: HIV and AIDS cases reported in Alaska in persons not known to have died, number and prevalence rate through 12/31/99 (N=471)

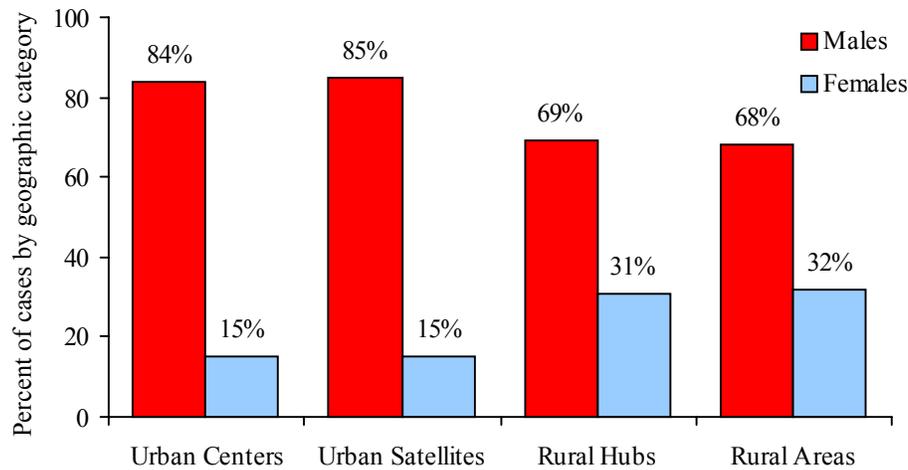
Geographic Category	All HIV and AIDS Cases Not Known to Have Died 1982 through 12/31/99 N=471			Denominator for prevalence calculation
	Number	%	Prevalence per 100,000	
Urban Centers	380	81%	101.8	373,353
Urban Satellites	62	9%	60.2	102,964
Rural Hubs	39	5%	63.7	61,224
Rural Areas	32	4%	37.9	84,459
Out of state	3	.6%	—	
Unknown	2	.4%	—	
Total	471	100%	75.7	622,000

In the urban centers, 16% of all cases are in females, and in urban satellites 15% of all cases are in females. This mirrors the national gender distribution of HIV and AIDS cases. Cases in rural hubs and rural areas have a much higher proportion of cases among females: 31% of cases in rural hubs are female and 32% of cases in rural villages are female. Table 25 and Figure 15 show the distribution of cases of HIV and AIDS cases in males and females by geographic category.

Table 25: HIV and AIDS cases in persons not known to have died, by gender by geographic category, through 12/31/99 (N=471)

Geographic Category	All HIV and AIDS Not Known to Have Died 1982 through 12/31/99 N = 471			
	Males		Females	
	Number	% of row total	Number	% of row total
Urban Centers	320	84%	60	16%
Urban Satellites	35	85%	6	15%
Rural Hubs	18	69%	8	31%
Rural Areas	13	68%	6	32%
Out of state/ Unknown	4		1	
Total	390		81	

Figure 15: HIV/AIDS in persons not known to have died, by gender by geographic category



The distribution of the 380 cases in the Urban Centers by race/ethnicity (Table 26) shows that Alaska Native, Black, and Hispanic men, and Alaska Native and Black women are over-represented in the HIV and AIDS cases relative to their proportions in the population.

Table 26: HIV and AIDS cases in persons not known to have died, urban centers by race/ethnicity, through 12/31/99 (N= 380)

Race/Ethnicity of Living HIV/AIDS Cases – Urban	Males		Females		Total	
	Number	%	Number	%	Number	%
White	169	52.8%	17	28%	186	48.9%
Black	27	8.4%	6	10%	33	8.7%
Alaska Native/Native American	50	15.6%	21	35%	71	18.7%
Asian/Pacific Islander	3	0.9%	1	1.6%	4	1.1%
Hispanic	28	8.8%	3	5%	31	8.2%
Unknown	43	13.4%			55	14.5%
Total	320	84%	60	16%	380	100%

Table 27 shows the distribution of the cases by exposure category by geographic category. Caution must be used in interpreting these data due to small numbers and the high number of cases for which exposure category is other/unknown/unspecified. These data indicate that:

- MSM is the predominant exposure category in all geographic categories.
- A higher proportion of cases in urban areas are among MSM than in other geographic categories.
- Heterosexual transmission accounts for a higher proportion of cases in rural hubs and villages than in urban centers and urban satellites.
- Cases attributed to injecting drug use are present in each of the geographic categories. Cases with identified IDU exposure account for a greater proportion of cases in urban satellites than elsewhere.

Table 27: Exposure category of adult/adolescent cases of HIV and AIDS not known to have died, 1982 through 12/31/99, by geographic category (N = 465; excludes 1 pediatric case by perinatal transmission and 5 out-of-state/unknown cases)

Exposure Category	Urban Centers		Urban Satellites		Rural Hubs		Rural Villages		Total
	#	%	#	%	#	%	#	%	#
MSM	164	43.2	9	22	7	27	6	31.6	188
IDU	48	13	8	19.5	6	23	2	10.5	64
MSM & IDU	18	4.7	2	4.8	2	7.7	0		22
Heterosexual contact	23	6	1	2.4	6	23	4	21	35
Hemophilic	3	0.8	1	2.4	0		0		4
Other/Unknown/Unspecified	123	32	20	49	5	19.2	7	37	157
Total	379	100	41	100	26	100	19	100	465

The data on the proportion of cases by race/ethnicity in each of the geographic categories (Table 28) contradicts a common misperception that rural cases imply Alaska Natives and that urban cases are non-Native. In rural hubs and villages, Alaska Natives comprise slightly more than a third of HIV/AIDS cases. In urban centers, Alaska Natives are over-represented among persons with HIV/AIDS as are Blacks and Hispanics.

Table 28: Race/ethnicity of HIV/ AIDS cases not known to have died, 1982 through 12/31/99, by geographic category (N = 466; excludes 5 out-of-state/unknown cases)

Race/Ethnicity of Living HIV/AIDS Cases	Urban Centers		Urban Satellites		Rural Hubs		Rural Villages		Total
	#	%	#	%	#	%	#	%	#
White	186	48.9	25	61	12	46.2	6	31.6	229
Black	33	8.7	1	2.4	0		2	10.5	36
Alaska Native/ Native American	71	18.7	5	12.2	10	38.5	7	36.8	93
Asian and Pacific Is.	4	1.1	0		0		1	5.3	4
Hispanic	31	8.2	0		3	11.5	1	5.3	36
Unknown	55	14.5	10	24.4	1	3.8	2	10.5	68
Total	380	100	41	100	26	100	19	100	466

CONCLUSIONS

The prevalence of HIV infection in Alaska is relatively low, although new cases of HIV and AIDS continue to occur. As is the case nationally, the epidemic disproportionately affects males in Alaska.

The greatest exposure risk in Alaska remains male-male sex, and an increasing proportion of HIV cases in adult/adolescent males is among racial/ethnic minority MSM. MSM is the predominant exposure risk in all geographic categories although a higher proportion of urban than other areas' cases is among MSM. Among young males (13-24 years) MSM is the predominant exposure risk. MSM who do not self-identify as gay may have low perception of risk. The Alaska experience is consistent with national trends and the importance of prevention activities for MSM is highlighted by recent national data indicating increased risk behavior in this population.

Injecting drug use is an important exposure risk for HIV in all areas of Alaska. IDU exposure risk accounts for a greater proportion of HIV and AIDS cases in urban satellites than in other areas, although cases related to this exposure risk are found in all geographic categories. IDU exposure risk accounts for the greatest proportion of female HIV and AIDS cases.

The combined exposure risks of MSM and IDU account for a relatively small but significant proportion of Alaska HIV and AIDS cases. National studies indicate high levels of risk behavior in MSM/IDU and indicate that this population acts as an important bridge for HIV exposure across the populations of MSM, IDU, crack users, and women.

Heterosexual contact with a person with or at high risk of HIV infection constitutes an important exposure risk, and is more prominent for females than males with HIV and AIDS in Alaska. Heterosexual risk accounts for a higher proportion of cases in rural hubs and villages than in urban centers and urban satellites. Perception of risk is generally low. Nationally, heterosexual contact to a person with or at high risk for HIV accounts for an increasing proportion of HIV and AIDS cases in females.

The proportion of HIV and AIDS cases in females, although much smaller than the proportion in males, is increasing in Alaska as well as in the rest of the nation. Alaska Native and Black females are disproportionately represented among cases of HIV and AIDS in Alaska. Nationally, HIV and AIDS disproportionately affect Black and Hispanic women and, while the numbers of cases are low in Alaska, it is reasonable to believe that prevention efforts are warranted for all racial/ethnic minority women at increased risk.

The predominant exposure risk for HIV and AIDS in children in Alaska and the rest of the nation is perinatal transmission from a mother with HIV infection. There are few cases of HIV and AIDS in Alaska children. Preventing perinatal transmission is most effectively addressed through increasing the proportion of women participating in prenatal care and providing case management and supportive services for HIV positive women.

Adolescents and young adults in Alaska account for a relatively small proportion of HIV and AIDS cases. Risk behavior, especially sexual risk behavior is prevalent in youth, and Black and Alaska Native youth are disproportionately represented among cases of chlamydia and gonorrhea. MSM is the most prominent exposure risk in HIV and AIDS cases among persons 13 to 24 years of age.

The proportion of HIV and AIDS cases in racial/ethnic minorities has increased as the epidemic has progressed over the years. Alaska Native and Black females, and Hispanic, Black, and Alaska Native males are over-represented among persons with HIV and AIDS in Alaska in comparison to their respective representation in the Alaska population.

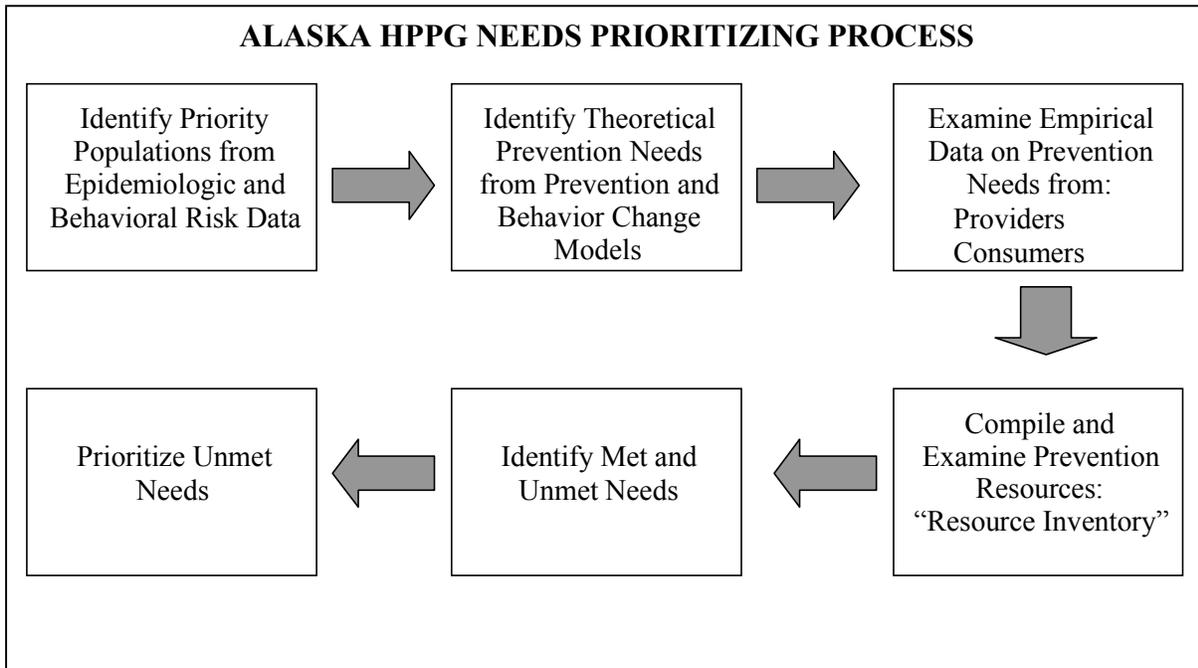
HIV positive individuals are an extremely important population for both preventing further transmission of HIV infection and for slowing progression to AIDS. Fortunately, the availability of increasingly effective therapies for HIV disease has contributed significantly to longer, healthier lives for many infected individuals. It is very important to increase the proportion of infected individuals who are aware of their HIV status and who participate in medical care, treatment, and other services supportive of primary and secondary prevention. Because of the low prevalence of HIV in Alaska and because partners' risk behaviors may be unknown, partner notification services play a key role in early diagnosis and access to care, as well as in averting further transmission.

From consideration of these data, the Alaska HIV Prevention Planning Group identified seven priority populations. Prevention interventions are deemed important for each priority population, so the following are not listed in any order of priority:

- Young adult men who have sex with men (MSM);
- Non-gay identified MSM;
- Ethnic minority MSM (Black, Alaska Native, and Hispanic);
- Injecting Drug Users;
- Heterosexual adults, especially Alaska Native and other ethnic minority women, with partners who are HIV positive or at high risk for HIV infection;
- Youth at increased risk due to sexual risk behaviors and other indicators of vulnerability;
- HIV positive persons are also a priority population for primary prevention, i.e., interventions to help prevent transmission of HIV, and as a focus of secondary prevention to slow progression to AIDS through referral to health care, treatment and other support services.

Section III. Needs Assessment and Needs Prioritization

This section describes the steps by which the Alaska HPPG developed a list of prioritized HIV prevention needs as depicted in the following flow chart.



Identification of Priority Populations

At their February 2000 two day meeting, the HIV Prevention Planning Group (HPPG) reviewed the most current data on HIV and AIDS in Alaska, STD data, and behavioral risk data from the Alaska BRFSS and preliminary data from the 1999 Youth Risk Behavior Survey. These data are included in the Epidemiologic Profile in Section II. On the basis of these data, the HPPG identified the following priority behavioral risk populations:

- injecting drug users (IDU);
- young adult men who have sex with men (MSM);
- ethnic minority MSM;
- MSM who do not identify as gay;
- heterosexual adults, especially Alaska Native and other ethnic minority women, with sexual partners who are HIV positive or at high risk of HIV infection (IDU and bi-sexual males);
- HIV positive persons; and
- Youth at increased risk due to sexual risk behaviors and other indicators of vulnerability.

A Theory-based Approach to Needs Assessment

To assess the HIV prevention needs of the seven priority populations, the Alaska HPPG began with the identification of factors that facilitate prevention. Prevention models that informed this step in the process are CDC's SAFE model (Sero-status Approach to Fighting the HIV/AIDS Epidemic) and theoretical models of behavior change based on behavioral and social science research.

The SAFE model promoted by CDC recommends that persons with risk factors learn their HIV status. If positive, a person should utilize health care and drug therapy, and HIV prevention services to prevent transmission; if HIV negative, access prevention services to adopt and maintain risk reduction. (See Figure 21 in Section V.)

Models of behavior change that have been applied to HIV prevention include: the Health Belief Model; Theory of Reasoned Action; Social Cognitive Theory; the AIDS Risk Reduction Model; Diffusion of Innovation; and Harm Reduction Model. The National Commission on AIDS has summarized the findings of behavioral science research on behavior change, identifying eight factors that contribute significantly to behavior change. The research suggests that a person is more likely to lower his or her risk of HIV infection if he or she:

- believes that the advantages of making a change in behavior are greater than the disadvantages;
- has formed a strong intention to change;
- has the skills to perform the behavior;
- believes he or she can make a change;
- believes that the changed behavior will more likely produce a more positive than negative emotional response;
- believes that the performance of the new behavior is consistent with his or her self-image;
- perceives that there is social support for the behavior change; and
- experiences no environmental barriers blocking the behavior change.

The Transtheoretical or "Stages of Change" Model (Prochaska and DiClemente, 1983) proposes that behavior change occurs in steps, starting with lack of awareness or denial of risk, and lack of commitment to change, proceeding to intention to change, initial steps to change, and finally a maintenance stage. Interventions are most effective if the methods and messages are tailored to the specific needs and stage of change of the individual.

From these models, the following theoretical HIV prevention needs were derived:

- awareness of risk and risk behaviors;
- knowledge of HIV status (HIV counseling and testing and partner notification);
- supports and skills to initiate and sustain healthier behaviors; and
- access to condoms, and for IDU, access to sterile needles and syringes.

The HPPG also identified system needs important to help individuals to initiate and sustain behavior change: access to substance abuse treatment, mental health services, prevention interventions in correctional facilities, and housing and health care for HIV positive persons.

With these theoretical needs as a starting point, the HPPG then considered empirical data and their own knowledge of and experience with the priority behavioral risk populations to determine which of these theoretical needs apply to each of the priority populations and what other prevention needs can be identified.

Empirical Data on Prevention Needs

Providers of HIV prevention and related services to populations with risk behaviors, and potential consumers of prevention activities, i.e., persons with risk behaviors, are sources of empirical data on prevention needs. The HPPG members examined data on needs for each of the seven priority behavioral risk populations. Data sources included:

- the Comprehensive HIV Prevention Plan 1997-2001 priorities;
- Year 2000 HIV/STD Program Prevention Plan objectives;
- the RWCA Alaska Statewide Coordinated Statement of Need, 1998;
- data from prevention activities carried out by the HIV/STD Program;
- statements of need from grantee applications for funding by the HIV/STD Program;
- data from prevention interventions carried out by grantees;
- utilization data and data on interventions provided through state agencies (Public Health Nursing, Department of Corrections, Division of Alcoholism and Drug Abuse, Department of Education and Early Development, and Division of Mental Health and Developmental Disabilities);
- information on interventions by community-based organizations directly funded by CDC;
- utilization data from Northern Exchange, a syringe exchange program; and
- data from the University of Alaska, Drug Abuse Research Field Station (DARFS), two multi-year NIDA-funded research projects on IDU in Anchorage.

These sources provided good utilization data on prevention services and programs serving persons at risk such as substance abuse treatment programs and correctional facilities. Providers of HIV prevention services contributed observations about needs and barriers to prevention for specific priority behavioral risk populations. Research conducted on IDU in Anchorage by DARFS projects provided the most in-depth, primary data on one of the Alaska priority populations. Other population-based data providing indicators of needs are behavioral risk factor data from the Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance System summarized in the Epidemiologic Profile in Section II. Below are summarized some of the salient characteristics relevant to HIV prevention of the Alaska priority populations.

Men Who Have Sex With Men

Although epidemiologic data on recently diagnosed HIV infection indicate continued risk behavior, community based organizations engaged in HIV prevention report lack of participation in HIV prevention activities. There is concern among providers and some members of the gay community that advances in anti-retroviral therapies have contributed to complacency about HIV transmission risk among gay men. One CBO reported a perceived invulnerability of young MSM and found an unwillingness of MSM to discuss sexual behaviors in a group of peers. Other CBOs have been unsuccessful in recruiting participants to group activities. Outside of Anchorage, there are no gay bars or other public places recognized in the community as a place for gay men to socialize, making MSM outreach more difficult. There is considerable interest in Anchorage for a gay community center, but presently there is no place in Anchorage or elsewhere for socializing in an alcohol-free environment specifically for gay and bi-sexual persons. In all communities, reaching MSM who do not identify as gay is problematic. Anchorage has several public sex environments where outreach is possible, but even there, distributing condoms and engaging contacts in dialogue about risk is very difficult. Outreach and prevention education efforts aimed at broader populations such as homeless and incarcerated men and substance abusers reach some MSM who do not identify as gay and who are unlikely to avail themselves of interventions specifically recruiting MSM. HIV counseling and testing is currently the most intensive intervention

accessed by MSM, providing individualized risk reduction counseling. Partner notification activities over the past year indicate that many HIV positive men and the men they named as sex partners did not identify as gay. Partner notification remains the most effective way of reaching MSM who are at highest risk, i.e., those who have been exposed through sexual contact to a person with HIV infection, and one of the few ways of reaching non-gay identified MSM and MSM in more rural areas.

In 1995 focus groups were conducted in Anchorage, Fairbanks, and Juneau to get input from gay men about needs and preferences for HIV prevention services. During the planning process in 2000, the HPPG identified the need for current input from MSM, especially the generation of young gay, bi-sexual, and questioning youth coming of age in the last five years. There is also a need for input about attitudes towards HIV risk and risk reduction from older men in this era of advanced HIV therapies. In 2000 and 2001, data on attitudes, needs, and intervention preferences of gay and bi-sexual men will be collected through a combination of focus groups, interviews, and survey methods. These data will inform the 2001 update of the Comprehensive HIV Prevention Plan and will help guide future prevention activities for MSM in Alaska.

Injecting Drug Users

Two multi-year research projects on IDU in Anchorage through the Drug Abuse Research Field Station (DARFS) provide the most in-depth data on IDU in Alaska. Quantitative data from DARFS studies are included in the Epidemiologic Profile in Section II. Below is summarized qualitative data from the research projects obtained for the HPPG through interviews with DARFS research staff and published results.

Observations about injecting practices in Anchorage: (data from DARFS Co-operative Project).

There is no shooting gallery situation in Alaska. The networks of sharing are very small, i.e., two or three people at a time; often a couple in a male/female sexual relationship. People use the drug in their home, car, or hotel room, depending on their money situation. In summer, they also shoot up outside, in parks or cars. Approximately 75% of the women exchange sex for money and then buy drugs with the money. Women are more likely to be injected by a male than visa-versa, i.e., the male administers the drug either sharing his rig with her or by injecting her with her own. Women don't usually inject the male partner. Women are more likely than men to inject with more people in the immediate environment, i.e., are more social in their injecting. Therefore, women are more likely to have used a needle after someone else has used it. A couple in a sexual relationship is unlikely to regard mutual use of the same needle/syringe as "sharing" needles. "Sharing needles" in the parlance of HIV risk reduction, as in something to be avoided, refers to sharing with someone who is not your primary intimate partner.

Few of the DARFS projects' clients use heroin exclusively, but staff observed differences between exclusively heroin users and other IDU. Heroin use is at a maintenance level-steady, predictable use, daily, timed, planned and more solitary. On the other hand, cocaine injecting is characterized by sporadic bingeing, more injections than heroin in a concentrated period of time, and it is more spontaneous, a matter of happenstance. Cocaine injecting is more likely done in a group with more sharing of works. Most IDU who use heroin also inject cocaine. They do not smoke crack. Speedball (heroin and cocaine mixed together in the same syringe) is not often done. Amphetamine use is not reported much in Anchorage even though it is very prevalent in Seattle.

Condom use: (data from DARFS Co-operative Project). When asked if they used a condom during the last time of intercourse, 8% of IDU said "yes" with main sex partner; 35% said "yes" with casual partner, including transactional sex. Anchorage data were the same as national data on the difference between use with steady vs. casual partners. The barrier to use in main partner relationships is that requesting condom use violates the level

of attachment and trust expected in a steady relationship. “If I ask my partner to use a condom, he/she will get suspicious.” Both men and women reflected this reluctance to use condoms with a main partner. On average, 17% of the women reported condom use at most recent intercourse (regardless of relationship to the partner).

There was a condom use efficacy scale on the questionnaires administered to IDU. Respondents were asked: “Could you ask your partner to use a condom if you wanted to?” Respondents consistently scored high (4 or 5 on a 1 to 5 scale) and they consistently reported perceiving more benefits than barriers to using a condom. Yet, reported condom use was low.

In focus groups conducted by DARFS researchers with Alaska Native women IDU or partners of IDU, women indicated that their main HIV prevention strategy was to get HIV tested frequently. They interpreted repeatedly testing HIV negative as validation that they had been adequately protecting themselves from infection. They continued to report risk behavior after receiving HIV counseling and testing.

DARFS staff found the drug using population to be complacent about HIV. Drug users expressed great concern about hepatitis C (HCV) infection and they reported knowing/seeing first hand the health consequences of HCV infection.

Investigators examined patterns of sexual behavior and condom use among 1,124 Black, White, and Alaska Native drug users. They reported: “Sex partner pairs involving a White man and an Alaska Native women were frequently reported. Level of condom use within these pairs was significantly lower than within all other pairs. The implication [is] a potential vector of HIV transmission from White, drug using men to Alaska Native women” (Fenaughty, Fisher, Cagle 1998).

Compared to IDU in Columbus (Ohio), Denver, Long Beach and New Orleans, Anchorage IDU had significantly higher educational attainment (87% high school graduate, GED, or post-secondary education) and the highest reading level scores (grade 9.2 to 10.1) (Johnson, Fisher, Davis, et al. 1996).

IDU in Fairbanks. Data on IDU in Fairbanks come from the local ASO serving that community. They reported that 19% of their HIV+ clients are IDU and that 63% of women accessing the ASO’s services in 1999 were either IDUs or partners of IDUs. IDUs are struggling with a variety of other health and social issues that make it difficult for them to access care.

Heterosexual Adults, Especially Alaska Native and Other Ethnic Minority Women

Primary data on prevention needs and preferences of this population are scarce and difficult to obtain. Data from partner notification activities indicate that most women whose sole risk is heterosexual contact and who test HIV positive or who are named as partners of HIV positives are unaware of their risk. One of the ASOs reported that women clients expressed ignorance of their partners’ risk behavior or HIV status prior to the women’s own HIV diagnosis. This indicates that women are unlikely to avail themselves of HIV prevention activities specifically recruiting women who perceive themselves at risk. Rather, HIV prevention efforts must reach out to vulnerable populations of women. Increased vulnerability comes from substance abuse other than from injecting drugs or sharing works, homelessness, survival sex (exchanging sex to meet material needs), sexual abuse and domestic violence, and from sexual partners who use drugs. One ASO reported that over half of the women they served have reported past or current experience with domestic violence or sexual abuse. A 1999 survey of homeless persons in Anchorage found that 4% (4 of 100) self-reported being HIV positive. A study of violence against women in Anchorage found that Alaska Native women were disproportionately

victimized by rape. Women are also vulnerable from their own use of drugs or that of their partners. In Fairbanks, 63% of women accessing the ASO's services in 1999 were either IDU or had sexual partners who were IDU. Drug use also contributes substantially to transactional sex as indicated by the DARFS data cited above. Among women incarcerated in Alaska, drug related crimes are the leading reason for incarceration.

Women need partner notification services and routine, voluntary prenatal screening to reach women who may be at risk but who are unaware of their risk and so would not otherwise seek HIV testing or prevention counseling. Prevention interventions should be incorporated into services reaching women at increased risk such as substance abuse treatment programs, correctional facilities and community residential centers (pre-release programs), and programs for homeless and victimized women. Needed also are HIV counseling and testing, especially in non-clinic settings outreaching to homeless and substance abusing women and sex workers, and provision of or referrals for HIV testing for women receiving treatment for STDs.

Youth at Increased Risk

The HPPG feels very strongly that all youth need education about HIV risks and prevention. The HPPG strongly endorses age-appropriate HIV awareness and prevention in the context of school health education at all grade levels. Increasingly, an HIV prevention component is available in the upper grade levels in Alaska schools. In the 1998 Alaska School Health Profile survey, principals and lead health educators responded "yes" to the question: "Is required HIV education taught in any of the following grades in this school?" as follows: 6th grade = 29%; 7th grade = 41%; 8th grade = 41%; 9th grade = 57%; 10th grade = 56%; 11th grade = 44%; and 12th grade = 41%.

For purposes of making recommendations for the allocation of the limited CDC HIV prevention funds, the HPPG priority is on youth with increased risk due to sexual behavior, substance abuse, or other indications of vulnerability such as victimization or involvement in illegal activity that has led to adjudication. YRBS data, teen pregnancy rates, and STD morbidity data (see Section II, Epidemiologic Profile) indicate the prevalence of sexual activity among adolescents. CBOs serving youth report that disenfranchised youth (i.e., school dropouts, homeless and runaway youth, gay or bi-sexual youth, substance abusers and juvenile offenders) need HIV prevention and education services easily accessible through programs that address their broader needs. Knowledge of HIV cannot be assumed and myths and misinformation persist, so activities that increase awareness of HIV risk, teach risk reduction skills, and provide accurate information about HIV testing are continually needed. Reluctance to access health care in clinical settings for sexuality-related issues, and embarrassment about purchasing condoms, mean that high risk youth need HIV testing, STD screening and access to condoms through alternative sites.

HIV Positive Persons

Advances in anti-retroviral therapies since 1996 have resulted in longer and healthier lives for persons with HIV infection. Nationally, there is an increased awareness of the need for services to help HIV positive persons reduce their risk of transmitting HIV (primary prevention) and to prevent or slow progression to AIDS through referral to health care, treatment and other support services (secondary prevention). Yet, nationally, there is little empirical evidence on the effectiveness of prevention interventions for HIV positive persons. In Alaska, ASOs have primarily focused on assessing and addressing care needs of their HIV positive clients. They have reported system needs for positive clients including mental health services and substance abuse counselors with specific training and sensitivity for HIV-related issues. The Alaska RWCA Statewide Coordinated Statement of Need in 1998 identified that co-occurrence of mental illness or substance abuse creates obstacles to adopting and maintaining risk reduction for HIV positive persons. Homelessness also contributes to engaging in risk

behaviors as well as placing additional strains on the health of an HIV positive person. ASOs also report difficulty engaging HIV positive persons in individual or group prevention health education and risk reduction activities when they are feeling healthy.

The HPPG recognizes the need for consumer input into the development of prevention services for HIV positive persons in Alaska. Assessing the prevention needs and preferences of HIV positive persons and the resources available to meet those needs is a priority activity for late 2000 and early 2001.

HIV Prevention Resources

To assess the resources in Alaska currently available to provide HIV prevention interventions and other supports to reduce risk behaviors, an HIV Prevention Resource Inventory was compiled using a format recommended in “Assessing the Need for HIV Prevention Services: A Guide for Community Planning Groups” (AED 1999). The Resource Inventory lists, by geographic area, organizations and contact information, the prevention focus, priority behavioral risk populations, types of intervention provided, and source and amount of funding. Supplemental resource lists appended to the Resource Inventory provide agency names and contacts for additional resources that currently or potentially provide HIV prevention activities. The resources that are listed are those available in the first half of the year 2000 at the time the HPPG was conducting the needs assessment process. The Resource Inventory is for planning purposes and it is not intended as an up-to-date resource guide since providers and funding amounts will change over time. However, the Resource Inventory is included with this document (Appendix 2) because it is a good representation of the overall resources presently available and that can be anticipated for HIV prevention in Alaska through the year 2003. Although some of the specific contacts and amounts are likely to change over the course of this multi-year plan, the agency and organization listings are useful for consumers, communities and other providers seeking information about HIV prevention and care services in their own or other locations. The Resource Inventory also identifies agencies that have the potential for further involvement in HIV prevention. Although not presently funded to provide HIV prevention, these agencies serve populations that may be at risk for HIV infection, and provide education and counseling to address behaviors that contribute to HIV risk.

Identifying Met and Unmet Needs

A list of specific needs for each of the seven priority behavioral risk populations was derived from the list of theoretical needs, the empirical data from the sources listed above, and the knowledge and experience of the HPPG members. The following grid shows what needs were identified for each population.

	HIV Positive	MSM young adult	MSM ethnic minorities	MSM non-gay identified	Injecting drug user	Heterosexuals with partners with HIV or high risk	Youth at increased risk
Prevention Need							
HIV Counseling and Testing		✓	✓	✓	✓	✓	✓
Partner Notification	✓	✓	✓	✓	✓	✓	✓
Awareness of risk and risk behavior	✓	✓	✓	✓	✓	✓	✓
Supports and skills to initiate and sustain healthier behaviors	✓	✓	✓	✓	✓	✓	✓
Access to condoms	✓	✓	✓	✓	✓	✓	✓
Access to sterile injecting equipment					✓		
Access to medical care	✓						
System Need							
Substance abuse treatment	✓	✓	✓	✓	✓	✓	✓
Mental health counseling	✓	✓	✓	✓	✓	✓	✓
Housing	✓						
Health care service							✓
Prevention programs in correctional facilities						✓	

To increase the specificity of the assessment, HPPG members considered the needs and resources of the priority behavioral risk populations in specific geographic locations. Five geographic categories were used – Anchorage, Fairbanks, Juneau, “urban satellite and rural hubs”, and “rural villages” (see Section II, pages 3-5 for definitions of the geographic categories). Information in the Resource Inventory was organized by geographic categories to facilitate analysis of resources by location.

The HPPG members worked in small work groups, each group focused on one or two of the priority behavioral risk populations. HPPG members assigned themselves to a work group according to their interests and experience with the populations and an HIV/STD Program staff member was present in each group to act as a resource.

The work group used the information from the Resource Inventory and other program utilization data and intervention data reports to assess the extent to which the identified needs were being met and what the funding sources were for the services meeting those needs. The HPPG needed to assess the degree to which each of the needs for the specific priority behavioral risk population and location was being met with services *other than* those being funded with CDC prevention funds through the State HIV/STD Program so as to project the needs warranting CDC prevention funds in the future. For example, if a prevention need of MSM in a location

was only being met at the present time by a CBO funded by CDC prevention funds through the State, this need would be unmet in the absence of these funds in the future, therefore this would be assessed as an unmet need for the purpose of planning for future allocation of CDC prevention funds. The term “metness” was coined to refer to the degree to which a prevention need was being met with services other than those being funded with CDC prevention funds through the State. Colored dots were used on the worksheets to indicate degree of “metness” using the following color coded scale:

- Red = Not at all available [a red flag]
- Yellow = Minimally available [it’s there, but weak]
- Blue = Somewhat available
- Green = Mostly available; as available as can be expected.

Through this exercise, the HPPG identified prevention needs that were unmet, minimally met, and somewhat met, and mostly met, for each of seven priority behavioral risk populations in each of five geographic categories.

Prioritizing Unmet Needs

To further prioritize prevention needs, the HPPG considered two other factors: “Importance” and “Feasibility.” Importance refers to the degree of need or prevention importance of the specific need for the specified priority behavioral risk population in the specific geographic location. Importance was rated on a scale of 1 (low importance) to 3 (high importance). Zero was not an option since being on the list of prevention needs indicated that it has some importance for the population.

Feasibility was defined as how realistic it is to try to do activities to meet the prevention need for the particular population in the specific geographic location. Factors that might affect feasibility are population size and distribution, cultural and social norms of the community, agency capability, and availability of providers. Feasibility was measured on a scale of 1 to 3 where 1 is low feasibility; 2 is medium feasibility; and 3 is high feasibility. HPPG members could also rate feasibility as zero (0), but used this only if they felt strongly that there is no way activities could be done, or be suitable, for this prevention need for this population in this specific geographic area.

Each of the work groups decided to produce one assessment worksheet for each of their assigned priority behavioral risk populations, each of which represented the group’s consensus. Figure 16 is an example of a needs assessment worksheet showing only the prevention needs, not the system needs, and only two of the five geographic categories.

Figure 16: Needs assessment worksheet

Priority Behavioral Risk Population: Young Adult MSM	Anchorage				Fairbanks			
Prevention Need	Importance	Feasibility	“Metness”	Unmet Needs Score	Importance	Feasibility	“Metness”	Unmet Needs Score
HIV Counseling and Testing								
Partner Notification								
Awareness of risk and risk behaviors								
Supports to initiate and sustain healthier behaviors, including skills.								
Access to condoms								

Once the needs assessment sheets were completed, the “Unmet Needs Score” was calculated as follows:

(1) “metness” scores were assigned a value. Red, denoting “not at all available” was assigned the highest value of 1, being the most unmet. The other colors representing degrees of being available (i.e., met) were therefore less unmet and hence given a proportionally lower value: Yellow = 0.75; Blue = 0.5; Green = 0.25.

(2) The Unmet Needs Score was then calculated by multiplying the scores for each domain: “Importance” times “Feasibility” times “Metness” yielding a positive integer between .25 and 9.0 which is the “Unmet Needs Score.”

The prevention needs for each population for each location were then listed in descending order of “Unmet Needs Score”, the higher the score, the greater the unmet need and hence the higher priority. Figure 17 provides an example of completed unmet needs scores.

Figure 17: Example of prioritized unmet needs scores

Injecting drug user (IDU) Prevention Need	Anchorage SCORE	Fairbanks SCORE	Juneau SCORE
1. Partner Notification	9.0	9.0	9.0
2. Supports to initiate and sustain healthier behaviors, including skills.	9.0	6.5	6.5
3. Access to sterile injecting equipment	9.0	4.5	4.5
4. Awareness of risk and risk behaviors	3.0	2.25	2.25
5. Access to condoms	2.25	2.25	2.25
6. HIV Counseling and Testing	1.5	1.5	1.5

Injecting drug user (IDU) Prevention Need	Satellites/Hubs SCORE	Rural Villages SCORE
1. Partner Notification	9.0	9.0
2. Awareness of risk and risk behaviors	6.75	4.5
3. Supports to initiate and sustain healthier behaviors, including skills.	6.0	3.0
4. Access to sterile injecting equipment	6.0	3.0
5. Access to condoms	2.25	4.5
6. HIV Counseling and Testing	1.5	2.0

Note in this example the differences in scores and order of priority depending on location. The differences in scores reflect the assessment of each of the domains of “metness,” importance, and feasibility. For example, access to sterile injecting equipment received the maximum unmet needs score in Anchorage, but not in Juneau and Fairbanks where there are syringe exchange programs. In general, unmet needs scores are lower in rural areas because of low feasibility.

Through this process, the HPPG arrived at approximately 200 Unmet Needs Scores for prevention needs – 7 priority behavioral risk populations times 5 or 6 prevention needs times 5 geographic categories. These prioritized needs formed the basis for the next step in the planning process – the identification and prioritization of interventions described in Section IV.

The HPPG also tried a different method of prioritizing populations with unmet needs. This method employs a non-quantifiable decision tree algorithm (Appendix 3) which leads the user through a series of yes or no questions about the prevalence of HIV and risk behaviors in the populations and the adequacy of services to meet prevention needs. Eleven HPPG members used the algorithm to consider each of the seven priority populations. Table 29 shows the results of this exercise. The numbers refer to the number of HPPG members who placed a population in the priority category indicated. All populations except “youth at increased risk” had the majority of scores in the category “highest priority.” The priority behavioral risk populations, in order according to the number of HPPG members categorizing the population as “highest priority,” are: HIV Positives and Heterosexuals with high risk or HIV positive partners (10 each), followed in descending order of priority by ethnic minority MSM, IDU, young adult MSM, and non-gay identified MSM. The results were most divergent for the population “youth at increased risk,” being assessed variously as highest, higher, mid-level, and lower priority population.

Table 29: Results from decision tree worksheets for prioritizing populations with unmet needs

Priority Behavioral Risk Population	Highest Priority	Higher Priority	Mid-level Priority	Lower Priority	Lowest Priority
HIV Positive	10		1		
Heterosexual with high risk or HIV+ partners	10		1		
MSM ethnic minorities	9		2		
IDU	9		1	1	
MSM young adult	8		2	1	
MSM non-gay identified	6		2	2	
Youth at increased risk	2	2	1	3	

While useful in validating the HPPG’s earlier conclusions based on examination of the epidemiologic and behavioral risk data, this exercise was not useful in prioritizing among these seven populations because it resulted in all but one of the priority populations being categorized as “high priority.”

The HPPG has decided that each of the priority populations warrants HIV prevention interventions. Thus, the seven populations are not further prioritized and are not presented in any order of priority in the Plan.

Section IV. Interventions

An HIV prevention intervention is a specific activity (or set of related activities) intended to bring about HIV risk reduction in a particular priority behavioral risk population using a common strategy for delivering the prevention messages (CDC 1999, *Evaluating CDC HIV Prevention Programs – Volume 1: Guidance: III-1*). The seven priority behavioral risk populations in the 2001-2003 Alaska HIV Prevention Plan are: (1) injecting drug users (IDU); (2) HIV positive persons; (3) young adult men who have sex with men (MSM); (4) ethnic minority MSM; (5) non-gay-identified MSM; (6) heterosexual adults, especially Alaska Native and other ethnic minority women; and (7) youth at increased risk. Judging each of the seven populations as equally important and warranting HIV prevention interventions, the HPPG did not place the seven populations in any order of priority.

In their process of choosing appropriate interventions to recommend in the 2001-2003 Comprehensive Plan, the Alaska HPPG examined summaries of the research on interventions and behavior change. To be considered for inclusion in the Plan, an intervention had to meet two important criteria. It had to be based on findings from the behavioral and social sciences on what influences behavior change; and there had to be evidence that the intervention is effective in generating behavior change.

The HPPG reviewed the following materials for their deliberations.

(1) Models of behavior change from behavioral science research.

Behavior change models that have been applied to HIV prevention include: the Health Belief Model; Theory of Reasoned Action; Social Cognitive Theory; AIDS Risk Reduction Model; Diffusion of Innovation; Transtheoretical or Stages of Change Model; and Harm Reduction. Summaries of these models are available from many sources. A brief summary and bibliography of behavior change theory titled “Can theory help in HIV prevention?” is available online at www.caps.ucsf.edu/FSindex.html. In assessing prevention needs and interventions, the HPPG used the summary of common theoretical factors affecting risk behavior change drawn from these theories of behavior change. These factors are listed in the previous chapter on needs assessment and reiterated here.

A person is more likely to lower his or her risk of HIV infection if he or she:

- believes that the advantages of making a change in behavior are greater than the disadvantages;
- has formed a strong intention to change;
- has the skills to perform the behavior;
- believes he or she can make a change;
- believes that the changed behavior will more likely produce a more positive than negative emotional response;
- believes that the performance of the new behavior is consistent with his or her self-image;
- perceives that there is social support for the behavior change; and
- experiences no environmental barriers blocking the behavior change.

(2) *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*. HIV/AIDS Prevention Research Synthesis Project, CDC, 1999.

The *Compendium* summarizes 24 interventions which have been rigorously evaluated and shown to be effective in generating behavior change (Figure 18). The *Compendium* includes interventions designed for IDU, heterosexual adults, MSM, and youth. Some of these interventions are programs that are part of CDC’s Replicating Effective Programs (REP) and Research to Classroom: Programs That Work (PTW) projects for which curricula, training and technical assistance are available. The full text of the *Compendium* is available through the CDC web site: www.cdc.gov/hiv/projects/rep/compend.htm or go to www.cdcnpin.org and search on “compendium.”

Figure 18.	
Prevention Interventions Included in the <i>Compendium of HIV Prevention Interventions with Evidence of Effectiveness</i>.	
Drug Users	ACDP ¹ Research Group, 1999, AIDS Community Demonstration Projects
	Des Jarlais, et al., 1992, AIDS/Drug Injection Prevention
	El-Bassel & Schilling, 1992, Skills Building
	Magura, et al. ¹ , 1994, Intensive AIDS Education in Jail
	McCusker, et al., 1992, Informational and Enhanced AIDS Education
Heterosexual Adults	ACDP Research Group, 1999, AIDS Community Demonstration Projects
	Cohen, et al., 1991, Condom Skills Education
	Cohen, et al., 1992, Group Discussion Condom Promotion
	DiClemente & Wingood, 1995, Social Skills Training
	Hobfoll, et al., 1994, Reducing AIDS Risk Activities
	Kamb, et al., 1998, Project RESPECT
	Kelly, et al., 1994, Cognitive-Behavioral Skills Training Group
	Lauby, et al., 1998, Real AIDS Prevention Project (RAPP)
	O’Donnell, et al., 1998, Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES)
Wenger, et al., 1991, HIV Education, Testing, and Counseling	
Men Who Have Sex with Men	ACDP Research Group, 1999, AIDS Community Demonstration Projects
	Kegeles, et al., 1996, Mpowerment Project
	Kelly, et al., 1989, Behavioral Self-Management and Assertion Skills
	Kelly, et al., 1992, Popular Opinion Leader (POL)
	Valdiserri, et al., 1989, Small Group Lecture Plus Skills Training
Youth	ACDP Research Group, 1999, AIDS Community Demonstration Projects
	Jemmott, et al., 1992, Be Proud! Be Responsible!
	Kirby, et al., 1991, Reducing the Risk
	Magura, et al., 1994, Intensive AIDS Education in Jail
	Main, et al., 1994, Get Real about AIDS © 1992
	Rotheram-Borus, et al., 1997, Street Smart
	Stanton, et al., 1996, Focus on Kids
	St. Lawrence, et al., 1995, Becoming a Responsible Teen (BART)

¹ ACDP and Magura include multiple priority behavioral risk populations, however, their summaries appear only once in the *Compendium*.

(3) “Interventions That Work: Research Summaries”, Maryland Department of Health and Mental Hygiene. This is a comprehensive summary and bibliography of research on HIV prevention which describes research findings about what works in general for HIV prevention, and findings from studies on specific priority behavioral risk populations. The summary was generously made available by the Maryland Dept. of Health through the National Association of State and Territorial AIDS Directors (NASTAD). It is available from the Alaska HIV/STD Program.

(4) Characteristics of Reputationally Strong Programs. This CDC sponsored project identified common elements of well-respected HIV prevention programs. Information on this project is available on line at www.cdc.gov/hiv/projects/rep/crsproj.htm. Reputationally strong programs share the following characteristics.

- Clearly defined priority behavioral risk audiences, goals, and interventions
- Program flexibility at the administrative level
- Sufficient program resources and internal agency support
- Intervention components based in behavioral/social science theory
- Comprehensive, multi-modal strategies for delivering prevention messages
- Audience-centered approaches that are relevant, appropriate, and culturally competent
- Program staff who are committed to their work and who treat all clients with respect

(5) “Fact Sheets” from the Center for AIDS Prevention Studies (CAPS) at University of California, San Francisco.

These facts sheets summarize research on various issues related to HIV prevention including research on risks, barriers, prevention needs and effective interventions of specific priority behavioral risk populations. A compilation of these fact sheets is available from the National Prevention Information Network (NPIN) at www.cdcnpin.org or the CAPS web site at www.caps.ucsf.edu.

Information from the “Fact Sheets” pertinent to the Alaska HPPG’s consideration of interventions was briefly summarized for the HPPG as shown in Figure 19.

Characteristics of Effective Interventions

The Alaska HPPG reiterates the importance of building into all interventions the characteristics of effective HIV prevention interventions that emerge from the years of prevention research and program experience. These “Characteristics of Effective Interventions” are listed on page IV-5.

Applicants for HIV prevention funds from the State of Alaska should incorporate these characteristics into their proposed interventions and programs, and applications for funding should be evaluated on the extent to which proposals include these characteristics.

Figure 19. Center for AIDS Prevention Studies (CAPS), UCSF “Fact Sheets” Summary of What Works for HIV Prevention	
IDU	<ul style="list-style-type: none"> • Starting HIV prevention efforts when rates of HIV are still low • Syringe Exchange Programs • Syringe availability over the counter • Community outreach to IDU • Providing treatment on demand.
MSM	<ul style="list-style-type: none"> • Cognitive-behavioral small group counseling and skills building (condom use, negotiation, refusal). • Peer outreach and education • HIV counseling and testing • Community role model endorsement (Popular Opinion Leader) (Kelly et al.) • Substance Abuse Treatment for MSM (Stall, et al) • Counseling support for maintenance of safer practices.
Young MSM	<ul style="list-style-type: none"> • “The myth that the gay community has been saturated with AIDS prevention services is in serious need of debunking. New young men will come out each year who have not been exposed to prevention campaigns of previous years, thus HIV prevention for young gay men must be ongoing and dynamic.” CAPS, 7/21/99 • Individualized risk reduction counseling followed by peer education and referrals to services. • Multi-session, cognitive-behavioral small group education and skills building – the more sessions the greater the reduction in risk behaviors. • Mpowerment project (Kegeles et al.) Young MSM community social norms, outreach at socializing venues. • Interventions designed by the priority behavioral risk population.
Youth	<ul style="list-style-type: none"> • Begin sex education before students initiate sexual activity. Kirby et al. • Abstinence only doesn’t reduce pregnancy. Condom education does not increase sexual activity. Rather, there is evidence that it lowers the number of partners and increases use of condoms and contraception.
Sex Workers	<ul style="list-style-type: none"> • Peer outreach workers. Condom distribution, HIVCT, STD services. • Methadone maintenance programs reduce prostitution. • Requiring condom use by prostitutes. (Examples: Thailand and rural Nevada counties) • Problem: condom use with primary partners.
Women	<ul style="list-style-type: none"> • Women opinion leaders trained in risk reduction. CAIR Partners in Prevention. • Peer led education for women visiting incarcerated male partners.
In General	<ul style="list-style-type: none"> • Interactional (client based) counseling is more effective than information giving. (Project Respect) • Multiple sessions over time are more effective than a single educational session (Project LIGHT). • Counseling for sero-discordant heterosexual couples. • Peer educators. • Priority behavioral risk population involvement in design and implementation of interventions. • More intensive interventions (more sessions) increase efficacy.
Policy	<ul style="list-style-type: none"> • Per NIH Consensus 2/97 Doc #104, lift government restrictions on Syringe Exchange Programs • Increase funding for drug and alcohol treatment. • Support comprehensive sex education including information about and access to condoms. • Lift constraints on condom availability in prisons.

Characteristics of Effective Interventions

Interventions should:

- have a clearly defined priority behavioral risk population;
- have clearly defined objectives and implementation plan;
- be accessible and affordable to the priority behavioral risk population, preferably taking the intervention to the intended population in the community or institutional settings;
- be based on sound behavioral science theory, focusing on factors that affect behavior change (skills, self-efficacy, expectation of positive response, consistency with self-image, perceived social norms, and reduction of external barriers);
- be based on intervention models scientifically evaluated with evidence of effectiveness or show evidence to support the expectation of effectiveness;
- be culturally competent and relevant to the targeted populations (i.e., consistent with norms, values, and traditions of the community);
- be appropriate for the developmental, age, and educational level of the intended population;
- be tailored to the gender and sexual orientation of the intended population;
- involve members of the priority behavioral risk population in program design, implementation and evaluation;
- utilize personnel who reflect the cultural and linguistic characteristics of the intended audience to deliver the intervention; utilize members of the priority behavioral risk population as peer educators;
- provide materials and deliver interventions in the primary language of the intended audience;
- focus on building and practicing skills (information alone is not enough), including harm reduction practices and communication, identifying triggers and coping with risk situations;
- provide, directly or by referral, risk reduction materials, minimally condoms;
- have ample duration and intensity to promote lasting behavior change (one time only interventions have limited effectiveness);
- be client-focused and tailored to client's stage of readiness, be non-judgmental, and be supportive of incremental change, recognizing that lapses are an expected part of the process of behavior change;
- be incorporated into services reaching persons at risk (e.g., drug and alcohol treatment, STD treatment); and
- have a mechanism in place for referring HIV positive individuals to health care and support services.

For interventions to be implemented successfully, HIV prevention programs should:

- have an established relationship with the priority behavioral risk population(s);
- have sufficient resources to accomplish their objectives;
- have flexibility to make mid-course modifications as necessary;
- be housed within an infrastructure that has an adequate management capability, and administrative and board support for the interventions;
- provide ongoing training and development of staff and volunteers;
- provide support and supervision of staff and volunteers, including field-based observation;
- develop linkages with services reaching the same behavioral risk populations to promote referrals; and
- evaluate interventions to assure that they are implemented as proposed and that objectives are being met.

Intervention Types

Ten intervention types were considered by the HPPG for selecting interventions to recommend for the 2001-2003 Comprehensive Plan. Each of these intervention types has examples of projects employing the intervention that were grounded in behavior change theory and had been scientifically evaluated and shown to be effective, or they are interventions strongly recommended by CDC as an important component of comprehensive HIV prevention services. The HPPG worked from the following descriptions of each of the intervention types with their corresponding applicable priority behavioral risk populations, behavior change objectives, essential components, theoretical underpinning, and studies indicating effectiveness. Most of these model programs or studies on effectiveness are drawn from the *Compendium*. Descriptions of these projects and complete citations for these studies can be obtained from the *Compendium* if not included here.

Key to notations

^{PTW} “Programs that Work”, CDC Div. of Adolescent and School Health. Curricula are available.

^{COM} “Compendium of HIV Prevention Interventions with Evidence of Effectiveness.” Evaluated projects with demonstrated effectiveness, compiled by CDC.

^{REP} “Replicating Effective Programs”, one of the “Compendium” projects with demonstrated effectiveness which has CDC support to replicate and make available materials for adopting the program for use elsewhere.

① There are trained facilitators for this curriculum in Alaska. Training of trainers is available.

Intervention Type: Street and Community Outreach

Applicable Priority Behavioral Risk Populations: high-risk youth, commercial sex workers, non-gay-identified MSM, IDU, female sex partners of IDU, and heterosexual adults.

Prevention Goal:

- reduce unsafe sexual behaviors; increase condom use; delay sexual activity
- reduce use of non-sterile injecting equipment; increase sterile syringe access and bleach cleaning.
- increase HIV counseling and testing

Essential Components for Effectiveness:

- Paid or volunteer peer outreach workers, culturally and linguistically representative of the priority behavioral risk population.
- Sustained and regular presence in the community.
- Focuses efforts on specific areas of a community frequented by persons in the priority behavioral risk population who engage in risk behavior.
- Minimally, provides risk reduction information and supplies- condoms and lubricant, injection harm reduction equipment as applicable, and information on HIV Health Education and Risk Reduction (HE/RR) and HIV Counseling and Testing (CT) resources.
- Ideally, facilitates personal risk perception and risk assessment.

- Provides skills training – condom use, needle/syringe cleaning, communication skills.
- Provides messages of peer and community support for safer behaviors.
- Provides specific referrals to more intensive risk reduction resources as appropriate, i.e., HIV CT, HE/RR, syringe exchange, and substance abuse treatment.

Behavioral/Social Science Theoretical Basis:

Transtheoretical Model of Behavior Change (stages of change model) and common theoretical factors derived from Health Belief Model, Theory of Reasoned Action, and Social Cognitive Learning Theory. Change occurs in stages in the context of perceived peer and community support. Tailor risk reduction messages to the individual's level of readiness according to the stages of change process and provide peer role models of successful risk reduction and community support for change (e.g., ORW as role model and role model stories from community members).

Evidence of Effectiveness (model or study):

1. ^{REP}AIDS Community Demonstration Projects 1999. Outcome: increased consistent condom use, especially with non-main partners.
2. ^{REP} Real AIDS Prevention Project (RAPP). Lauby et al. 1998. Outcome: increased condom use with non-main partners by women in inner city communities.
3. AIDS Evaluation of Street Outreach Projects (AESOP). Outcome: increased condom use among IDU and high-risk youth.

Intervention Type: Outreach by Peer Opinion Leaders (POLs) a.k.a Popular Opinion Leader (Kelly et al. 1992)

Applicable Priority Behavioral Risk Populations: MSM; Heterosexual women with partners at high risk.

Prevention Goal:

- reduce unsafe sexual behaviors;
- increase condom use

Essential Components:

- Identification and training of volunteer peer educators recruited from among peer opinion leaders who are considered respected members of the community.
- Peer educators commit to conversing about risk reduction with a specified number of peers.
- Risk reduction workshops for the opinion leaders and HIV prevention events implemented by the POLs.

Behavioral/Social Science Theoretical Basis:

- Theories of social influence and diffusion of innovation.

Evidence of Effectiveness (model or study):

1. ^{REP} Kelly et al 1992. *Community AIDS/HIV Risk Reduction: The Effects of Endorsements by Popular People in Three Cities*. Outcome: Self-reported reduction in unprotected anal intercourse among gay men in small cities.
2. ^{REP} Kegeles 1996. *The MPowerment Project: A Community-level HIV Prevention Intervention for Young Gay Men*. Outcome: reduced unprotected anal intercourse among young gay men.
3. Sikkema, Kelly et al. 2000. *Outcomes of a Randomized Community-Level HIV Prevention Intervention for Women Living in 18 Low-Income Housing Developments*. Outcome: reduced unprotected sexual intercourse; increased use of condoms.

Intervention Type: Syringe Exchange

Applicable Priority Behavioral Risk Populations: IDU

Prevention Goal:

- reduce use of non-sterile injecting equipment;
- reduce unsafe sexual behaviors;
- increase HIV Counseling and Testing

Essential Components:

- Paid or volunteer peer outreach workers, culturally and linguistically representative of the priority behavioral risk population.
- Sustained and regular presence in the community.
- Provide sterile new syringes, needles and other sterile injecting drug equipment in exchange for used needles.
- Provide referrals to drug treatment, methadone maintenance programs and other services to help users reduce their drug use.
- Provide risk reduction information and supplies- condoms and lubricant, and information on HIV HE/RR and CT resources.

Behavioral/Social Science Theoretical Basis:

- Multiple empirical studies.
- Addresses two components of theoretical factors affecting HIV risk behavior – perceived social norms for safer behavior, and reduced environmental barriers.

Evidence of Effectiveness (model or study):

1. National Research Council, Institute of Medicine 1995. *Preventing HIV Transmission: The Role of Sterile Needles and Bleach*.
2. National Institutes of Health Consensus Development Statement #104, 1997, *Interventions to Prevent HIV Risk Behaviors*.

Intervention Type: Group Health Education/Risk Reduction – Multiple Sessions

Applicable Priority Behavioral Risk Populations: High-risk youth, heterosexual adults, IDU, sexual partners of IDU, MSM.

Prevention Goal:

- reduce unsafe sexual behaviors
- increase condom use
- in youth, decrease number of sexual partners and delay initiation of sexual activity.

Essential Components:

- Structured group education program with specific goals tailored to a specific audience, ideally based on a curriculum with demonstrated effectiveness. Curriculum modified for local use must retain essential components of the original.
- Includes skills building opportunities for condom use and communication (refusal and negotiation).
- Interactive, not didactic.
- Groups targeting a specific ethnicity include a component on ethnic pride.
- Groups targeting women include gender and power issues.

Behavioral/Social Science Theoretical Basis:

- Transtheoretical model of stages of behavior change and common theoretical factors derived from the Health Belief Model, Theory of Reasoned Action, and Social Cognitive Learning Theory (expectation of positive outcome, intention to change, skills, expectation of positive emotional response, consistency with self-image, perceived social norms, and reduction of environmental constraints).
- Behavioral theory on ethnic pride and gender and power issues.

Evidence of Effectiveness (model or study):

Youth in Community

1. ^{REP} “Be Proud Be Responsible!” Jemmott 1992. A five hour curriculum that can be taught in one or multiple sessions. Outcome: increased use of condoms and fewer sex partners among teenaged African-American males.
2. ^{REP} Stanton et al 1996. Eight sessions for African-American adolescents (9 to 12 years) at community recreation center and rural campsite. Outcome: increased condom use among the 36% who were sexually active.

Incarcerated, Drug-using Youth

1. ^{COM} Magura 1994. Four 60 minute sessions for teenage, predominantly African-American, incarcerated males. Outcome: increased condom use, fewer high-risk sex partners.

Youth, School-based

1. ^{REP} “Get Real About AIDS.” Main 1994. 15 session skills-based curriculum taught by high school teachers. Outcome: fewer sex partners, increased condom use.
2. ^{REP} “Reducing the Risk” Kirby 1991. 15 session curriculum taught as part of a 10th grade health curriculum. Emphasis on role plays. Outcome: less likely to initiate sexual intercourse, reduced unprotected intercourse among sexually active students.

Youth in Shelters

1. ^{REP} Rotheram-Borus et al 1997. Ten sessions, offered three times a week, and one individual counseling session, for male and female teenagers in shelters for runaways. Outcome: reduced unprotected sex, reduced substance use.

Youth in Clinics

1. ^{REP} “Becoming a Responsible Teen (BART) St. Lawrence et al 1995. Eight weekly sessions of 1½ to 2 hours for low income, male and female teenagers, diagnosed with an STD, at an inner-city public health clinic. Financial incentive for participation.

Heterosexual Women

1. ^{COM} DiClemente 1995. Five 2 hour sessions for African-American women residents of a housing project. Outcome: increased condom use, decreased unprotected sex.
2. ^{COM} Hobfoll 1994. Four 2-hour sessions for low-income, single, pregnant women. Outcome: increased condom use. Financial incentive to attend.
3. ^{COM} Kelly et al 1994. Four weekly 1½-hour sessions for low-income, predominantly African-American women at a public health clinic. Outcome: increased condom use, decreased unprotected sex.

MSM

1. ^{COM} Kelly et al. 1989. Twelve weekly group sessions for gay men. Outcome: reduced unprotected anal intercourse and increased condom use.
2. ^{COM} Valdiserri 1989. Two 1½- hour small group lecture and skills training at CBO office for gay men. Outcome: increased condom use for anal intercourse.

IDU in Treatment

1. ^{COM} El-Bassel 1992. Five 2-hour sessions for women in a methadone maintenance clinic. Outcome: increased condom use. Financial incentive to attend.

Intervention Type: Group Health Education/Risk Reduction – Single Session

Applicable Priority Behavioral Risk Populations: Heterosexual Adults, MSM, Youth At-Risk.

Prevention Goal:

- reduce unsafe sexual behaviors;
- increase condom use

Essential Components:

- Culturally appropriate materials.
- Skill-building component.
- Interactive discussion or role play.

Behavioral/Social Science Theoretical Basis: Cognitive learning theory; empirical studies.

Evidence of Effectiveness (model or study):

Heterosexual Adults

1. ^{REP}“Voices/Voces” O’Donnell 1998. Single, hour-long session consisting of video and group discussion for African-American and Hispanic males subsequent to an STD clinic visit. Outcome: lower rate of repeat STD infection.
2. ^{COM}Cohen 1991 and 1992. A single, 30 minute condom skills education session taught in small groups for men and woman waiting for their STD appointment in a Los Angeles clinic. Outcome: reduced rate of return to clinic for a new STD.

Youth

1. ^{REP}® “Be Proud Be Responsible!” Jemmott 1992. A five hour curriculum that can be taught in one or multiple sessions. Outcome: increased use of condoms and fewer sex partners among teenaged African-American males.
2. [®]Reducing AIDS Risk Effectively in Teens (RARE-T)

Intervention Type: Individual HE/RR

Applicable Priority Behavioral Risk Populations: Heterosexual Adults; High-risk Youth.

Prevention Goal:

- reduce unsafe sexual behaviors;
- increase condom use

Essential Components:

- Individualized, interactive, client-centered, risk reduction counseling and skill building.

Behavioral/Social Science Theoretical Basis: Theory of Reasoned Action and Social Cognitive Theory.

Evidence of Effectiveness (model or study):

1. ^{REP} “Project RESPECT” Kamb et al. 1998. “Enhanced” model consisted of four 1-hour sessions over 3 to 4 weeks. “Brief” model consisted of two 20-minute sessions within 7 to 10 days. The brief model is based on the CDC Guideline for Prevention Counseling for HIV testing. Outcome: Both interventions increased condom use and decreased repeat STDs among male and female participants at an inner-city STD Clinic.
2. ^{COM} Wenger et al 1991. Enhanced counseling component with HIV testing. Outcome: reduced unprotected sex.

Intervention Type: Prevention Case Management

Applicable Priority Behavioral Risk Populations: HIV positive persons and HIV negative persons at high risk.

Essential Components: Multiple, one-on-one sessions for intensive risk reduction counseling for persons having difficulty initiating or sustaining risk reduction practices.

Provided by, or under the supervision of, a mental health professional or clinical social worker.

Includes: client recruitment, screening and assessment, development of a client-centered prevention plan, multiple sessions for risk reduction counseling, coordination of services with active follow-up, monitoring and reassessing clients' needs and progress, and discharge.

Follows CDC guidance, *HIV Prevention Case Management*, 1997.

Intervention Type: HIV Counseling and Testing

Applicable Priority Behavioral Risk Populations: All. The availability of effective drug therapies makes it more important than ever for HIV-infected persons to know their serostatus. Early recognition of infection allows persons to consider treatment options and also allows them to take steps to prevent transmitting the virus to others. Client-centered HIV risk reduction counseling in the context of HIV testing can help non-infected persons reduce their risk of acquiring HIV.

Essential Components:

- Risk reduction and test decision counseling provided by persons who have been trained in the CDC protocol for HIV counseling and testing.
- Individualized, interactive, client centered risk assessment and risk reduction counseling and skill building. Includes instruction in condom use.
- Receive test results and follow-up risk reduction counseling and referrals.
- Test for HIV antibodies.
- Anonymous HIV testing should be an available option for persons seeking to learn their HIV status.

Behavioral/Social Science Theoretical basis: Theory of Reasoned Action and Social Cognitive Theory.

Evidence of Effectiveness (model or study):

1. ^{REP} “Project RESPECT” Kamb et al. 1998. “Enhanced” model consisted of four 1-hour sessions over 3 to 4 weeks. “Brief” model consisted of two 20-minute sessions within 7 to 10 days. The brief model is based on the CDC Guideline for Prevention Counseling for HIV testing. Outcome: Both interventions increased condom use and decreased repeat STDs among male and female participants at an inner-city STD Clinic.
2. ^{COM} Wenger et al 1991. Enhanced counseling component with HIV testing. Outcome: reduced unprotected sex.
3. Wolitski et al 1997. The effects of HIV counseling and testing on risk-related practices and help-seeking behavior. *AIDS Educ. Prev.* 1997;suppl B:52-67.
4. CDC. Adoption of Protective Behaviors Among Persons with Recent HIV Infection and Diagnosis – Alabama, New Jersey, and Tennessee, 1997-1998. *MMWR* 2000; 49:512-515.

Intervention Type: Partner Notification

Applicable Priority Behavioral Risk Populations: Any person named as a sex or needle sharing contact of a person with HIV.

Essential Components:

- A voluntary, confidential service to notify named sex or needle sharing partners to HIV positive individuals that they have been exposed to HIV.
- Optimally assisted by public health personnel.
- Should be offered to all persons diagnosed with HIV or AIDS.
- Provide HIV prevention counseling, HIV testing, and referrals to appropriate services to named contacts consistent with CDC guidelines, *HIV Partner Counseling and Referral Services*.
- CDC considers voluntary, confidential notification of potentially exposed partners to be an essential component of a comprehensive HIV prevention program.

Evidence of Effectiveness:

1. Varghese B, Peterman TA, Holtgrave DR. 1999. Cost-effectiveness of counseling and testing and partner notification: a decision analysis. *AIDS*, 13(13): 1745-51.
2. West GR, Stark KA. 1997. Partner notification for HIV prevention: A critical re-examination. *AIDS Education and Prevention*, 9, Supplement B: 68-78.
3. Wykoff et al 1991. Notification of the Sex and Needle-Sharing Partners of Individuals with HIV in Rural South Carolina: 30-Month Experience. *Sexually Transmitted Diseases*, 18(4): 217-222.

Intervention Type: Targeted Health Communication / Public Information (HC/PI)

Applicable Priority Behavioral Risk Populations: Any specified priority behavioral risk population.

Essential Components:

- Use of broadcast (tv, radio), electronic (www), and print media, and hotlines, advertised to and accessed by a specific priority behavioral risk population.
- Culturally, linguistically, and community appropriate messages to raise awareness, educate about risk reduction, and to influence community norms.

It is appropriate and recommended that in adopting any of these interventions for implementation in Alaska, programs tailor the model, curriculum and materials to the intended priority behavioral risk population and location. However, adaptations must retain the essential components of the model and fidelity to the underlying theory.

Prioritizing Interventions

To prioritize interventions for recommendation in the 2001-2003 Comprehensive Plan, the Alaska HPPG selected interventions from the ten intervention types described above that have a theoretical basis and evidence of effectiveness or are strongly recommended by CDC. The HPPG also sought to recommend a continuum of prevention interventions for priority behavioral risk populations and specific geographic locations. The HPPG worked in small groups, each focusing on one or more priority behavioral risk populations, and then discussed their work group recommendations in full group session and reached consensus on the priority interventions to recommend. In the small work groups, HPPG members went through the following steps for each priority behavioral risk population:

- 1) Examine the priority needs of each priority behavioral risk population in each of five geographic locations as determined during the needs prioritizing process (see Section III of the Plan).
- 2) Review the materials on interventions and research on effectiveness for the priority behavioral risk population.
- 3) Match each of the identified needs with intervention(s) to address those needs. More than one intervention could be matched with a priority need.

In their deliberations, HPPG members took into consideration the following factors:

- acceptability of the intervention by the priority behavioral risk population and/or community;
- feasibility of the intervention, especially regarding geographic location;
- availability of related resources;
- intensity of the intervention – more intensive (duration, repetition, and individualization) interventions have a higher priority;
- percentage of the priority behavioral risk population that could be reached by the intervention; and
- number of persons in the priority behavioral risk population reached per time/effort expended.

The feasibility of meeting the need, the importance of the need for the priority behavioral risk population, and the degree to which a need was being met through other resources were each assessed in the process of prioritizing needs (see Section III).

The result of the small work group and full HPPG deliberations was a list of prioritized interventions for each of the seven priority populations for each geographic location. The geographic location categories are: Anchorage, Fairbanks, Juneau, urban satellites and rural hubs, and rural villages (see Section II for definitions of urban satellites and rural hubs, and rural villages). Figure 20 is an illustration of how interventions were matched to the prioritized needs, yielding a prioritized list of interventions.

Figure 20. Example of interventions matched to prioritized needs for priority behavioral risk population and location.

Priority Behavioral Risk Population: Injecting Drug Users (IDU)

Prevention Need	Anchorage SCORE	Interventions to address prevention need	Interventions in order of priority
1. Partner Notification	9.0	Partner Notification	Partner Notification
2. Supports to initiate and sustain healthier behaviors, including skills.	9.0	Group Multi-session & Group-session in jails and half-way houses. Individual HE/RR counseling- in treatment as part of treatment plan	Group Multi-session in jails and half-way houses.
3. Access to sterile injecting equipment	9.0	Syringe Access	Group Single-session in jails and half-way houses.
4. Awareness of risk and risk behaviors	3.0	Targeted Outreach at sites where users are, (e.g., needle exchanges) and tell users about resources like SEP and HIVCT	Individual HE/RR in treatment as part of treatment plan
5. Access to condoms	2.25	Targeted Outreach at sites where users are, (e.g., needle exchanges) and tell users about resources like SEP and HIVCT	Syringe Access
6. HIV Counseling and Testing	1.5	HIV CT non-clinic settings accessible to IDU	Targeted Outreach at sites where users are, (e.g., needle exchange and tell users about resources like SEP and HIVCT.
			HIV CT non-clinic settings accessible to IDU

Priority interventions for each of the seven priority behavioral risk populations for each of the five location categories are listed below. Because all priority behavioral risk populations are deemed equally important for prevention, the populations are not listed in any order of priority. Where the lists of priority interventions for more than one location are the same, the location categories are combined into one column in the table.

Prioritized Interventions

Priority Behavioral Risk Population: Injecting Drug Users (IDU)

IDU Anchorage Fairbanks, Juneau	IDU Urban Satellites & Rural Hubs	IDU Rural Villages
1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION
2. GROUP: MULTI-SESSION in jails and half-way houses	2. GROUP: MULTI-SESSION in jails and half-way houses	2. HEALTH COMMU./PUBLIC INFO.- general info on not sharing, access to sterile eqpt, testing, resources (HIV counseling and testing and syringe exchange in cities)
3. GROUP: SINGLE SESSION in jails and half-way houses	3. GROUP SINGLE SESSION in jails and half-way houses	
4. INDIVIDUAL COUNSELING in treatment as part of treatment plan	4. INDIVIDUAL COUNSELING in treatment as part of treatment plan	
5. SYRINGE ACCESS	5. SYRINGE ACCESS	
6. TARGETED OUTREACH at sites where users are: tell users about resources like syringe exchange and HIV counseling and testing. Massage parlors, etc.		
7. HIV Counseling and Testing - non-clinic settings		

Priority Behavioral Risk Population: HIV Positive Persons

HIV Positives Anchorage, Fairbanks, Juneau	HIV Positives Urban Satellites & Rural Hubs	HIV Positives Rural Villages
1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION
2. PREVENTION CASE MANAGEMENT	2. PREVENTION CASE MANAGEMENT	2. INDIVIDUAL COUNSELING
3. GROUP: SINGLE SESSION	3. INDIVIDUAL COUNSELING	3. TARGETED OUTREACH – condom availability
4. INDIVIDUAL COUNSELING	4. HEALTH COMMUN./PUBLIC INFO. – newspaper, community bulletin boards	
5. OUTREACH BY PEER OPINION LEADERS	5. TARGETED OUTREACH - condom availability	
6. GROUP: MULTI-SESSION		
7. TARGETED OUTREACH through support services		

Priority Behavioral Risk Population: Heterosexual adults, especially Alaska Native and other ethnic minority women, with partners who are HIV positive or high risk (IDU, bi-sexual male)

Heterosexual Women Anchorage, Fairbanks Juneau	Heterosexual Women Urban Satellites & Rural Hubs	Heterosexual Women Rural Villages
1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION
2. GROUP: MULTI-SESSION	2. HIV COUNSELING & TESTING – non-clinic	2. HIV COUNSELING & TESTING
3. TARGETED OUTREACH	3. GROUP: SINGLE-SESSION	3. HEALTH COMMUNIC./ PUBLIC INFO.
4. GROUP: SINGLE SESSION	4. HEALTH COMMUNIC./ PUBLIC INFO.	4. GROUP: SINGLE SESSION
5. OUTREACH BY PEER OPINION LEADERS	5. INDIVIDUAL COUNSELING	5. TARGETED OUTREACH condom availability
6. HEALTH COMMUNIC./ PUBLIC INFO.	6. TARGETED OUTREACH condom availability	
7. INDIVIDUAL COUNSELING		
8. HIV COUNSELING & TESTING non-clinic sites		

Priority Behavioral Risk Population: Youth at increased risk

Youth at Risk Anchorage, Fairbanks, Juneau	Youth at Risk Urban Satellites & Rural Hubs	Youth at Risk Rural Villages
1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION
2. INDIVIDUAL COUNSELING	2. GROUP: MULTI-SESSION - school based curricula	2. GROUP: MULTI-SESSION – school based curricula
3. GROUP: MULTI-SESSION	3. GROUP: SINGLE SESSION	3. GROUP: SINGLE SESSION
4. HIV COUNSELING & TESTING	4. HIV COUNSELING & TESTING	4. TARGETED OUTREACH – condom availability.
5. GROUP: SINGLE SESSION	5. TARGETED OUTREACH condom availability	5. HEALTH COMMUNIC./ PUBLIC INFO.
6. TARGETED OUTREACH	6. HEALTH COMMUNIC./ PUBLIC INFO. - newsletters	
7. HEALTH COMMUNIC./ PUBLIC INFO.		

Priority Behavioral Risk Population: Men who have sex with men (MSM) - Young Adults

MSM Young Adults Anchorage, Fairbanks, Juneau	MSM Young Adults Urban Satellites & Rural Hubs	MSM Young Adults Rural Villages
1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION
2. GROUP: MULTI-SESSION	2. GROUP: MULTI-SESSION	2. GROUP: SINGLE SESSION (community forum to try to reach some MSM)
3. HIV COUNSELING & TESTING	3. HIV COUNSELING & TESTING	3. HIV COUNSELING & TESTING
4. INDIVIDUAL COUNSELING	4. INDIVIDUAL COUNSELING	4. HEALTH COMMUNIC./ PUBLIC INFO.
5. PREVENTION CASE MANAGEMENT	5. PREVENTION CASE MANAGEMENT	
6. OUTREACH BY POL	6. OUTREACH BY POL	
7. TARGETED OUTREACH	7. TARGETED OUTREACH	

**Priority Behavioral Risk Population: Men who have sex with men (MSM) - Ethnic Minority
(African-American, Alaska Native, Hispanic)**

Minority MSM Anchorage, Fairbanks, Juneau	Minority MSM Urban Satellites & Rural Hubs	Minority MSM Rural Villages
1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION
2. OUTREACH BY POL	2. HEALTH COMMUN./PUBLIC INFO.	2. HIV COUNSELING & TESTING
3. HIV COUNSELING & TESTING	3. GROUP: SINGLE SESSION Community forum, some will be MSM; correctional facilities; substance abuse tx.	3. TARGETED OUTREACH - materials distributed
4. GROUP: SINGLE SESSION	4. GROUP: MULTI-SESSION – Community forum, some will be MSM; correctional facilities; substance abuse tx.	4. INDIVIDUAL COUNSELING through existing health services and substance abuse counseling
5. GROUP: MULTI-SESSION	5. HIV COUNSELING & TESTING	5. HEALTH COMMUNIC./ PUBLIC INFO.
6. INDIVIDUAL COUNSELING	6. INDIVIDUAL COUNSELING – existing providers, substance abuse counselors	6. GROUP: SINGLE SESSION – Community forum will include some MSM
7. PREVENTION CASE MANAGEMENT	7. OUTREACH BY POL	7. OUTREACH BY POL
8. HEALTH COMMUNIC./ PUBLIC INFO.		
9. TARGETED OUTREACH		

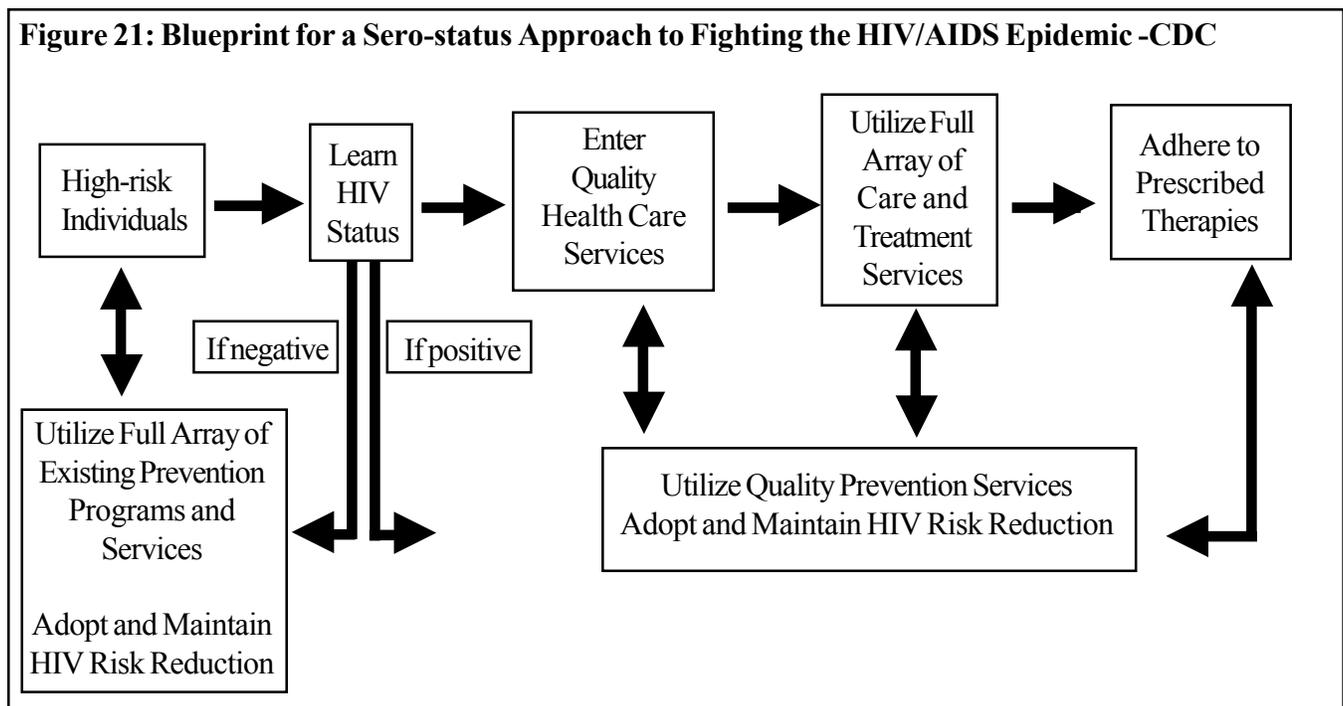
Priority Behavioral Risk Population: Men who have sex with men (MSM) - Non-gay-identified

MSM Non-gay-identified Anchorage & Fairbanks	MSM Non-gay identified Juneau
1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION
2. HIV COUNSELING & TESTING	2. HIV COUNSELING & TESTING
3. TARGETED OUTREACH	3. GROUP: SINGLE SESSION in correctional facilities
4. GROUP: SINGLE SESSION in correctional facilities	4. GROUP: MULTI-SESSION in correctional facilities
5. GROUP: MULTI-SESSION – in correctional facilities	

MSM Non-gay-identified Urban Satellites and Rural Hubs	MSM Non-gay identified Rural Villages
1. PARTNER NOTIFICATION	1. PARTNER NOTIFICATION
2. HIV COUNSELING & TESTING	2. HIV COUNSELING & TESTING
3. GROUP: SINGLE SESSION in correctional facilities	3. HEALTH COMMUNICATION/ PUBLIC INFORMATION
4. GROUP: MULTI-SESSION – in correctional facilities	

Section V. Recommendations

The Alaska HIV Prevention Planning Group finds that, in this low prevalence state, a combination of targeted prevention interventions and, for those at high risk, an HIV status approach promoted in recent recommendations from CDC (Figure 21) are useful strategies for preventing new HIV infections and reducing the incidence of AIDS. An important step in this approach is for persons with risk factors to learn their HIV status. For those testing HIV positive, knowing their status can lead to prevention counseling and ongoing services as needed to reduce transmission of the virus to others (primary prevention) and facilitates entry into health care and support services to reduce the progression to AIDS (secondary prevention). For those testing HIV negative, the testing process provides an opportunity for individualized risk reduction counseling and referrals to more intensive interventions as appropriate.



In Alaska, we have seen that participation in group HIV educational sessions such as presentations in substance abuse treatment programs, shelters and correctional facilities, or being contacted individually through targeted outreach, raises awareness of HIV risk and prompts some persons with risk behaviors to seek HIV counseling and testing. Nationally, research has shown that an important factor stimulating high risk persons to have an HIV test is a recommendation to do so from their health care provider.

Statewide HIV Counseling, Testing, Referral and Partner Notification Services

HIV counseling, testing and referral (HIVCT), and Partner Notification are cornerstones of the HIV-status approach to HIV/AIDS prevention. The epidemiology of HIV and AIDS in Alaska demonstrates that, while persons with HIV and AIDS are more likely to reside in the urban centers, HIV infection has no geographic boundaries. HIV counseling and testing must be made available as widely as possible around the state. The HIV Prevention Planning Group strongly supports efforts to maintain and expand the availability of HIV counseling and testing throughout Alaska. The Planning Group strongly encourages the State, private health care providers, borough health departments and tribal health entities to increase voluntary HIV counseling and

testing services in their regions, and encourages the use of innovative service delivery mechanisms, including the use of rapid and non-serologic testing technologies as they become available, to increase access to HIV testing statewide.

At highest risk for HIV infection are persons who have been exposed to HIV through sex and/or needle sharing with HIV positive partners. Many persons who have been exposed to HIV are unaware of their exposure, not knowing the HIV status of their partners. Others, aware of a partner's HIV positive status, may have minimized their risk from the exposure or have delayed HIV testing for a variety of reasons. Partner notification and the offer of immediate, field-based HIV counseling and testing, encourages and helps people who have had an exposure to learn their HIV status. Although partner notification is a resource intensive intervention, it has proven to be the most effective and efficient way of identifying persons who have been exposed to HIV and providing them with HIV testing and prevention counseling. Partner notification also results in earlier identification of previously undiagnosed HIV infection. The Prevention Planning Group has made partner notification the number one priority for all priority behavioral risk populations in all geographic categories. The Planning Group fully supports the HIV/STD Program's role in directly providing partner notification services statewide and in providing technical assistance for partner notification to other public health providers and, as appropriate, to private sector medical providers.

The Strategy for HIV Prevention in Urban Alaska

The three urban centers in Alaska - Anchorage, Fairbanks and Juneau - have sufficient population and HIV prevention resources to provide a continuum of HIV prevention services. Well established AIDS service organizations (ASOs) and select community organizations in these three cities have developed ties to the at-risk populations and have staff who specialize in HIV prevention. The HIV prevention strategy in these urban communities, due largely to priorities in prior Plans, is characterized by outreach and risk reduction education for specific populations - injecting drug users, men who have sex with men, transactional sex workers and high risk youth - and referrals and recruitment efforts to funnel the most high risk to more intensive interventions for individualized prevention counseling and to group interventions specific to the priority behavioral risk populations. The size of the priority behavioral risk populations and their concentration in identifiable locations in the urban setting make targeted outreach possible and make group interventions feasible for persons with demographic and behavioral risk factors in common. Substance abuse treatment facilities, social service organizations and correctional facilities in the urban centers provide additional venues for group interventions to reach individuals with behavioral risks for HIV infection. The population distribution and the epidemiology of HIV indicate that the urban centers of Anchorage, Fairbanks, and Juneau warrant the allocation of the majority of those CDC HIV Prevention funds that the State HIV/STD Program distributes through contractual mechanisms to community based organizations and governmental entities.

The HIV Prevention Planning Group strongly encourages the use of CDC HIV prevention funds to support the prevention activities of community based organizations and local health departments with ties to and a history of involvement with the affected communities in Anchorage, Fairbanks and Juneau. The Planning Group also encourages capacity building for other community groups interested in initiating HIV prevention activities. The Comprehensive Plan includes specific recommendations for a full continuum of prevention services targeting persons in specific risk categories in the urban centers. The chart below summarizes the recommended interventions for the populations with unmet prevention needs in Anchorage, Fairbanks and Juneau. Priority

behavioral risk populations are not listed in any priority order. The HPPG believes that each of these populations have priority prevention needs. Specific objectives for these interventions are listed by priority behavioral risk population beginning on page V-8.

ANCHORAGE, FAIRBANKS, JUNEAU										
PRIORITY BEHAVIORAL RISK POPULATION	INTERVENTION									
	Targeted Outreach	Peer Opinion Leader	Syringe Access	Group HE/RR- Multiple Session	Group HE/RR- Single Session	Individual HE/RR	Partner Notification	Prevention Case Management	Health Communication/ Public Information	HIV Counseling and Testing-Non-Clinic
IDU	✓		✓	✓	✓	✓	✓			✓
HIV Positives	✓	✓		✓	✓	✓	✓	✓		
Heterosexual women-minority	✓	✓		✓	✓	✓	✓		✓	✓
Youth at risk	✓			✓	✓	✓	✓		✓	✓
MSM-young adult	✓	✓		✓		✓	✓	✓		✓
MSM-ethnic minorities	✓	✓		✓	✓	✓	✓	✓	✓	
MSM-non gay identified	✓			✓	✓		✓			

The Strategy for HIV Prevention in Rural Alaska

In areas of the state outside of the three urban centers, lower population and lower HIV and AIDS prevalence generally preclude the establishment of AIDS specific organizations and prevention programs focused exclusively or predominantly on HIV and staffed by HIV prevention specialists. Rather, HIV prevention must rely heavily on providers working in other agencies and organizations to incorporate HIV prevention into the counseling services or health education endeavors they provide for their clients and communities. Similarly, lower population and HIV prevalence and the social dynamics and cultural factors of rural communities generally preclude HIV prevention activities that target persons with a known, specified behavioral risk factor. Rather, HIV prevention efforts must cast a wider net, with outreach and education to a broader audience of persons potentially at risk because of substance abuse and/or sexual activity with the intention of raising awareness of risk and providing referrals. In so doing they will reach some individuals who are at high risk with risk reduction advice and skills, and referrals for individualized risk reduction counseling in the context of HIV testing or substance abuse treatment. For example, whereas offering health education and risk reduction groups for men who have sex with men is not feasible in rural communities, HE/RR groups conducted for the institutionalized population of men in a correctional facility or a substance abuse treatment program are likely to

reach some men who are at high risk because of same gender sex or needle sharing practices. The Planning Group believes that, for rural Alaska, CDC prevention funds are most efficiently used to retain the capacity of the State of Alaska, HIV/STD Program to support and promote the efforts of rural providers, through training, technical assistance, capacity building and quality assurance, and, to a limited extent, to fund rural-specific HIV prevention projects or special initiatives.

The Alaska HIV Prevention Planning Group strongly urges rural providers of health and social services to increase the availability of HIV prevention interventions for their client populations and the communities they serve. The HIV/STD Program can assist rural providers by disseminating information about training opportunities offered by HIV training centers, the CDC, associations of health and social service professions and courses offered by the HIV/STD Program. The two charts below summarize the recommended interventions for the populations with unmet prevention needs in (a) urban satellites and rural hubs and (b) rural villages. Because of the larger population and infrastructure of health and social services and correctional facilities in urban satellites and rural hubs compared to rural villages, more and varied interventions are feasible in the satellite and hub communities than in the outlying villages (see Section II, pages 3 to 5 for descriptions of these geographic categories). Specific objectives for these interventions are listed by priority behavioral risk population beginning on page V-16. Again, priority behavioral risk populations are not listed in any order of priority.

URBAN SATELLITES AND RURAL HUBS										
PRIORITY BEHAVIORAL RISK POPULATION	INTERVENTION									
	Targeted Outreach*	Peer Opinion Leader	Syringe Access	Group HE/RR- Multiple Session	Group HE/RR- Single Session	Individual HE/RR	Partner Notification	Prevention Case Management	Health Communication/ Public Information	HIV Counseling and Testing-Non-Clinic
IDU			✓	✓	✓	✓	✓			
HIV Positives	✓					✓	✓	✓	✓	
Heterosexual women-minority	✓				✓	✓	✓		✓	✓
Youth at risk	✓			✓	✓		✓		✓	✓
MSM-young adult	✓	✓		✓		✓	✓	✓		✓
MSM-ethnic minorities		✓		✓	✓	✓	✓		✓	✓
MSM-non-gay identified				✓	✓		✓			✓

*Targeted Outreach in satellites, hubs and rural villages refers to condom distribution only.

RURAL VILLAGES										
PRIORITY BEHAVIORAL RISK POPULATION	INTERVENTION									
	Targeted Outreach*	Peer Opinion Leader	Syringe Access	Group HE/RR- Multiple Session	Group HE/RR- Single Session	Individual HE/RR	Partner Notification	Prevention Case Management	Health Communication/ Public Information	HIV Counseling and Testing-Non-Clinic
IDU							✓		✓	
HIV Positives	✓					✓	✓			
Heterosexual women-minority	✓				✓		✓		✓	✓
Youth at risk	✓			✓	✓		✓		✓	
MSM-young adult					✓		✓		✓	✓
MSM-ethnic minorities	✓	✓			✓	✓	✓		✓	✓
MSM-non-gay identified							✓		✓	✓

*Targeted Outreach in satellites, hubs and rural villages refers to condom distribution only.

Prevention Goals and Objectives

Goals

1. Reduce transmission of HIV through early identification and notification of sex and needle sharing partners of persons reported with HIV infection.
2. Reduce transmission of HIV by providing targeted behavior change interventions for persons with HIV infection and for HIV-negative persons and persons of unknown sero-status who have behavioral risk factors for HIV infection.
3. Reduce the annual incidence of AIDS cases by linking persons with newly diagnosed HIV infection to health care and support services.

Objectives

In the following section, objectives are listed for each of the priority populations with unmet prevention needs, first for the urban centers of Anchorage, Juneau and Fairbanks, then for rural Alaska including the recommendations for (a) urban satellite and rural hub communities and (b) for the smaller rural towns and villages. The language of the objectives reflects the approach to resource allocation based on consideration of geographic category, infrastructure, and the setting of interventions as discussed in the previous overview of the overall strategy for urban and rural Alaska. Objectives using the verbs “provide,” “fund” and “offer” indicate that the intention of the Alaska HIV Prevention Planning Group is that CDC Prevention funds to the State HIV/STD Program be expended to provide the interventions either directly by the HIV/STD Program or indirectly through contractual mechanisms to non-profit organizations or other governmental entities. Objectives worded as “support,” “promote,” or “encourage” signal the Planning Group’s intention that HIV prevention activities be offered through existing services and programs which do not receive CDC prevention funds through the State, but which can be supported by the HIV/STD Program with training, technical assistance, program coordination, policy development, and capacity building.

Counseling, Testing, Referral and Partner Notification — Statewide

Objectives:

- Support HIV counseling, testing and referral services consistent with CDC guidelines at public health clinics in Anchorage, Fairbanks, Juneau and at least thirteen urban satellite and rural hub communities.
- Support the Department of Corrections to provide voluntary HIV counseling, testing and referral services at all adult correctional institutions.
- Support the Division of Juvenile Justice to provide voluntary HIV counseling, testing and referral services at all youth detention facilities statewide.
- Offer partner notification services to 100% of individuals with HIV and AIDS reported to the Section of Epidemiology.
- Offer HIV counseling and testing to 100% of locatable partners named by persons with HIV infection.

Injecting Drug Users - Urban

Priority Interventions:

1. Partner Notification	5. Syringe Access
2. Group HE/RR: Multi-Session	6. Targeted Outreach
3. Group HE/RR: Single Session	7. HIV Counseling and Testing
4. Individual HE/RR Counseling	

Objectives:

1. Partner Notification (see statewide objectives on p.V-7)

2. Group HE/RR: Multi-Session

3. Group HE/RR: Single Session

- Support the Division of Alcohol Drug Abuse (ADA) and ADA-funded substance abuse treatment programs to provide HE/RR groups - multiple or single session with a skills component in programs in Anchorage, Fairbanks and Juneau.
- Support all State correctional facilities and community residential centers to offer HE/RR groups - multiple or single session with a skills component to inmates on a regular basis.

4. Individual HE/RR Counseling

- Support ADA to include individual HIV prevention counseling as part of the treatment plan for all substance abuse clients in treatment programs who have a history of injecting drug use, especially clients in methadone maintenance programs.

5. Syringe Access

- Increase the availability of sterile needles and syringes through advocating for policy changes to allow for over the counter sale of syringes without a prescription and for the use of federal funds for syringe exchange programs (SEPs).
- Encourage privately funded entities to offer SEP.

6. Targeted Outreach

- Fund CBOs to conduct active street outreach to adult IDU and, in communities with operating SEPs, to collaborate with SEPs to outreach to IDU with sexual risk reduction messages, harm reduction materials (except needles and syringes), referrals to HIV counseling and testing, and targeted messages displayed in venues likely to be seen by IDU, such as public transportation signage.

7. HIV Counseling and Testing

- Provide HIV testing in non-clinic settings at places frequented by IDU such as at or near syringe exchange programs and commercial sex environments.

HIV Positive Individuals - Urban

Priority Interventions:

1. Partner Notification	5. Outreach by Peer Opinion Leaders
2. Prevention Case Management	6. Group HE/RR: Multi-Session
3. Group HE/RR: Single Session	7. Targeted Outreach
4. Individual HE/RR Counseling	

Objectives:

1. Partner Notification (see statewide objectives on .V-7)

2. Prevention Case Management

- Pending assessment of consumer interest and preferences, and provider resources, provide Prevention Case Management to HIV positive persons in Anchorage, Fairbanks, and/or Juneau.

3. Group HE/RR: Single-Session

6. Group HE/RR: Multi-Session

- Offer facilitated (preferably peer-led) HE/RR multiple or single session groups for HIV positive persons in Anchorage, Fairbanks, and Juneau if warranted by consumer interest. Groups should emphasize skill building including condom use and negotiation, communication, and needle use harm reduction, and should provide up-to-date information about transmission risks associated with specific sexual activities.
- Support sobriety self-help groups for HIV positive persons, and their partners as appropriate.

4. Individual HE/RR Counseling

- Support and/or fund innovative approaches to offering individual counseling and peer support for safer behaviors such as an HIV positive buddy or sponsor system, phone line, or computer chat room.
- Support training for physicians, nurses, and other clinical and non-clinical personnel as well as ASO staff to communicate effectively and sensitively to HIV positive clients about risk reduction and transmission risks associated with specific sexual activities.
- Support Dept. of Corrections to assure discharge planning for HIV positive inmates.

5. Outreach by Peer Opinion Leaders

- Provide HIV positive peer opinion leaders (POL) to promote HIV risk reduction among HIV positive persons in their social networks.

7. Targeted Outreach

- Distribute risk reduction materials and referral information about individual and group HE/RR opportunities to HIV positive persons through support services provided by AIDS Service Organizations (ASOs) for clients (such as housing programs and food banks).

Heterosexual Women at Increased Risk - Urban

Priority Interventions:

1. Partner Notification	5. Outreach by Peer Opinion Leaders
2. Group HE/RR: Multi- Session	6. Health Communication/Public Information
3. Targeted Outreach	7. Individual HE/RR Counseling
4. Group HE/RR: Single Session	8. HIV Counseling and Testing

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Group HE/RR: Multi-Session

4. Group HE/RR: Single Session

- Provide single or multi-session group HE/RR in women-specific substance abuse treatment programs and shelters and at the women’s correctional facility
- Encourage women-specific single or multi-session group HE/RR in correctional facilities, homeless shelters, and substance abuse treatment programs.
- Provide group HE/RR single session interventions for female partners of IDUs.

3. Targeted Outreach

- Provide targeted outreach in settings frequented by women at increased risk such as bars, street areas, commercial sex environments, and in conjunction with existing Syringe Exchange programs. Take appropriate steps to enlist participation by ethnic minorities.

5. Outreach by Peer Opinion Leaders

- Provide outreach by peer opinion leaders (POL) in at least one urban center specifically outreaching to Alaska Native women at increased risk for HIV because of their substance abuse or their sexual partners who are at increased risk.

6. Health Communication/Public Information

- Promote the distribution of women-specific risk reduction messages through print media (pamphlets and posters) at agencies and places frequented by women such as shelters, bars, rest rooms, and substance abuse treatment facilities. Assure that materials reflect the cultural and linguistic diversity of the intended audience.

7. Individual HE/RR Counseling

- Support counselors in programs specifically serving women such as substance abuse treatment programs, and domestic violence and homeless shelters to incorporate individualized, culturally and linguistically appropriate risk reduction into their counseling services.

8. HIV Counseling and Testing

- Provide HIV counseling and testing in at least one non-clinic setting in Anchorage, Fairbanks, and Juneau in venues convenient to women at increased risk such as commercial sex environments, shelters, bars, or at ASO offices.
- Promote as the standard of prenatal care, the offering of routine, voluntary HIV testing with consent to all pregnant women.

Youth at Increased Risk - Urban

Priority Interventions:

1. Partner Notification	5. Group HE/RR: Single Session
2. Individual HE/RR Counseling	6. Targeted Outreach
3. Group HE/RR: Multi-Session	7. Health Communication/Public Information
4. HIV Counseling and Testing	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Individual HE/RR Counseling

- Support counselors in programs serving high risk youth such as substance abuse treatment programs, outreach programs, homeless shelters, group homes for youth in state custody, and juvenile detention facilities to incorporate individualized risk reduction into their counseling services.

3. Group HE/RR: Multi-Session

5. Group HE/RR: Single Session

- Provide multi-session HE/RR groups following a “Programs that Work” curriculum in each of the juvenile detention facilities in Anchorage, Fairbanks, and Juneau minimally once each quarter.
- Provide single or multi-session HE/RR groups with a skills component at agencies or drop-in sites serving youth at increased risk.
- Support in-school peer education programs for high school students, particularly in alternative schools.

4. HIV Counseling and Testing

- Provide HIV counseling and testing in non-clinic settings convenient to high risk youth.

6. Targeted Outreach

- Provide peer or “near peer” targeted outreach at places frequented by youth at increased risk in at least one urban center.

7. Health Communication/Public Information

- Display posters and distribute informational materials in places frequented by high risk youth and in easily portable formats. Preferably involve members of the priority behavioral risk population in the selection or production of materials incorporating role model messages reinforcing norms for safer sex.

MSM - Young Adult- Urban

Priority Interventions:

1. Partner Notification	5. Prevention Case Management
2. Group HE/RR: Multi-Session	6. Outreach by Peer Opinion Leaders
3. HIV Counseling and Testing	7. Targeted Outreach
4. Individual HE/RR Counseling	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Group HE/RR: Multi-Session

- Offer facilitated (preferably peer-led) HE/RR multiple session groups for young MSM as warranted by consumer interest. Groups should emphasize skill building including condom use and negotiation skills.

3. HIV Counseling and Testing

- Provide HIV Counseling and Testing in non-clinic settings convenient to MSM such as bars, ASOs, and gay community events in Anchorage, Fairbanks, and Juneau.

4. Individual HE/RR Counseling

- Support innovative approaches to offering individual counseling and peer support for safer behaviors such as a buddy or sponsor system, phone line, or computer chat room.

5. Prevention Case Management

- Pending assessment of consumer interest and preferences, and provider resources, provide Prevention Case Management to high risk HIV negative young MSM.

6. Outreach by Peer Opinion Leaders

- Provide outreach to young MSM through peer opinion leaders (POL) to promote HIV risk reduction among peers in their social networks.

7. Targeted Outreach

- Where outreach with POL is not feasible, provide peer outreach to MSM at sites and at times most likely to reach young MSM.

MSM — Ethnic Minority - Urban

Priority Interventions:

1. Partner Notification	6. Individual HE/RR Counseling
2. Outreach by Peer Opinion Leaders	7. Prevention Case Management
3. HIV Counseling and Testing	8. Health Communication/Public Information
4. Group HE/RR: Single Session	9. Targeted Outreach
5. Group HE/RR: Multi-Session	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Outreach by Peer Opinion Leaders

- Provide outreach to African-American, Hispanic, and Alaska Native MSM through peer opinion leaders (POL) to promote HIV risk reduction among peers in their social networks.

3. HIV Counseling and Testing

- Provide HIV Counseling and Testing in non-clinic settings convenient to MSM such as bars, ASOs, and gay community events in Anchorage, Fairbanks, and Juneau.

4. Group HE/RR: Single Session

5. Group HE/RR: Multi-Session

- Offer facilitated (preferably peer-led) HE/RR multiple or single session groups for ethnic minority MSM. Emphasizing skill building including condom use and negotiation skills.

6. Individual HE/RR

- Support innovative approaches to offering individual counseling and peer support for safer behaviors such as a buddy or sponsor system, phone line, or computer chat room.

7. Prevention Case Management

- Pending assessment of consumer interest and preference, and provider resources, provide Prevention Case Management to high risk HIV negative ethnic minority MSM.

8. Health Communication/Public Information

- Display and distribute materials with safer sex and HIV testing messages reflecting the ethnic and sexual orientation diversity of the epidemic.

9. Targeted Outreach

- Where outreach with POL is not feasible, provide peer outreach to ethnic minority MSM at sites and at times most likely to reach them, such as shelters, streets, bars, and “urban camps” (temporary outdoor shelters or gathering places for homeless persons).

MSM - Non-Gay Identified - Urban

Priority Interventions:

Anchorage and Fairbanks	Juneau
1. Partner Notification	1. Partner Notification
2. HIV Counseling and Testing	2. HIV Counseling and Testing
3. Targeted Outreach	3. Not feasible
4. Group HE/RR: Single Session	4. Group HE/RR: Single Session
5. Group HE/RR: Multi-Session	5. Group HE/RR: Multi-Session

Objectives:

1. Partner Notification

(see statewide objectives on p. V-7)

2. HIV Counseling and Testing

- Provide HIV counseling and testing in non-clinic settings likely to reach non-gay identified MSM such as shelters, streets, and bars.

3. Targeted Outreach

- Conduct targeted outreach including evenings and weekends in public sex environments in Anchorage and Fairbanks.

4. Group HE/RR: Single Session

5. Group HE/RR: Multi-Session

- Provide HE/RR groups - multiple or single-session with a skill building component to the general population in correctional facilities, substance abuse treatment programs, and homeless shelters.

1. Partner Notification

(see statewide objectives on p. V-7)

2. HIV Counseling and Testing

3. Not feasible

4. Group HE/RR: Single Session

5. Group HE/RR: Multi-Session

Injecting Drug Users - Rural Urban Satellites and Rural Hubs

Priority Interventions:

1. Partner Notification	4. Individual HE/RR Counseling
2. Group HE/RR: Multi-Session	5. Syringe Access
3. Group HE/RR: Single Session	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Group HE/RR: Multi-Session

3. Group HE/RR: Single Session

- Provide group HE/RR - multiple- or single-session with a skills component in substance abuse treatment programs funded by the State Division of Alcoholism and Drug Abuse (ADA) in Kenai Peninsula and Mat-Su Boroughs and in rural hub communities.
- Support all state correctional facilities and community residential centers to offer group HE/RR - multiple- or single-session with a skills component to inmates and residents on a regular basis.

4. Individual HE/RR Counseling

- Support ADA funded programs to include individual HIV prevention counseling as part of the treatment plan for all injecting drug users in treatment programs.

5. Syringe Access

- Increase the availability of sterile needles and syringes through advocating for policy changes to allow for (a) the use of federal funds for Syringe Exchange programs and (b) for over-the-counter sale of syringes without a prescription.

Rural Villages

Priority Interventions:

1. Partner Notification	2. Health Communication/Public Information
-------------------------	--

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Health Communication/Public Information

- Support and encourage rural-serving agencies to disseminate broadcast and print media with appropriate risk reduction and harm reduction messages in their respective areas of the state.

HIV Positive Individuals - Rural Urban Satellites and Rural Hubs

Priority Interventions:

1. Partner Notification	4. Health Communication/Public Information
2. Prevention Case Management	5. Targeted Outreach
3. Individual HE/RR Counseling	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Prevention Case Management

- Depending on consumer interest and provider resources, support HIV Care Case Managers and/or mental health clinicians in rural hubs to implement Prevention Case Management for HIV positive persons.

3. Individual HE/RR Counseling

- Support health and social service providers in existing programs and agencies in urban satellites and rural hubs to incorporate risk reduction counseling into the services they provide to HIV positive persons and their partners as appropriate.

4. Health Communication/Public Information

- Use local and regional broadcast and print media outlets to disseminate messages about the importance of knowing one's HIV status and transmission risks, HIV counseling and testing resources, and the benefits of treatment for persons with HIV.

5. Targeted Outreach

- Dispense free condoms at public health clinics, community residential centers, substance abuse treatment programs, shelters, mental health centers and other sites as appropriate.

HIV Positive Individuals Rural Villages

Priority Interventions:

1. Partner Notification	3. Targeted Outreach
2. Individual HE/RR	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Individual HE/RR

- Encourage medical providers to incorporate prevention into case management and medical care to assure a prevention component in the services provided to HIV positive patients and their partners, as appropriate.

3. Targeted Outreach

- Dispense free condoms at village clinics and other sites as appropriate.

Heterosexual Women at Increased Risk - Rural Urban Satellites and Rural Hubs

Priority Interventions:

1. Partner Notification	4. Health Communication/Public Information
2. HIV Counseling and Testing	5. Individual HE/RR Counseling
3. Group HE/RR Single Session	6. Targeted Outreach

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. HIV Counseling and Testing

- Offer HIV counseling and testing in a non-clinic setting in conjunction with group HE/RR presentations at substance abuse treatment programs or shelters serving women in urban satellite or rural hub communities.

3. Group HE/RR Single Session

- Support Group HE/RR presentations at agencies and substance abuse treatment programs specifically serving women in urban satellite or rural hub communities.

4. Health Communication/Public Information

- Promote the distribution of women-specific risk reduction messages through print media (pamphlets and posters) at agencies and places frequented by women such as shelters, bars, rest rooms, and substance abuse treatment facilities.

5. Individual HE/RR Counseling

- Support counselors in programs such as substance abuse treatment programs, and domestic violence and homeless shelters to incorporate individualized risk reduction into their counseling services for women.

6. Targeted Outreach

- Dispense free condoms at public health clinics, community mental health centers, community residential centers, substance abuse treatment programs, and shelters.

Heterosexual Women at Increased Risk Rural Villages

Priority Interventions:

1. Partner Notification	4. Group HE/RR: Single Session
2. HIV Counseling and Testing	5. Targeted Outreach
3. Health Communication/Public Information	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. HIV Counseling and Testing

- Support innovative service delivery mechanisms and the use of rapid testing technologies, when available, to increase access to HIV counseling and testing in rural villages through existing village and itinerant providers with institutional ties to health care, and encourage referrals to HIV counseling and testing resources in rural hubs.

3. Health Communication/Public Information

- Promote the distribution of women-specific risk reduction messages through print media (pamphlets and posters) at village clinics, stores, and shelter/safe home programs.

4. Group HE/RR: Single Session

- Support and encourage the inclusion of single session HE/RR groups with skills building components at community workshops or spirit camps in conjunction with other program activities for substance abuse, interpersonal violence, or suicide prevention.

5. Targeted Outreach

- Dispense free condoms at village clinics and other sites as appropriate.

Youth at Increased Risk - Rural Urban Satellites and Rural Hubs

Priority Interventions:

1. Partner Notification	4. HIV Counseling and Testing
2. Group HE/RR: Multi-Session	5. Targeted Outreach
3. Group HE/RR: Single Session	6. Health Communication/Public Information

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Group HE/RR: Multi-Session

3. Group HE/RR: Single Session

- Provide multi-session HE/RR groups following a “Programs that Work” curriculum in the juvenile detention facilities in Bethel and Nome as feasible.
- Support the use of school-based curricula with a skills component, preferably using a “Programs that Work” curriculum in middle and high schools.
- Promote the inclusion of group HE/RR - multiple- or single-session with a skills component in substance abuse treatment programs, shelters, and spirit camps.

4. HIV Counseling and Testing

- Offer HIV counseling and testing in non-clinic settings in conjunction with group HE/RR sessions, through collaboration between Public Health Nursing and facilities serving high risk youth in urban satellite or rural hub communities.

5. Targeted Outreach

- Dispense free condoms and age-appropriate risk reduction literature to sexually active youth at public health clinics and other sites as appropriate.

6. Health Communication/Public Information

- Use local and regional broadcast and print media outlets to raise awareness about risks, risk reduction, and referrals for local services for youth.

Youth at Increased Risk Rural Villages

Priority Interventions:

1. Partner Notification	4. Targeted Outreach
2. Group HE/RR: Multi-Session	5. Health Communication/Public Information
3. Group HE/RR: Single Session	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Group HE/RR: Multi-Session

- Support the use of school-based curricula with a skills component, preferably using a “Programs that Work” curriculum in middle and high schools.

3. Group HE/RR: Single Session

- Provide group single session awareness raising presentations in rural communities to combat misconceptions.
- Support and encourage the inclusion of single session HE/RR groups with skills building components at community workshops or spirit camps in conjunction with other program activities for substance abuse, interpersonal violence, or suicide prevention.

4. Targeted Outreach

- Dispense free condoms at village clinics and other sites as appropriate.

5. Health Communication/Public Information

- Use local and regional broadcast and print media outlets to raise awareness about risks, risk reduction, and referrals for local, confidential services for youth.

MSM - Young Adult- Rural Urban Satellites and Rural Hubs

Priority Interventions:

1. Partner Notification	5. Prevention Case Management
2. Group HE/RR: Multi-Session	6. Outreach by Peer Opinion Leaders
3. HIV Counseling and Testing	7. Targeted Outreach
4. Individual HE/RR Counseling	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Group HE/RR: Multi-Session

- Offer HE/RR multiple or single session groups including a skills component in correctional facilities and substance abuse treatment programs for male residents. The intervention may reach MSM in these institutional settings without requiring that they identify as MSM.

3. HIV Counseling and Testing

- Provide HIV counseling and testing in non-clinic settings in conjunction with group HE/RR presentations.

4. Individual HE/RR Counseling

- Support health and social service providers in existing programs and agencies in urban satellites and rural hubs to incorporate risk reduction counseling into the individual counseling they provide to clients.

5. Prevention Case Management

- Support mental health providers and HIV Care case managers in two urban satellite or rural hub communities to provide Prevention Case Management to high risk HIV negative MSM especially sexual partners of HIV positive clients.

6. Outreach by Peer Opinion Leaders

- Promote outreach by peer opinion leaders (POL) to rural areas through their social networks and through sponsorship of POL to participate in community forums in urban satellites and rural hubs.

7. Targeted Outreach

- Dispense free condoms at public health clinics, community mental health centers, community residential centers, substance abuse treatment programs, and shelters.

MSM - Young Adult Rural Villages

Priority Interventions:

1. Partner Notification	3. HIV Counseling and Testing
2. Group HE/RR: Single Session	4. Health Communication/Public Information

Note: All MSM objectives for rural villages are addressed under MSM ethnic minorities for rural villages.

MSM - Ethnic Minority- Rural Urban Satellites and Rural Hubs

Priority Interventions:

1. Partner Notification	5. HIV Counseling and Testing
2. Health Communication/Public Information	6. Individual HE/RR Counseling
3. Group HE/RR: Single Session	7. Outreach by Peer Opinion Leaders
4. Group HE/RR: Multi-Session	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. Health Communication/Public Information

- Use local and regional broadcast and print media outlets to disseminate messages about the importance of knowing one’s HIV status and transmission risks and HIV counseling and testing resources.

3. Group HE/RR: Single Session

4. Group HE/RR: Multi-Session

- Offer HE/RR multiple or single session groups including a skills component in correctional facilities and substance abuse treatment programs for male residents. The intervention may reach MSM in these institutional settings without requiring that they identify as MSM.

5. HIV Counseling and Testing

- Provide HIV counseling and testing in non-clinic settings in conjunction with group HE/RR presentations.

6. Individual HE/RR Counseling

- Support health and social service providers in existing programs and agencies in urban satellites and rural hubs to incorporate risk reduction counseling into the individual counseling they provide to clients.

7. Outreach by Peer Opinion Leaders

- Provide outreach by Alaska Native peer opinion leaders (POL) to rural areas through their social networks and through sponsorship of POLs to participate in community forums in urban satellites and rural hubs.

MSM - Ethnic Minority Rural Villages

Priority Interventions:

1. Partner Notification	5. Health Communication/Public Information
2. HIV Counseling and Testing	6. Group HE/RR: Single Session
3. Targeted Outreach	7. Outreach by Peer Opinion Leader
4. Individual HE/RR Counseling	

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. HIV Counseling and Testing

- Support innovative service delivery mechanisms and the use of rapid testing technologies, as available, to increase access to HIV counseling and testing in rural villages through existing village and itinerant providers with institutional ties to health care, and encourage referrals to HIV counseling and testing in rural hubs.

3. Targeted Outreach

- Dispense free condoms at village clinics and other sites as appropriate.

4. Individual HE/RR Counseling

- Support health and social service providers (public health nurses, substance abuse and mental health counselors) itinerating to rural villages and local counselors to incorporate risk reduction counseling into the individual counseling they provide to clients.

5. Health Communication/Public Information

- Support and encourage rural serving agencies and providers to disseminate broadcast and print media with appropriate risk awareness and harm reduction messages and identifying HIV counseling and testing resources in their respective areas of the state.

6. Group HE/RR: Single Session

- Support and encourage the inclusion of single session HE/RR groups with skills building components at community workshops or spirit camps in conjunction with other program activities for substance abuse, interpersonal violence, or suicide prevention.

7. Outreach by Peer Opinion Leader

- Provide outreach by Alaska Native peer opinion leaders (POL) to rural villages through their social networks and through sponsorship of POLs to participate in village forums and spirit camps.

MSM - Non-Gay Identified - Rural Urban Satellites and Rural Hubs

Priority Interventions:

1. Partner Notification	3. Group HE/RR: Single Session
2. HIV Counseling and Testing	4. Group HE/RR: Multi-Session

Objectives:

1. Partner Notification (see statewide objectives on p. V-7)

2. HIV Counseling and Testing

- Provide HIV counseling and testing in non-clinic settings in conjunction with group HE/RR presentations

3. Group HE/RR: Single Session

4. Group HE/RR: Multi-Session

- Provide HE/RR groups - multiple or single-session with a skill building component to the general population in correctional facilities and substance abuse treatment programs in urban satellite and rural hub communities.

Rural Villages

Priority Interventions:

1. Partner Notification	3. Health Communication/Public Information
2. HIV Counseling and Testing	

Note: All MSM objectives for rural villages are addressed under MSM ethnic minorities for rural villages.

Recommendations for Program Coordination

A. Linkages between Primary and Secondary HIV prevention activities

Primary prevention refers to preventing transmission or acquisition of HIV infection. Secondary prevention refers to delaying or halting the onset of illness and progression to AIDS in a person who is HIV positive. There are a number of mechanisms in place whereby persons identified as HIV positive through primary prevention activities are linked to HIV-specific secondary prevention activities and other health, mental health, and ancillary services that can help support the health and longevity of HIV positive persons.

The HPPG recommends the continued provision of the following linkages:

- HIV/STD Program staff provide follow-up with providers on every reported case of HIV to facilitate access to care, case management, partner notification, and other support services.
- All HIV positive persons identified through partner notification services are referred to HIV care, case management, and other services, and assisted to make appointments with providers.
- Persons testing HIV positive through State-supported facilities, such as Public Health Nursing clinics, State-funded substance abuse treatment programs (STOP AIDS), or correctional institutions are referred to or provided medical follow-up, STD and TB screening, family planning, and case management, as appropriate.
- The Municipality of Anchorage Department of Health and Human Services and the Anchorage Neighborhood Health Center (ANHC) both receive HIV prevention funds and also operate health clinics which provide HIV counseling and testing, STD services, family planning, TB screening, and immunizations. ANHC provides medical care and medical case management for HIV positive patients.
- The HIV/STD Program provides current information on care and supportive resources including Ryan White CARE Consortia and the AIDS Drug Assistance Program, and available HIV prevention interventions for HIV positive persons, to providers and consumers through provider training opportunities, resource sheets included with HIV positive laboratory results from the Alaska Virology Laboratory, and funding an AIDS Helpline.
- Three community based organizations receive funds for and house both prevention programs and Ryan White CARE programs, thus facilitating close linkages between primary and secondary prevention services. Title II HIV services are provided through the Alaskan AIDS Assistance Association serving Anchorage, Juneau, and the rest of the state except Fairbanks, and the Interior AIDS Association, serving Fairbanks. These two agencies are funded by the State to accept referrals from counseling and testing sites and other providers to offer support, case management, eligibility determination and entry into the AIDS Drug Assistance Program, and financial assistance for care to HIV positive persons. Both of the agencies are also HIV Prevention grantees. This optimizes coordination of prevention and care services. A third agency, the Anchorage Neighborhood Health Center is independently federally funded to provide medical case management and primary health care services as well as being a State-funded prevention grantee.
- Networking between providers of substance abuse treatment and mental health services with HIV case managers and other HIV care providers through participation in Ryan White CARE Consortia helps facilitate service referrals for HIV positive clients.
- The HIV/STD Program works with the State Division of Alcohol and Drug Abuse and the Division of Mental Health and Developmental Disabilities to ensure that HIV positive individuals have access to appropriate substance abuse treatment and mental health services.

- HIV and STD partner notification services are conducted and coordinated by the State HIV/STD Program thus facilitating coordination of follow-up for HIV positive persons with STD or named as a contact of someone with an STD.

B. Coordination between governmental and non-governmental agencies.

The 2001-2003 Alaska HIV Prevention Plan is disseminated widely among providers of health and social services, substance abuse treatment and prevention programs, health educators, school districts and communities with the intention of providing a blue-print for program planners and providers in the public and private sectors to stimulate and provide guidance for a comprehensive and coordinated approach to HIV prevention in Alaska. HIV prevention priorities of the State HIV/STD Program correspond closely to the recommendations in the Plan. State funds received from CDC are awarded through competitive grants to applicants from non-profit community-based organizations, school districts, Alaska Native tribal entities, and local government health departments. This grant process assures close coordination between the State HIV/STD Program and agencies and organizations involved in prevention activities. Coordination is further facilitated through bi-monthly HIV Prevention Providers teleconferences hosted by the HIV/STD Program. These teleconferences are open to all interested participants. Notices and minutes are presently sent to over fifty providers statewide. The HPPG supports the continuation of these coordination activities and urges providers, consumers and other interested parties to participate. In addition, working with the Department of Education, the Department of Corrections, and the Division of Juvenile Justice as well as their collaborating agencies and their client populations remains a priority.

Assistance and Support Activities

A. Surveillance and Research Activities

HIV/AIDS surveillance and prevention activities in Alaska are conducted under the guidance of the State Epidemiologist and within the HIV/STD Program, Section of Epidemiology, Division of Public Health, Department of Health & Social Services. Alaska's HIV/AIDS and STD Programs are organizationally and functionally merged, facilitating surveillance, prevention, and care activities. HIV/STD Program staff use the epidemiologic data to guide prevention, care, training, and technical assistance activities as well as to shape policy and strategy through their presentation to the HIV Prevention Planning Group, Ryan White CARE Act Consortia, as well as other community and governmental agency representatives and decision makers.

Disease reporting and other surveillance activities are conducted under the State's public health authority. HIV and AIDS are both conditions reportable by name in the State of Alaska, and HIV/AIDS surveillance activities are ongoing. Syphilis, gonorrhea, and chlamydia; hepatitis C; and tuberculosis data from disease reporting also contribute to the Epidemiologic Profile. Section of Epidemiology staff conduct special studies to evaluate surveillance activities and to guide public health programs, as necessary. For example, HIV/STD Program staff will evaluate the accuracy of racial/ethnic classifications for reported Native/non Native HIV/AIDS cases in the final quarter of CY 2000 by replicating a special study we conducted in 1992. In 1992, all reported AIDS cases were matched to two large Alaska databases including Alaska Native and non-Alaska Native individuals (one database included 90,000 individuals and the other 450,000 individuals). The 1992 study found no instances in which individuals classified as Alaska Native or American Indian in either of these two unassociated databases were classified as being a race other than Alaska Native or American Indian in the AIDS cases database. Two AIDS cases classified as Alaska Native in the AIDS case database were not confirmed as Alaska Native by the external databases (nor were they contradicted). This study led us to conclude that,

unlike the situation in some other states, Alaska case data at that time accurately reflected the race/ethnicity of reported Alaska Native/American Indian cases.

Epidemiologic data from disease reporting and other surveillance activities are instrumental in guiding (through the Epidemiologic Profile and regular presentation to the HIV Prevention Planning Group) development of the HIV Prevention Plan.

Ongoing behavioral surveillance activities include the Behavioral Risk Factor Surveillance Survey conducted by the State's Division of Public Health, the Youth Risk Behavior Survey jointly conducted by the State's Section of Epidemiology and Department of Education and Early Development, and the Pregnancy Risk Assessment Monitoring System conducted through the State's Section of Maternal, Child and Family Health. These behavioral surveillance activities contribute data to the Epidemiologic Profile and help shape the HIV Prevention Plan.

Data from these surveillance activities directly support and guide the HIV Prevention Planning Group's identification of priority populations for HIV prevention strategies and interventions. These data are also relevant to evaluation activities, helping to broadly assess penetration into priority behavioral risk populations (where feasible).

Special studies as referenced above are conducted as necessary to guide programmatic activities. Additionally, special studies may be periodically conducted to gain additional information on priority behavioral risk populations (such as the prevalence of certain risk behaviors and/or client service preferences, as referenced in the section in this document on projected needs assessment activities). These are conducted on an as-needed basis and are not envisioned to be ongoing activities.

B. Technical Assistance

The following technical assistance needs have been identified for the HIV/STD Program, the Alaska HPPG, and for community-based prevention providers.

HIV/STD Program staff need to keep abreast of developments in the science of HIV prevention, particularly innovative and scientifically evaluated prevention interventions demonstrating effectiveness in helping persons reduce risk behaviors. Information on effective interventions for HIV positive persons is especially relevant to priorities in the 2001-2003 Plan. HIV/STD Program staff also could benefit from technical assistance in identifying and acquiring tested evaluation instruments for assessing knowledge, behavior, and intention to change resulting from participation in prevention interventions.

The Alaska HIV Prevention Planning Group has accessed and will seek additional technical assistance to meet community planning core objectives, specifically to ensure parity, inclusion and representation of the planning group and broad community involvement. The HPPG continues to rely on the support of the HIV/STD Program for epidemiologic and behavioral data and interpretation and the conduct of needs assessment activities for input from consumers and providers into the planning process.

Community-based providers have ongoing needs for the most current information about effective prevention interventions, particularly those for HIV positive persons and innovative approaches to interventions for men who have sex with men. To meet HIV/STD Program requirements for collecting and reporting data on prevention activities, grantees will require technical assistance from the HIV/STD Program to implement the

proposed computerized data management system to be provided to grantees by the HIV/STD Program in 2001.

C. Evaluation of the Community Planning Process

The Alaska HIV Prevention Planning Group self-evaluates its process and its success in meeting the five core objectives of HIV Prevention Community Planning. The five core objectives are:

1. Foster the open and participatory nature of the community planning process.
2. Ensure that the community planning group reflects the diversity of the epidemic in the jurisdiction, and that experts in epidemiology, behavioral science, health planning, and evaluation are included in the process.
3. Ensure that priority HIV prevention needs are determined based on an epidemiologic profile and a needs assessment.
4. Ensure that interventions are prioritized based on explicit consideration of priority needs, outcome effectiveness, cost effectiveness, social and behavioral science theory, and community norms and values.
5. Foster strong, logical linkages between the community planning process, plans, applications for funding, and allocation of CDC HIV prevention resources.

To assess their internal process and some aspects of core objective #1, members complete a meeting evaluation questionnaire at the end of each HPPG meeting to assess the members' satisfaction and concerns about the process and content of the meeting. This provides valuable information to the HPPG co-chairs about the conduct of the meeting and to HIV/STD Program staff about the clarity and relevance of information presented to the HPPG. Concerns are addressed at the subsequent meeting or in the interim between meetings as appropriate.

For the year 2001, the HPPG will use an expanded version of this questionnaire developed in the third quarter of 2000 by a sub-committee of the HPPG. This will provide additional feedback on group process and meeting content. Per the sub-committee's recommendation, the HPPG will institute an exit survey, with the option of an in-person interview, for members who are stepping down from the HPPG. The survey/interview will ask the member to reflect on the pros and cons of their experience on the HPPG and to provide suggestions for improvement.

The HPPG's accomplishment of the five core objectives of HIV Prevention Community Planning are assessed through five means:

1. *The Profile of the Community Planning Group Members* describes the socio-demographic and professional experience makeup of the HPPG as an indication of the HPPG's member recruitment process (Core Objective 1) and how well the HPPG reflects the epidemic and contains the necessary planning expertise (Core Objective 2).
2. *The 2001 - 2003 Alaska HIV Prevention Plan* documents the year long planning process by which the HPPG developed recommendations for priority interventions based on epidemiologic data and a needs assessment process (Core Objectives 3 and 4).
3. The HPPG compares the goals and objectives in the Alaska HIV/STD Program application to CDC to the recommendations in the HPPG's Comprehensive Plan to assess the correspondence between the Comprehensive Plan and the State's application for funding, which in turn guides the State's funding of grantees (Core Objective 5).
4. *The Table of Estimated Expenditures for HIV Prevention*, submitted to CDC by the HIV/STD Program, summarizes the allocation of HIV prevention funds (Core Objective 5).
5. The HPPG conducts an end-of-year self-evaluation survey of HPPG members and co-chairs which asks members to give their perceptions of how well the HPPG met each of the core objectives.

The HPPG's self-assessment through these mechanisms is conducted yearly. In 2000, the HPPG evaluation sub-committee decided to revise the HPPG self-evaluation survey because of concerns that there were differences of interpretation of some of the questions by HPPG members. The revised survey will be used for the year 2000 end-of-year assessment.

The 2001 - 2003 Alaska HIV Prevention Plan contains a mail-in evaluation form asking for feedback from service providers and community members about the clarity and utility of the Plan. This questionnaire is also on the Section of Epidemiology web site. This feedback will be compiled by HIV/STD Program staff and results will be presented to the HPPG in 2001.

Appendix 1
The Process of Formal Consensus

Introductions

Introduction by Facilitator
Proposal by Presenter
Questions to Clarify Proposal

Level One: Broad Discussion

General Discussion
Call for Consensus

Level Two: Groups of Concerns

List all Concerns
Resolution of Concerns
Call for Consensus

Level Three: Individual Concerns

Restate Each Concern
Questions to Clarify Concern
Discuss the Concern
Each Concern Resolved

Closing Options

Withdraw Concern (Stand Aside)
Send Proposal to Committee
Declare the Proposal Blocked

The Process of Formal Consensus

Consensus

On Conflict & Consensus: A Handbook on Formal Consensus Decisionmaking, Butler, C.T. Lawrence and Rothstein, Amy. Food Not Bombs Publishing. August 1991.

Appendix 2
The Alaska HIV Prevention
Resource Inventory, 2000

Alaska HIV Prevention Resource Inventory 2000

Abbreviations and acronyms used in the Resource Inventory

ADAP	AIDS Drug Assistance Program
AHFC	Alaska Housing Financing Corporation
AN/AI	Alaska Native/ American Indian
DASH	Division of Adolescent and School Health, CDC
HC/PI	Health Communication/ Public Information
HD	Health Department, i.e., AK Section of Epidemiology, HIV/STD Program
HE/RR	Health Education/Risk Reduction
HIV CT	HIV counseling and testing
HOPWA	Housing Opportunities for People with AIDS
HRSA	Health Resource Services Administration
HUD	Housing and Urban Development
IHS	Indian Health Service
NNAAPC	National Native American AIDS Prevention Consortium
PN	Partner Notification
PCM	Prevention Case Management
RARE-T	Reducing AIDS Risk Effectively in Teens peer education program

Intervention Types

Intervention Type	Abbreviation	Subtype	Definition/Examples
Health Communication/ Public Information	HC/PI	General	Broadcast media, print media, health fairs, and hot lines directed toward and/or accessed by the general public. Example: America Responds to AIDS materials; public radio PSA's; staffing a table at a health fair for the general public.
		Targeted	Selected use of broadcast or print media, health fairs, or hot lines, accessed primarily by the priority behavioral risk population. Example: safer sex posters in gay bars and adult bookstores.
Outreach	OR-C	Contact	Dispensing prevention information and materials, including community resource information. One-on-one exchange or one worker talking to a few of the priority behavioral risk population. Usually brief. Information flow is predominantly from outreach worker to person in the priority behavioral risk population.
		Encounter	A dialogue between a worker and a member of a priority behavioral risk population. Involves some disclosure of risk/concerns by the targeted person and, from the worker, some client centered risk reduction counseling or referral to specific risk reduction resources. The encounter may take place in an outreach setting (bar, street, drop-site, etc.) or elsewhere (office, home, treatment center, shelter, etc.) or over the phone, as a client initiated follow-up to an outreach or health education activity. Encounters may be brief or lengthy; single or multiple interactions with the same client; spontaneous or pre-arranged.
		Peer Opinion Leader	Outreach done by opinion leaders in the community being outreach. Popular Opinion Leader Model (Kelly et al. 1992)
Group Health Education/ Risk Reduction	Group HE/RR	Single Session	A presentation to or facilitated interactive discussion with a group of participants from the priority behavioral risk population on a single occasion. Ideally it includes a skills component.
		Multiple Session	A structured series of presentations, discussions, or curricula whereby the same group of participants from the priority behavioral risk population meet multiple times over a specified period of time. Involves a skill building component and some opportunity for participant self-assessment of personal risk.
Individual Health Education/ Risk Reduction	Individual HE/RR		One-on-one, in person, client centered HIV risk assessment and risk reduction counseling that is not an outreach encounter nor Prevention Case Management and is not done in the context of HIV testing. It can be a single session or multiple sessions with the same client.
HIV Counseling and Testing	HIV CT		Client centered HIV risk assessment and risk reduction counseling in the context of HIV testing. May take place in an outreach setting or in a clinic or agency office.
Partner Notification	PN		Voluntary services to notify named sexual and needle-sharing partners to HIV positive individuals of their HIV exposure, and to provide risk reduction counseling, HIV testing, and other appropriate services/referrals per CDC <i>HIV Partner Counseling and Referral Services</i> .

Intervention Types (continued)

Intervention Type	Abbreviation	Subtype	Definition/Examples
Prevention Case Management	PCM		Multiple, one-on-one sessions for intensive risk reduction counseling for HIV positive persons having difficulty initiating or sustaining practices that reduce or prevent HIV transmission, and HIV negative persons (or of unknown serostatus) at high risk of HIV infection, following the CDC <i>HIV Prevention Case Management Guidance</i> , Sept. 1997, provide by, or under the supervision of, a mental health professional or clinical MSW.
Capacity Building			(a) HIV prevention training for providers of health care, social services, counseling, and health education to enhance their ability to provide HIV prevention activities for their clients. (b) Information sessions to further HIV prevention efforts in communities and institutions.

Geographic Project Area	Organization and Contact Information	Prevention Focus	Priority Behavioral Risk Populations	Types of Interventions	Annual # Served (all interven.)	Funding Source		
						CDC Through State HD	Other CDC	State Other HIV
Anchorage/Matanuska-Susitna Borough	Alaska Youth & Parent Foundation Sheila Gaddis Executive Director David Barney, Peer Outreach Coord. 3745 Community Park Loop Anchorage, AK 99508 (907) 274-6541 Fax: (907) 277-2428	• HIV	• Homeless, runaway and other at-risk youth	• Street Outreach • Group HE/RR Single Session • HC/PI	7,500	\$20,000		
	Alaskan AIDS Assistance Assoc. Martha Griffin, Educ. and Prev. Coord. 1057 W. Fireweed Lane Anchorage, AK 99503 (907) 263-2050 Fax: (907) 263-2051	• HIV	• MSM • Ethnic Minorities • Homeless • Incarcerated	• Outreach • Group HE/RR Multi-Session • Group HE/RR Single-Session • HC/PI: Helpline	3,750	Prevent.: \$140,000		\$4,000 Private HOPWA/AHFC: \$557,185 HUD: \$466,000 AHFC: \$90,000 Ryan Wh Care thru State: \$167,719 ADAP thru state: \$350,000
	Anchorage Neighborhood Health Ctr Sharon Zandman-Zeman, Prog. Dir. 1217 E. 10th Avenue Anchorage, AK 99501 (907) 257-4637 Fax: (907) 257-4654	• HIV	• HIV+ • Ethnic Minorities	• Individual HE/RR • Group HE/RR Multi-Session	700	\$30,000		Ryan Wh Title III from HRSA: \$228,988
	Anchorage School District Sharon Vassiere, Hlth Curric. Coord. PO Box 196614 Anchorage, AK 99519-6614 (907) 787-3074 Fax: (907) 3918	• HIV	• Youth	• Peer Education (RARE-T) • HC/PI	7,000	\$25,000		

Geographic Project Area	Organization and Contact Information	Prevention Focus	Priority Behavioral Risk Populations	Types of Interventions	Annual # Served (all interven.)	Funding Source			Other HIV
						CDC Through State HD	Other CDC	State	
Anchorage/Matanuska-Susitna Borough	Mat-Su Alternative School Diane Demoski, Project Director 1775 W. Parks Highway Wasilla, AK 99654 (907) 373-7775 Fax: (907) 373-1430	• HIV	• Youth at Increased Risk	• Outreach • Group HE/RR Single-Session • HC/PI	4,000	\$20,000			\$10,000
	Municipality of Anchorage Cathy Feaster, STD Clinic Manager 825 L Street Anchorage, AK 99501 (907) 343-4794 Fax: (907) 343-4674	• HIV • STD	• MSM • Youth • Transactional Sex Workers	• HIV CT • PN • Outreach • Individual HE/RR • Group HE/RR Single-Session • HC/PI	2,223 tests 1,500	\$95,000			
Fairbanks/Interior	STOP AIDS Project Center for Drug Problems Cynthia Aikens, Exec. Dir. 520 E. 4th Avenue Anchorage, AK 99501 (907) 278-5019 Fax: (907) 276-3637	• HIV	• Injecting Drug Users • Sexual Partners of IDU	• HIV CT • Outreach • Group HE/RR Single-Session	107 tests 3,400			Div. of Alcohol Drug Abuse \$69,805	
	Interior AIDS Association Bonnie McCorquodale 710 Third Avenue PO Box 71248 Fairbanks, AK 99707 (907) 452-4222 Fax: (907) 452-8176	• HIV	• MSM • HIV+ • IDU • Incarcerated • Women at Risk • Youth at Risk	• Outreach • Group HE/RR Multi-Session • Group HE/RR Single-Session • PCM • Individual HE/RR • HIV CT	1,000 19 tests	\$95,000			Ryan Wh Care thru State: \$36,000 HOPWA thru AHFC Borough HSS grant: \$42,100

Geographic Project Area	Organization and Contact Information	Prevention Focus	Priority Behavioral Risk Populations	Types of Interventions	Annual # Served (all interven.)	Funding Source			
						CDC Through State HD	Other CDC	State	Other HIV
Juneau/Southeast	Shanti of Southeast Alaska Ed Linsell, Exec. Director 222 Seward Street, Suite 200 PO Box 22655 Juneau, AK 99802 (907) 463-5665 Fax: (907) 586-3025	• HIV	<ul style="list-style-type: none"> • HIV+ • IDU • Incarcerated • Youth at Risk • Ethnic Min. - homeless and in substance abuse treatment 	<ul style="list-style-type: none"> • Outreach • Individual HE/RR • Group HE/RR Single-Session • Group HE/RR Multi-Session 	1,500	\$45,000			Ryan Wh Care thru State HD: \$35,000
So. Central, Kodiak, YK Delta	Chugachmiut Heather Davis, Project Director 4201 Tudor Centre Drive, Ste. 210 Anchorage, AK 99508 (907) 562-4155 Fax: (907) 563-2891	• HIV	<ul style="list-style-type: none"> • Incarcerated • AN/AI HIV+ 	<ul style="list-style-type: none"> • Capacity Blding • Group HE/RR Single-Session • Case Mngmt. • HIV CT • HC/PI 		\$153,000			HRSA-SPNS \$263,600 (subcontracts to YKHC-\$43,032 KANA-\$64,638)
Anchorage, Juneau	Northern Exchange PO Box 71248 Fairbanks, AK 99707 University of Alaska Student Health Clinics - Anchorage, Southeast, and Fairbanks Campuses	<ul style="list-style-type: none"> • HIV • STD 	<ul style="list-style-type: none"> • IDU • Students 	<ul style="list-style-type: none"> • Syringe Exchange • HIV CT 				not specified	Drug Policy Foundation: \$14,900
Statewide	Alaska Native Health Board Cynthia Navarrette, CEO 4201 Tudor Centre Drive, Suite 105 Anchorage, AK 99508 (907) 562-6006 Fax: (907) 563-2001	• HIV	<ul style="list-style-type: none"> • AN/AI General Population • AN/AI MSM 	<ul style="list-style-type: none"> • Group HE/RR Multi-Session • Group HE/RR Single Session • HC/PI - Rural AK • Capacity Blding 	2,000	\$80,000	\$81,000 NNAAPC in 2000 CDC direct \$192,000/yr; 2000-2003		HRSA Ryan Wh Title III Planning Grant \$50,000 HRSA-AIDS Educ. Training Grant

Geographic Project Area	Organization and Contact Information	Prevention Focus	Priority Behavioral Risk Populations	Types of Interventions	Annual # Served (all interven.)	Funding Source			Other HIV	
						CDC Through State HD	Other CDC	State		
Statewide	16 Public Health Nursing Centers in Barrow, Bethel, Dillingham, Fairbanks, Juneau, Haines, Kenai, Ketchikan, Kodiak, Kotzebue, Nome, Petersburg, Sitka, Seward, Wasilla, and Wrangell	<ul style="list-style-type: none"> • Immunizat. • Well Child • HIV • STD 	<ul style="list-style-type: none"> • All populations 	<ul style="list-style-type: none"> • HIV CT • PN • Group HE/RR • Single Session • HC/PI 	1,971 HIV tests	\$90,000 (\$30,000 each to Bethel Fairbanks Juneau)	\$281,700			
	13 Correctional Centers (Department of Corrections): Anvil Mountain CC, Cook Inlet Prertial, Fairbanks CC, Hiland Mountain CC, Ketchikan CC, Lemon Creek CC, Mat-Su Prertial, Meadow Creek CC, Palmer CC, Sixth Avenue CC, Spring Creek CC, Wildwood CC, Yukon-Kuskokwim CC	<ul style="list-style-type: none"> • Substance Abuse • HIV 	<ul style="list-style-type: none"> • Incarcerated 	<ul style="list-style-type: none"> • Voluntary HIVCT • Group HE/RR • Single-Session through substance abuse treatment and education programs 	984 HIV tests			not specified		
	AK Department of Education and Early Development Beth Shober, Health Educ. Specialist 801 W. 10th St., Ste. 200 Juneau, AK 99801-1894 (907) 465-8719	<ul style="list-style-type: none"> • HIV 	<ul style="list-style-type: none"> • Youth • Youth at Increased Risk 	<ul style="list-style-type: none"> • Capacity Building • Technical Assistance • Curricula 			\$225,000 DASH			
	Division of Juvenile Justice Youth Facilities: Bethel; Nome; Juneau; Fairbanks; Anchorage	<ul style="list-style-type: none"> • HIV 	<ul style="list-style-type: none"> • Youth at Increased Risk 	<ul style="list-style-type: none"> • Group HE/RR • Multi-Session (Be Proud/ Be Responsible) • HIVCT 	650		not specified			

Geographic Project Area	Organization and Contact Information	Prevention Focus	Priority Behavioral Risk Populations	Types of Interventions	Annual # Served (all interven.)	Funding Source		
						CDC Through State HD	Other CDC	State Other HIV
Statewide	Section of Epidemiology HIV/STD Program Wendy Craytor, Program Coordinator 3601 C Street, Ste. 540 PO Box 240249 Anchorage, AK 99524-0249 (907) 269-8000 Fax: (907) 561-0453	<ul style="list-style-type: none"> • HIV • STD 	<ul style="list-style-type: none"> • All populations • Prevention and Care providers 	<ul style="list-style-type: none"> • PN • Capacity Building • Technical Assistance 		Prevention: \$1,177,575 [\$550,000 to grantees and \$90,000 to Pub. Hlth Nursing] \$160,000 supplement starting 9/2000		Ryan Wh Care \$281,019 [\$238,719 to grantees] ADAP \$383,677 [\$350,000 to grantees]
	State Virology Laboratory Don Ritter PO Box 60230 Fairbanks, AK 99706-0230 (907) 474-7017 Fax: (907) 474-4036	<ul style="list-style-type: none"> • HIV 	<ul style="list-style-type: none"> • All 	<ul style="list-style-type: none"> • HIV antibody testing 	13,000 tests		\$363,264	
	AK Div. of Alcohol and Drug Abuse funded and approved treatment and prevention programs. Div. of Alcohol and Drug Abuse Marilee Fletcher PO Box 110607 Juneau, AK 99811-0607 (907) 465-2071 Fax (907) 465-2185 Toll Free 800-478-2072 Adult Treatment in 44 communities Prevention and Outreach in 34 communities. (See supplemental resource list.)	<ul style="list-style-type: none"> • Substance Abuse • HIV 	<ul style="list-style-type: none"> • Substance Abusers • Adolescent Treatment Programs: Anch (2); Fairbanks (2); Juneau (2); Sitka (1); Willow (1) 	<ul style="list-style-type: none"> • In- and Out-patient treatment • Group and Individual HE/RR 			not specified	

Additional resources related to, but not specifically funded for, HIV prevention.

Geographic Project Area	Organization and Contact Information	Prevention Focus	Priority Behavioral Risk Populations	Types of Interventions	Source of Funding
Anchorage	Planned Parenthood, Anchorage Katherine Davey (Health Education) 3401 E 42nd St., Ste. 200 Anchorage, AK 99508 (907) 565-7526 Fax 565-7529	<ul style="list-style-type: none"> • Family Planning • Reproductive Health • HIV • STD 	<ul style="list-style-type: none"> • General Population • Youth 	<ul style="list-style-type: none"> • HIV CT • Group HE/RR Single and Multiple Sessions • HC/PI 	<ul style="list-style-type: none"> • Private Foundation • Client Fees • State Grants
Bethel	Bethel AIDS Task Force Michelle Nicholas Yukon-Kuskokwim Hlth Corp. c/o Social Services PO Box 287, Ste. 300 Bethel, AK 99559	<ul style="list-style-type: none"> • HIV 	<ul style="list-style-type: none"> • General Population 	<ul style="list-style-type: none"> • HC/PI 	Volunteer
Fairbanks	American Red Cross Tanana Valley Chapter Romina Kline 626 2nd St., Ste 202 Fairbanks, AK 99701 (907) 456-5937 Fax 456-7329	<ul style="list-style-type: none"> • Emergency Preparedness • CPR; First Aid • HIV and other communicable diseases 	<ul style="list-style-type: none"> • General Population • Workplace • High School Students • Health Care Providers 	<ul style="list-style-type: none"> • Group HE/RR Single Session • HC/PI 	
Homer	Katchemak Bay Family Planning Clinic Michelle Waneka 3581 Main St. Homer, AK 99603 (907) 235-3436 Fax 235-8346	<ul style="list-style-type: none"> • Family Planning • HIV 	<ul style="list-style-type: none"> • All Populations • Youth 	<ul style="list-style-type: none"> • HIV CT • Group HE/RR Single Session (RARE-T) • HC/PI 	<ul style="list-style-type: none"> • Client Fees • State Grants • Private Foundation
Kenai/Soldotna	Planned Parenthood, Soldotna Jennifer Cowan, Jackie Barsis 44109 Sterling Hwy, Ste. D Soldotna, AK 99669 (907) 262-2622	<ul style="list-style-type: none"> • Family Planning • Reproductive Health • STD • HIV 	<ul style="list-style-type: none"> • All Populations • Youth 	<ul style="list-style-type: none"> • HIV CT 	<ul style="list-style-type: none"> • Private Foundation • Client Fees • State Grants

Geographic Area	Organization and Contact Information	Prevention Focus	Priority Behavioral Risk Populations	Types of Interventions	Source of Funding
Kenai/Soldotna	Hospice of Central Peninsula Liz Schubert 35477 Kenai Spur Hwy Ste 214 Soldotna, AK 99669 (907) 262-0453	• HIV	• General Population	• HC/PI	Volunteer
Sitka	Planned Parenthood of Sitka Colette Casavant, Center Mngnr. PO Box 515 Sitka, AK 99835 (907) 747-3883 Fax: 747-8282	• Family Planning • Reproductive Health • STD • HIV	• General Population • Youth	• HIV CT • Group HE/RR Single Sessions • HC/PI - Health Fairs	• Private Foundation • Client Fees • State Grants
	Sitka Teen Resource Center Sitka Prevention & Treatment P.O. Box 1034 Sitka, AK 99835 (907) 747-3636 Fax: 747-5316	• Substance Abuse • HIV	• Youth	• Group HE/RR Single Session (RARE-T)	
Statewide	AK Native Tribal Health Organizations - clinical services and health education programs (See supplemental resource list)		• Alaska Native beneficiaries and their dependents • Rural communities	Varies by region. • Diagnosis and treatment for HIV, STD, and TB. • Substance Abuse Treatment • Mental Health • Group HIV/HE/RR Single Session • HC/PI	IHS through PL638 contracting

Geographic Area	Organization and Contact Information	Prevention Focus	Priority Behavioral Risk Populations	Types of Interventions	Source of Funding
Statewide	Division of Mental Health and Developmental Disabilities grantees. Leonard Abel, Community Mental Hlth Serv. Admin. 350 Main St. PO Box 110620 Juneau, AK 99811-0620 (907) 465-3370 Fax 465-2668 www.hss.state.ak.us/dimhnh (See supplemental resource list)		<ul style="list-style-type: none"> • All populations 	<ul style="list-style-type: none"> • Individual and Group counseling • Crisis Intervention 	<ul style="list-style-type: none"> • State • Medicaid • Client Fees
	AK Network on Domestic Violence and Sexual Assault funded programs in 19 communities. Trish Gentle, Exec. Dir. PO Box 111200 Juneau, AK 99811-1200 (907) 465-4356 Fax 465-3627 (See supplemental resource list)	<ul style="list-style-type: none"> • Domestic Violence • Sexual Assault 	<ul style="list-style-type: none"> • Women 	<ul style="list-style-type: none"> • Individual and Group counseling • HC/PI • Victim Advocacy 	State

Division of Mental Health and Developmental Disabilities funded programs.

Alaska Youth & Parent Foundation Sheila Gaddis, Director 3745 Community Park Loop #202 Anchorage, AK 99508 Phone: 274-6541 Fax: 277-2428 Email: AYPF@AONLINE.COM	Alternatives CMHC, Inc. David Newell, Executive Director 1675 "C" Street, Suite 117 Anchorage, AK 99501-5198 Phone: 274-8281 Fax: 274-4055 Email: ALTCHMC@PTIALASKA.NET	Anchorage Center for Families Steve Barrett, M.Ed., Director 3745 Community Park Loop, Suite 102 Anchorage, AK 99508 Phone: 276-4994 Fax: 276-6930 Email: SBARRETT@ACFONLINE.ORG
Southcentral Counseling Center Ken Taylor, Mental Health Director 4020 Folker Street Anchorage, AK 99508 Phone: 563-1000 Fax: 563-2045 TDD: 563-3200 Help Line: 563-3200	Southcentral Foundation Behavioral Health Section 670 W. Fireweed Lane, Suite 106 Anchorage, AK 99503 Phone: 265-4912 Fax: 265-4928	Kuskokwim Native Association Michael Bricker, Director P.O. Box 155 Aniak, AK 99555 Phone: 800-478-5622/675-4445 Fax: 675-4456 Emergency: 675-4475 or (800) 478-5622
North Slope Borough CMHC New Horizons Jerry Nordstrom, Acting Director P.O. Box 69 Barrow, AK 99723 Phone: 852-0366 Fax: 852-0315 Emergency: 852-0366	Yukon-Kuskokwim Health Corporation Sandra Mironov, MH Program Administrator P.O. Box 528 Bethel, AK 99559 Phone: 543-6100 Fax: 543-6712	Copper River Community MH Center Ed Krause, Health & Human Services Director Drawer "H" Copper Center, AK 99573 Phone: 822-5241 Fax: 822-8801 Emergency: 822-5241
Sound Alternatives Donna Teekell, Director P.O. Box 160 Cordova, AK 99574 Phone: 224-5257 Fax: 424-8116 Hospital: 424-8645 Emergency: 424-4357 days or 424-8000, eves 424-8300	C.O.H.O. Doug Viet, MH Director P.O. Box 805 Craig, AK 99921 Phone: 826-3662 Fax: 826-2917 Email: COHO@PTIALASKA.NET	Bristol Bay Area Health Corp. MH Center Joan M. Ribich, MH Administrator Director P.O. Box 130 Dillingham, AK 99576 Phone: 842-1230 Fax: 842-5174 Emergency: 842-1230 or (800) 510-1230 days, 842-1230 Eves
Fairbanks Community MH Center Doug Pomeroy, Ph.D., Director 122 First Avenue #5 Fairbanks, AK 99701 Phone: 452-1575 Fax: 452-2173 TDD: 452-5785	Fairbanks Native Association James W. Underwood, Executive Director 201 First Avenue, Suite 200 Fairbanks, AK 99701-4848 Phone: 452-1648 Fax: 456-4148	Tanana Chiefs Conference, Inc. Mark Snipes, Director 122 First Avenue, Suite 600 Fairbanks, AK 99701 Phone: 452-8251 ext. 3162 Fax: 459-3850 Email: msnipes@tananachiefs.org
Yukon-Tanana Counseling Services Dennis Hojna, Director 1302 21ST Avenue Fairbanks, AK 99701 Phone: 459-3930 Fax: 459-3833	Yukon Flats Care Center Barbara Green, Executive Director P.O. Box 21 Fort Yukon, AK 99740 Phone: 662-2526 Fax: 662-2627	Yukon-Koyukuk MH & Alcohol Prgm. Maureen Suttman, Acting Director P.O. Box 17 Galena, AK 99741 Phone: 656-1617 Fax: 656-1581
Lynn Canal Counseling Center Johanna Younger, Director P.O. Box 90 Haines, AK 99827 Phone: 766-2177 Fax: 766-2977 Emergency: 766-2121 Email: JOH_10@HOTMAIL.COM	South Peninsula Mental Health Association, Inc. Kemper Breeding MA, Executive Director 3948 Ben Walters Lane Homer, AK 99603 Phone: 235-7701 Fax: 235-2290 Email: CMHC@XYZ.NET	Juneau Community Mental Health Center Christine Blackgoat, Director 3406 Glacier Highway Juneau, AK 99801 Phone: 463-3008 Fax: 463-5349 Emergency: 586-4357

Division of Mental Health and Developmental Disabilities funded programs.

<p>Juneau Youth Services, Inc. Chuck Bennett, Director P.O. Box 3-2839 Juneau, AK 99803 Phone: 789-7610 Fax: 789-8443 Email: CHUCKB@JYS.org</p>	<p>REACH, Inc. Rod Moline, Ph.D., Director P.O. Box 34197 Juneau, AK 99803 Phone: 586-8228 Fax: 586-8226</p>	<p>Central Peninsula Counseling Service Jim Spielman, Acting Director 506 Lake Street Kenai, AK 99611 Phone: 283-7501 Fax: 283-9006 Emergency: 283-7511</p>
<p>Kenaitze Indian Tribes Rita Smagge, Executive Director P.O. Box 988 Kenai, AK 99611 Phone: 283-6423 Fax: 283-3052 Email: NAKENU@ALASKA.NET</p>	<p>Community Connections Bess Clark, Executive Director 2030 Sealevel Drive, Suite 350 Ketchikan, AK 99901 Phone: 225-7826 Fax: 225-1541</p>	<p>Gateway Center for Human Services Ron Adler, Director 3050 5TH Avenue Ketchikan, AK 99901 Phone: 225-4135 Fax: 247-4135</p>
<p>Providence Kodiak Island MH Center Welby Jensen, MD, Director 717 E. Rezanof Drive Kodiak, AK 99615 Phone: 486-9100 Fax: 486-9119</p>	<p>Maniilaq Counseling Services Bruce Ruttenburg, Ph.D. Director P.O. Box 256 Kotzebue, AK 99752 Phone: 442-7400 Fax: 442-7306 Emergency: 486-9100 or 486-9140</p>	<p>Four Rivers Counseling Service Israel Nelson, Director P.O. Box 229 McGrath, AK 99627 Phone: 524-3781 Fax: 524-3519 Email: fourriversmh@prodigy.com</p>
<p>Railbelt Mental Health & Addictions Mary Entrican, Director P.O. Box 159 Nenana, AK 99760 Phone: 832-5557 Fax: 832-5564</p>	<p>Norton Sound Behavioral Hlth Services Randy Moss, Director Behav. Hlth Svs. P.O. Box 966 Nome, AK 99762 Phone: 443-3344 Fax: 443-5645 Emergency: 443-5206 or (800) 478-3318</p>	<p>New Horizons Val Vasquez, AYI Coordinator P.O. Box 966 Nome, AK 99762 Phone: 443-4592 Fax: 443-5645</p>
<p>Daybreak, Inc. Bill Aube, MSW - Executive Director P.O. Box 1107 Palmer, AK 99645 Phone: 745-6019 Fax: 745-6146 Email: DAYBREAK@CORECOM.NET</p>	<p>Petersburg Mental Health Services Susan Ohmer, MSW, Director P.O. Box 556 Petersburg, AK 99833 Phone: 772-3332 Fax: 772-2122 Email: OLLIE@ALASKA.NET</p>	<p>Eastern Aleutians Tribes (& Pribilof Is.) Chris Dezlin, Executive Director P.O. Box 527 Sand Point, AK 99661 Phone: 383-5421 Fax: 383-5420 Phone: 277-1440 Email: EAT@ALASKA.NET</p>
<p>Seaview Community Services Melissa Stone, Director P.O. Box 1045 Seward, AK 99664 Phone: 224-5257 Fax: 224-7081</p>	<p>SEARHC-Behavioral Health Services Patrick Hefley, MPH, Director 222 Tongass Drive Sitka, AK 99835 Phone: 966-2451 Fax: 966-8707</p>	<p>Sitka Mental Health Clinic, Inc. Camielle Call-Tarbet, Director 1310-A Sawmill Creek Road Sitka, AK 99835 Phone: 747-8994 Fax: 747-6801 Emergency: 747-3241</p>
<p>Tok Area Mental Health Center Jonathan Lundy, MA Director P.O. Box 398 Tok, AK 99780 Phone: 883-5106 Fax: 833-5108</p>	<p>Iliuliuk Family & Health Services, Inc. Jean Richards, ANP - Director of MH P.O. Box 144 Unalaska, AK 99685 Phone: 581-1202 Fax: 581-2331 Email: ILIULIUK@ANSI.NET</p>	<p>Valdez Counseling Center Virginia Rhodes, Director P.O. Box 1050 Valdez, AK 99686 Phone: 835-2838 Fax: 835-5927 Emergency: 835-2838</p>

Division of Mental Health and Developmental Disabilities funded programs.

Life Quest William H. Hogan, Chief Exec. Officer 230 East Paulson, Suite 68 Wasilla, AK 99654 Phone: 376-2411 Fax: 352-3282 Emergency: 376-2411 or (800) 478-2410	Wrangell Community Services, Inc. Mark Walker, LCSW, Director P.O. Box 1615 Wrangell, AK 99929 Phone: 874-2373 Fax: 874-2576	
---	---	--

Alaska Native Tribal Health Organizations

<p>Maniilaq Association Shannon Linebarger Health Education Coordinator P.O. Box 43 Kotzebue, AK 99752 Phone: 442-7176 Fax: 442-7129</p>	<p>Kodiak Area Native Association Rebecca Dawn HIV/AIDS Case Manager 3449 E. Rezanof Drive Kodiak, AK 99615 Phone: 486-9800 Fax: 486-9897</p>	<p>Aleutians/Pribilof Islands Assoc. Michelle Klaas Health Education Coordinator 401 E. Fireweed Lane, Suite #210 Anchorage, AK 99503 Phone: 276-2700 Fax: 276-4894</p>
<p>Tanana Chiefs Conference Margaret Wilson Health Education Manager 122 First Avenue Fairbanks, AK 99701 Phone: 452-8251 x315 Fax: 459-3850</p>	<p>Southcentral Foundation Pauline Johnson 4501 Diplomacy Drive, Suite 200 Anchorage, AK 99508 Phone: 729-3344 Fax: 265-4928</p>	<p>Yukon Kuskokwim Health Corp. Joe Klejka P.O. Box 528 Bethel, AK 99559 Phone: 543- 6028 Fax: 543-6006</p>
<p>Bristol Bay Area Health Corporation Darrell Richardson, Acting Health Education Manager P.O. Box 130 Dillingham, AK 99576 Phone: 842-9347 Fax: 842-9354</p>	<p>Chugachmiut Heather Davis AIDS Case Management Project Director 4201 Tudor Centre, Suite 210 Anchorage, AK 99508 Phone: 562-4155 Fax: 563-2891</p>	<p>Dept. of Hlth and Social Services North Slope Borough Health Department Susan Rinker, Health Director P.O. Box 69 Barrow, AK 99723 Phone: 852-0260 Fax: 852-8844</p>
<p>SouthEast Alaska Regional Health Consortium Roz Jenkins HIV/AIDS Coordinator 222 Tongass Drive Sitka, AK 99835 Phone: 966-8734 Fax: 966-8707</p>	<p>Norton Sound Health Corporation Melanie Edwards Health Education Manager P.O. Box 966 Nome, AK 99762 Phone: 443-3478 Fax: 443-3851</p>	<p>Copper River Native Association Michelle Varas Health Education Coordinator Drawer H Copper Center, AK 99573 Phone: 822-5241 Fax: 822-8803</p>
<p>Metlakatla Clinic Metlakatla Indian Community Sandy King P.O. Box 439 Metlakatla, AK 99926 Phone: 886-4788 Fax: 886-4743</p>	<p>Eastern Aleutian Tribes, Inc. Peggy Osterback Health Director 721 Sesame Street, Suite 2C Anchorage, AK 99503 Phone: 563-1414 Fax: 563-1428</p>	<p>Native Village of Eklutna Debra Till Health Director 26339 Eklutna Village Road Chugiak, AK 99567 Phone: 688-6020 Fax: 688-6021</p>
<p>Mt. Sanford Tribal Consortium Wilson Justin Health Director P.O. Box 4 Gakona, AK 99586 Phone: 822-5399 Fax: 822-5810</p>	<p>Ninilchik Village Trad. Council Mark Rested Health Systems Administrator P.O. Box 39368 Ninilchik, AK 99639 Phone: 567-3970 Fax: 567-3902</p>	<p>Seldovia Village Tribe Chrystal Collier Tribal Director Drawer L Seldovia, AK 99663 Phone: 234-7625 Fax: 234-7637</p>
<p>Valdez Native Tribe Benna Hughey IHS Health Program Director P.O. Box 1108 Valdez, AK 99686 Phone: 835-4951 Fax: 835-5589</p>	<p>Native Village of Tyonek Cassandra Trenton Health Director P.O. Box 82029 Tyonek, AK 99682 Phone: 583-2135 Fax: 583-2442</p>	

AK Network on Domestic Violence and Sexual Assault FY00 FUNDED PROGRAMS

<p>AVV 835-2980 Catherine Vaara, Executive Dir. Advocates for Victims of Violence P O Box 524 Valdez, AK 99686 FAX: 835-2981 Avv@alaska.net 1-800-835-4044</p>	<p>KWRCC 486-6171 Letitia Raub, Executive Director Kodiak Women's Resource and Crisis Center P O Box 2122 Kodiak, AK 99615 FAX: 486-4264</p>	<p>USAFV 581-1500 Lynn Crane, Executive Director Unalaskans Against Sexual Assault and Family Violence P O Box 36 Unalaska, AK 99685 FAX: 581-4568 1-800-478-7238</p>
<p>AWAIC 279-9581 Jan MacClarence, Executive Director Abused Women's Aid In Crisis 100 West 13th Avenue Anchorage, AK 99501 FAX: 279-7244 ruawaic@alaska.net</p>	<p>NSBCS 852-0274 Formerly(AWIC) Don MacRae, Program Administrator North Slope Borough Counseling Services P O Box 69 Barrow, AK 99723 FAX: 852-0389 1-800-478-6606 jcross@co.north-slope.ak.us</p>	<p>VFJ 278-0977 Cathryn Wells, Executive Director Victims For Justice 921 W. 6th Ave. Anchorage, AK 99501 FAX: 258-0740 vfj@alaskalife.net</p>
<p>AWARE 586-6623 Annette Coggins, Executive Director Aiding Women from Abuse and Rape Emergencies P O Box 20809 Juneau, AK 99802-0809 FAX : 586-2479 aware@alaska.net 1-800-478-1090</p>	<p>SAFE 842-2320 Ginger Baim, Executive Director Safe and Fear-Free Environment P O Box 94 Dillingham, AK 99576 FAX: 842-2198 besafe@nushtel.com 1-800-478-2316</p>	<p>VWRC 746-4080 Amy L. Smith, Executive Director Valley Women's Resource Center 403 South Alaska Street Palmer, AK 99645 FAX: 746-1177 vwrc@akcache.com</p>
<p>AWRC 279-6316 (Administrative) Diane Heard, Executive Director Alaska Women's Resource Center 111 W. 9th Avenue Anchorage, AK 99501 FAX: 279-6754 Angie 276-0528 (Program Information) FAX: 278-8944</p>	<p>SAFV 747-3370 Grace Brooks, Executive Director Sitkans Against Family Violence P O Box 6136 Sitka, AK 99835 FAX: 747-3450 akwoman@ptialaska.net 1-800-478-6511</p>	<p>WIC-CA 452-2293 Brenda Stanfill, Executive Director Women In Crisis-Counseling & Assistance 717 9th Avenue Fairbanks, AK 99701 FAX: 452-2613 women@polar.net 1-800-478-7273</p>
<p>BSWG 443-5491 Janet Ahmasuk, Executive Director Bering Sea Women's Group P O Box 1596 Nome, AK 99762 FAX: 443-3748 bswg@nome.net</p>	<p>SCS 224-5257 Melissa Stone, Executive Director Virginia Hawick, DV/SA Coordinator Seaview Community Services P O Box 1045 Seward, AK 99664 FAX: 224-7081 1-888-224-5257</p>	<p>WISH 225-0202 Gigi Pilcher, Executive Director Women In Safe Homes P O Box 6552 Ketchikan, AK 99901 FAX: 225-2472 vawa@ptialaska.net 1-800-478-9474</p>
<p>CFRC 424-5674 Samaria Ross, Executive Director Cordova Family Resource Center P O Box 863 Cordova, AK 99574 FAX: 424-5673 cfrf@ptialaska.net</p>	<p>SPWS 235-7713 Laurentia Chamblee, Executive Director South Peninsula Women's Service 3776 Lake Street, Suite 100 Homer, AK 99603 FAX: 235-2733 1-800-478-7712</p>	<p>ANDVSA 586-3650 Lauree Hugonin, Executive Director Alaska Network on Domestic Violence and Sexual Assault 130 Seward St., Suite 209 Juneau, AK 99801 FAX: 463-4493 www.andvsa.org</p>
<p>EWS 949-1443 Lenora (Lynn) Hootch, Executive Dir. Emmonak Women's Shelter P O Box 207 Emmonak, AK 99581 FAX: 949-1718 1-800-478-1434</p>	<p>STAR 276-7279 Karen Bitzer, Executive Director Standing Together Against Rape 1057 W. Fireweed, Suite 230 Anchorage, AK 99503 FAX: 278-9983 star@aonline.com 1-800-478-8999</p>	<p>ANDVSA 586-5643 Legal Advocacy Project Kari Robinson, Project Attorney 1-800-614-STOP (7867) FAX: 907-586-3152 www.andvsa.org</p>

AK Network on Domestic Violence and Sexual Assault FY00 FUNDED PROGRAMS

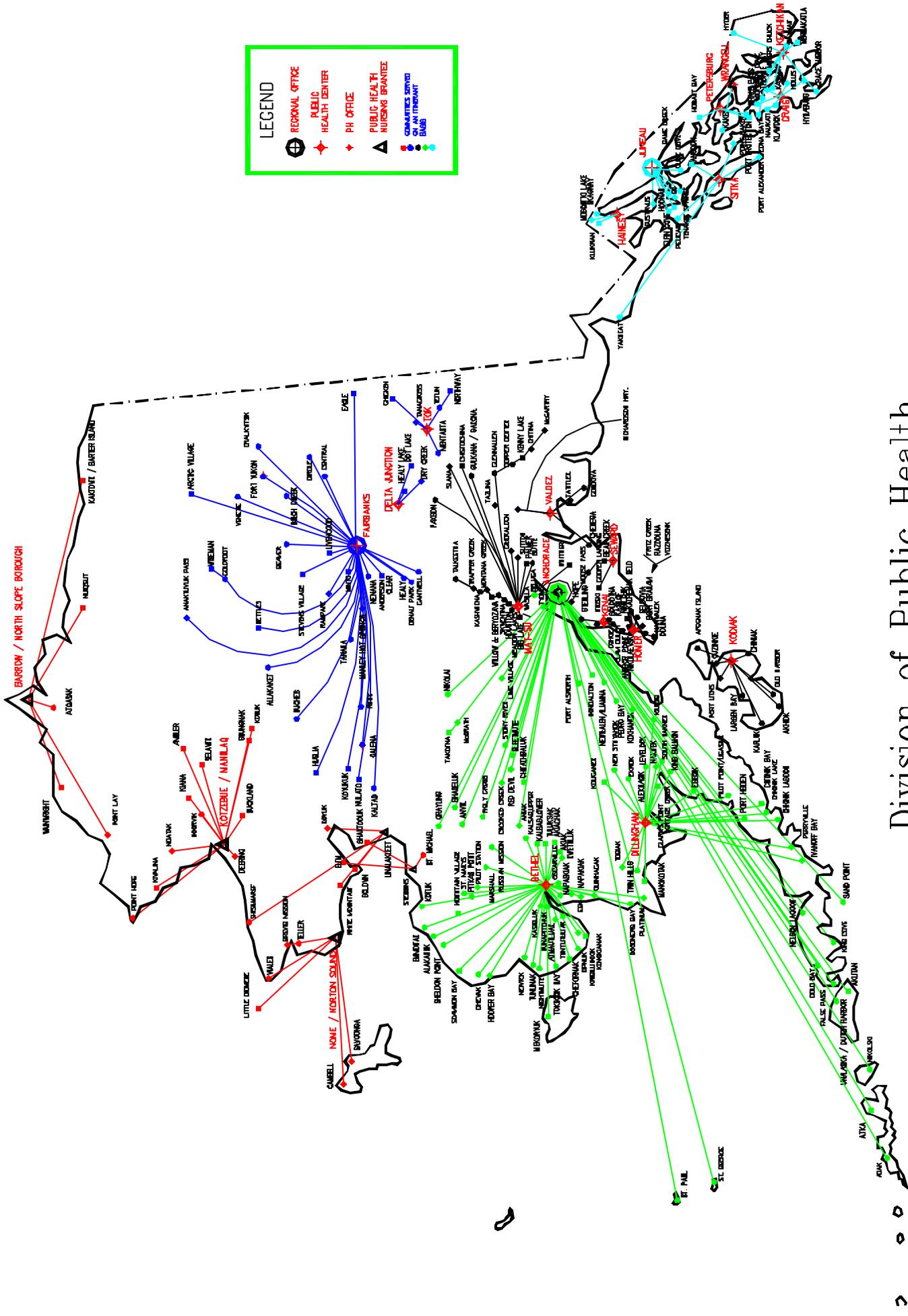
<p>K/SWRCC 283-9479 Heather Arnett, Interm Executive Director Kenai/Soldotna Women's Resource and Crisis Center 325 Spruce Street Kenai, AK 99611 FAX: 283-5844 wrcc@alaska.net</p>	<p>TWC 543-3455 Agnes P. Phillips, Executive Director Tundra Women's Coalition P O Box 1537 Bethel, AK 99559 FAX: 543-3752 1-800-478-7799 twcpeace@alaska.com</p>	
---	---	--

State of Alaska, Section of Public Health Nursing

<p>Anchorage Itinerant Services Anita Roth Regional Nurse Manager 701 E. Tudor Road, Suite 280 Anchorage, AK 99503-7445 Phone: 562-5454 Fax: 562-7140</p>	<p>Bethel Public Health Center Donna Chris Public Health Nurse Team Leader 700 Chief Eddie, Hoffman Hwy P.O. Box 1048 Bethel, AK 99559 Phone: 543-6530 Fax: 543-6536</p>	<p>Bethel Itinerant Nursing Dorene Vallee, Nurse Manager 401 Ridgecrest Drive P.O. Box 1048 Bethel, AK 99559 Phone: 543-2110 Fax: 543-5271</p>
<p>Craig Public Health Center Colleen Watson, Public Health Nurse III 404 Spruce P.O. Box 130 Craig, AK 99921 Phone: 826-3343 Fax: 826-3435</p>	<p>Delta Junction Public Hlth Center Janice Templin-Weller Public Health Nurse III 2857 Alaska Highway, Room 215 P.O. Box 1511 Delta Junction, AK 99737 Phone: 895-4292 Fax: 895-4264</p>	<p>Dillingham Public Health Center Jean Timmerman, Nurse Manager 125 Main Street P.O. Box 1489 Dillingham, AK 99566 Phone: 842-5981 Fax: 842-4396</p>
<p>Fairbanks Regional Public Hlth Center Verl Harrison, Nurse Manager 1025 West Barnette Fairbanks, AK 99701-4541 Phone: 452-1776 Fax: 451-4611 Toll free: 800-478-1777</p>	<p>Fort Yukon Public Health Center Martin Becker, Public Health Nurse III 1 Spruce Street P.O. Box 316 Fort Yukon, AK 99740 Phone: 662-2460 Fax: 662-3462 Toll free: 800-478-1777</p>	<p>Galena Public Health Center Margaret Huntington, Admin. Clerk III Antoski Avenue P.O. Box 64 Galena, AK 99741 Phone: 656-1200 Fax: 656-1525</p>
<p>Glennallen Public Health Center Glennallen, AK 99588 (Call for appointment) Joanne (JD) Pross Public Health Nurse III Phone: 822-3209 Fax: 822-3367</p>	<p>Haines Public Health Center Naomi Kerwin, Public Health Nurse III Gateway Building, Main Street P.O. Box 717 Haines, AK 99827 Phone: 766-3300 Fax: 766-3368</p>	<p>Homer Public Health Center Donna Fenske, Public Health Nurse III 195 West Bunnell Avenue, Suite C Homer, AK 99603 Phone: 235-8857 Fax: 235-7090</p>
<p>Juneau Public Health Center Mary Frances Richmond Nurse Manager 3412 Glacier Highway Juneau, AK 99801-9501 Phone: 465-3353 Fax: 465-3389</p>	<p>Kenai Public Health Center JoAnn Hagen, Nurse Manager 210 Fidalgo Avenue, Room 102 Kenai, AK 99611 Phone: 283-4871 Fax: 283-7447</p>	<p>Ketchikan Public Health Center Corky Olsen, Nurse Manager 3054 Fifth Avenue Ketchikan, AK 99901 Phone: 225-4350 Fax: 247-0978</p>
<p>Kodiak Public Health Center Ruth Ann O’Gorman, Nurse Manager 316 Mission Road, Room 207 Kodiak, AK 99615 Phone: 486-3319 Fax: 486-8149</p>	<p>Mat-Su Public Health Center Jerry Troshynski, Nurse Manager 1830 East Parks Highway, A-134 Wasilla, AK 99654 Phone: 376-2437 Fax: 376-3096</p>	<p>Petersburg Public Health Center Marlene Cushing Public Health Nurse III 103 Fram Street P.O. Box 377 Petersburg, AK 99833 Phone: 772-4611 Fax: 772-4617</p>
<p>Seward Public Health Center Lois Daubney, Public Health Nurse III 216 Fourth Avenue P.O. Box 810 Seward, AK 99665 Phone: 224-5567 Fax: 224-2385</p>	<p>Sitka Public Health Center Patricia Lehmann, Nurse Manager 210 Moller Street Sitka, AK 99835 Phone: 747-3255 Fax: 747-4899</p>	<p>Tok Public Health Center Penny Pfeffer, Public Health Nurse III 1314 Alaska Highway P.O. Box 186 Tok, AK 99780 Phone: 883-4101 Fax: 883-4102 Toll free: 800-478-4101</p>

State of Alaska, Section of Public Health Nursing

<p>Valdez Public Health Center Pam Shirrell Public Health Nurse III 1001 Meals Avenue P.O. Box 950 Valdez, AK 99686 Phone: 835-4612 Fax: 835-2419</p>	<p>Wrangell Public Health Center Janet Strom Public Health Nurse III 215 Front Street P.O. Box 379 Wrangell, AK 99929 Phone: 874-3615 Fax: 874-2991</p>	
<p>Public Health Nursing Contracts with Tribal Health Organizations</p>		
<p>North Slope Borough Health & Social Services Agency Griest Family Services Leeanne Mercier Program Manager 1296 Agrik Street P.O. Box 69 Barrow, AK 99723 Phone: 852-0270 Fax: 852-2855</p>	<p>Maniilaq Association Public Health Nursing Peggy Sue Wright Program Manger P.O. Box 170 Kotzebue, AK 99652 Phone: 442-7144 Fax: 442-7306</p>	<p>Norton Sound Health Corporation Nome Health Center Julie Serstad Director Public Health Nursing P.O. Box 1710 Nome, AK 99762 Phone: 443-3221 Fax: 443-4869</p>



LEGEND

- ⊕ REGIONAL OFFICE
- ⬠ PUBLIC HEALTH CENTER
- ◆ PH OFFICE
- ▲ PUBLIC HEALTH NURSING BRANTEE
- COMMUNITIES SERVED ON AN ITINERARY
- BUSES

Division of Public Health PUBLIC HEALTH NURSING

January, 2000

Division of Alcohol and Drug Abuse Approved Programs

To be a State approved treatment program, a program must meet the state standards for treatment programs. Additionally, all publicly funded programs must comply with state grant regulation (7AAC78), and special grant conditions. Part of these special grant conditions give priority consideration for pregnant women, injection drug users, and HIV positive persons seeking treatment. HIV prevention counseling must be included in the client treatment plan for injection drug users.

<p>Allakaket Counseling Center Julia Simon, Counselor P.O. Box 89 Allakaket, AK 99720 Phone: 968-2210 Fax: 968-2288</p>	<p>Akeela, Inc. Robert Galea, Director 4111 Minnesota Drive Anchorage, AK 99503 Phone: 258-6021 Ext. 34 Fax: 258-6052</p>	<p>The Ernie Turner Center Alaska North Addiction Recovery Center Obed Nelson, Executive Directory 4330 South Bragaw Street Anchorage, AK 99508 Phone: 561-5537 Fax: 276-4534</p>
<p>Alaska Women Resource Center/ New Dawn Diane Heard, Executive Director 111 W. 9th Avenue Anchorage, AK 99501 Phone: 276-0528 Fax: 276-4534</p>	<p>Aleutian/Pribiloff Island Association Michele Klaas, Coordinator 201 East 3rd Avenue Anchorage, AK 99501 Phone: 276-2700 Fax: 279-4351</p>	<p>Arc of Anchorage Bryn Mawr Substance Abuse Program Margaret Lowe, Project Director 2211 Arca Drive Anchorage, AK 99508 Phone: 338-3686 Fax: 272-2161</p>
<p>Center for Drug Problems Narcotic Drug Treatment Center Cynthia E. Aiken, Executive Director 520 East 4th Avenue Suite 102 Anchorage, AK 99501 Phone: 276-6430 Fax: 276-3637</p>	<p>Clitheroe Center Salvation Army Sheila Burke, Director 1709 South Bragaw Street, Suite B Anchorage, AK 99508 Phone: 276-2898 Fax: 279-8526</p>	<p>Eastern Aleutian Tribes, Inc. Patty Linduska, Executive Director 1600 A Street, Suite 104 Anchorage, AK 99501 Phone: 277- 1440 Fax: 277-1446</p>
<p>Booth Memorial Youth & Family Services Salvation Army Julia Person, Clinical Director 3600 East 20th Avenue Anchorage, AK 99508 Phone: 279-0522 Fax: 278-5073</p>	<p>Southcentral Foundation Dena A. Coy, Future Generations Kathleen Johnson, Acting Director 3916 East 9th Avenue Anchorage, AK 99508 Phone: 333-6677 Fax: 333-1716</p>	<p>Volunteers of America of Alaska/ ASSIST Elaine Dahlgren, Executive Director 441 West 5th Avenue Suite 202 & 301 Anchorage, AK 99501 Phone: 279-9634 Fax: 276-5489</p>
<p>Rural Alcoholism Program SEARHC Sharon McIndoo/Lenora Cooper CFSW P.O. Box 27 Angoon, AK 99820 Phone: 788-3893/3636 Fax: 788-3180</p>	<p>KNA Community Counseling Center Kuskokwim Native Association Mike Bricker, Project Director P.O. Box 155 Aniak, AK 99557 Phone: 675-4445 Fax: 675-4456</p>	<p>North Slope Borough Counseling Service North Sope Borough Dept. H&SS Don McCrae, Clinical Director P.O. Box 69 Barrow, AK 99723 Phone: 852-0274 Fax: 852-0389</p>
<p>Village Sobriety Project Yukon-Kuskokwim Health Corp. Sandy Mironov, Project Director P.O. Box 528 Bethel, AK 99559 Phone: 543-6760 Fax: 543-6712</p>	<p>Family Spirit Project Yukon-Kuskokwim Health Corp. Ray Watson, Project Director P.O. Box 528 Bethel, AK 99559 Phone: 543-6726 Fax: 543-6006</p>	<p>Yukon-Kuskowim Hlth Corp./PAT/ DOC Raymond Watson, Project Director P.O. Box 528 Bethel, AK 99559 Phone: 543-6700 Fax: 543-6712</p>

Division of Alcohol and Drug Abuse Approved Programs

<p>Behavioral Health Services Yukon-Kuskokwim Health Corp. Sandy Mironov, Project Director P.O. Box 1087 Bethel, AK 99559 Phone: 543-6700/6100 Fax: 543-6008</p>	<p>Chemical Treatment & Recovery Svcs. Yukon-Kuskokwim Health Corp. Alexie H. Kanrilak, Counselor I P.O. Box 246 Chevak, AK 99563 Phone: 858-7267 Fax: 858-7257</p>	<p>Cordova Community Hospital Sound Alternatives Donna Teekel, Program Director P.O. Box 160 Cordova, AK 99574 Phone: 424-8300 Fax: 424-8645</p>
<p>Communities Organized for Health Options (COHO) Lloyd Gatham, Executive Director P.O. Box 805 Craig, AK 99921 Phone: 826-3662 Fax: 826-2917</p>	<p>Alcoholism & Drug Abuse Program Bristol Bay Area Health Corp. Cristy Willer Tilden, Program Director P.O. Box 130 Dillingham, AK 99576 Phone: 842-5266 Fax: 842-5915</p>	<p>Volunteers of America of Alaska/ ARCH Karen Schaff, Treatment Service Director HC 85, P.O. Box 9549 Mile-2, Highland Road Eagle River, AK 99577 Phone: 694-3336 Fax: 694-8840</p>
<p>Graf-Rheeneerhaahii Fairbanks Native Association Barb Kootuk, Acting Program Director P.O. Box 80450 Fairbanks, AK 99708 Phone: 455-4725 Fax: 455-4730</p>	<p>New Hope Center Fairbanks Native Association Greg Selid, Treatment Supervisor 3051 N. VanHorn Road Fairbanks, AK 99707 Phone: 451-1170 Fax: 451-0962</p>	<p>Regional Center for Alcohol & Other Addictions Fairbanks Native Association Kathy Wilson, Acting Program Director 3100 South Cushman P.O. Box 74450 Fairbanks, AK 99707 Phone: 456-7819 Fax: 456-4849</p>
<p>LifeGivers Fairbanks Native Association Valerie Naquin, Program Director 605 Hughes Avenue Fairbanks, AK 99701 Phone: 452-1274 Fax: 452-1282</p>	<p>Women & Children Residential Prgm Fairbanks Native Association Cyndi Nation-Cruikshank, Program Director P.O. Box 71048 Fairbanks, AK 99707 Phone: 451-8164 Fax: 451-0273</p>	<p>Yukon Tanana Counseling Services Tanana Chiefs Conference, Inc. Dennis Hojna, Program Director 1302 21st Avenue Fairbanks, AK 99701 Phone: 459-3930 Fax: 459-3833</p>
<p>Family Recovery Camp Tanana Chiefs Conference, Inc. Victor Joseph, Coordinator 122 1st Avenue, Suite 600 Fairbanks, AK 99701 Phone: 452-8251 Fax: 452-3835</p>	<p>CATG Yukon Flats C.A.R.E. Council of Athabascan Tribal Gvrmt. Barbara Greene, Administrative Director P.O. Box 21 Fort Yukon, AK 99740-0021 Phone: 662-2526 Fax: 766-2627</p>	<p>Rural Alcoholism Program SEARHC Lorraine Kaska/Ellen Carey-Starr CFSW P.O. Box 888 Haines, AK 99827 Phone: 766-2959 Fax: 766-2680</p>
<p>Railbelt Mental Health & Addictions Mary Entrican, Director P.O. Box 128 Healy, AK 99743 Phone: 683-2743 Fax: 683-2598</p>	<p>Cook Inlet Council on Alcohol & Drug Abuse (CICADA) Henry Novak, Executive Director P.O. Box 2352 Homer, AK 99603 Phone: 235-8001 Fax: 235-8099</p>	<p>Hoonah Indian Association Johanna Dybdahl, Tribal Administrator 254 Roosevelt Street P.O. Box 602 Hoonah, AK 99829-0602 Phone: 945-3545 Fax: 945-3703</p>

Division of Alcohol and Drug Abuse Approved Programs

<p>Village Sobriety Project Yukon-Kuskokwim Health Corp. Henrietta Long/Martha Simon Counselor (s) P.O. Box 169 Hooper Bay, AK 99604 Phone: 758-4811 Fax: 758-4927</p>	<p>Chemical Dependency Division/DHSS City & Borough of Juneau Christen Blackgoat, Administrator 3250 Hospital Drive Juneau, AK 99801 Phone: 586-9508 Fax: 586-5605</p>	<p>Gastineau Human Services Greg R. Pease, Executive Director 5597 Aisek Street Juneau, AK 99801 Phone: 780-4338 Fax: 780-4098</p>
<p>Rural Alcoholism Program SEARHC Dinah Aceveda/Jada Smith, CFSW P.O. Box 589 Kake, AK 99830 785-3895/4892 Fax: 785-3350</p>	<p>Cook Inlet Council on Alcohol & Drug Abuse (CICADA) Henry Novak, Executive Director P.O. Box 882 Kenai, AK 99611 Phone: 283-3658 Fax: 283-5046</p>	<p>Nakenu Chemical Dependency Recovery Center Kenaitze Indian Tribe Linda Perry, MSW Human Services Director 150 N. Willow, Suite 17 P.O. Box 988 Kenai, AK 99611 Phone: 283-6693 Fax: 283-7088</p>
<p>Gateway Center for Human Services Alcohol & Drug Abuse Services Kevin Murphy, Program Director 3050 5th Avenue Ketchikan, AK 99901 Phone: 225-4154 Fax: 247-4135</p>	<p>Rural Alcoholism Program SEARHC Janice Hotze, Director P.O. Box 690 Klukwan, AK 99827 Phone: 767-5592 Fax: 767-5592</p>	<p>Safe Harbor Kodiak Council on Alcoholism Rick Leland, Director 115 Mill Bay Road Kodiak, AK 99615 Phone: 486-3535 Fax: 486-7689</p>
<p>Maniilaq Addiction & Support Services George Baker, Program Director P.O. Box 256 Kotzebue, AK 99752 Phone: 442-7640 Fax: 442-7822</p>	<p>Railbelt Mental Health & Addictions Mary Entrican, MS, LMFT Director P.O. Box 159 Nenana, AK 99760 Phone: 832-5557 Fax: 832-5564</p>	<p>Behavioral Outpatient Services Norton Sound Health Corporation Jane Franks, Director P.O. Box 966 Nome, AK 99762 Phone: 443-3344 Fax: 443-5645</p>
<p>Changing Tides Counseling Services Larry King, Director P.O. Box 1066 Petersburg, AK 99833 Phone: 772-3552 Fax: 772-3580</p>	<p>Eastern Aleutian Tribes, Inc. David Herman, Director P.O. Box 527 Sand Point, AK 99661 Phone: 383-5421 Fax: 383-5420</p>	<p>Chemical Misuse Treatment & Recovery Services Yukon-Kuskokwim Health Corp. Irene Kaganak/Aaron Kaganak Counselor (s) P.O. Box 129 Scammon Bay, AK 99662 Phone: 558-5343 Fax: 558-5343</p>
<p>Village Tribe/SKIAP Alcohol Program Denita Higman, Program Coordinator P.O. Box 197 Seldovia, AK 99663 Phone: 234-7807 Fax: 234-7493</p>	<p>SeaView Community Services Melissa Stone, Executive Director 302 Railway Avenue, SeaView Plaza P.O. Box 1045 Seward, AK 99664 Phone: 224-5257 Fax: 224-7081</p>	<p>Bill Brady Healing Center SEARHC Pat Hefley, Director 222 Tongass Drive Sitka, AK 99835 Phone: 966-8360 Fax: 966-8494</p>

Division of Alcohol and Drug Abuse Approved Programs

<p>Raven's Way Paty Hefley, Director 222 Tongass Drive, Pouch R Sitka, AK 99835 Phone: 966-8726 Fax: 966-8705</p>	<p>Sitka Prevention & Treatment Services, Inc. Jeffery Budd, Director P.O. Box 1034 Sitka, AK 99835 Phone: 747-3636 Fax: 747-5316</p>	<p>Behavioral Health Services SEARHC Pat Hefley, Director 222 Tongass Drive Sitka, AK 99835 Phone: 966-8710 Fax: 966-8707</p>
<p>Pribiloff Counseling Center Aleutian/Pribiloff Island Association Michele Klaas, Counselor P.O. Box 65 St. Paul, AK 99669 Phone: 546-2342 Fax: 546-2343</p>	<p>Sunshine Community Health Center Jessica Stevens, Coordinator P.O. Box 787 Talkeetna, AK 99676 Phone: 733-2273 Fax: 733-1735</p>	<p>Tanana Counseling Center Tanana Tribal Council Faith Peters, Counselor P.O. Box 130 Tanana, AK 99777 Phone: 366-7154 Fax: 366-7195</p>
<p>Upper Tanana Alcoholism Program Tanana Chiefs Conference, Inc. Jan Donnelly, Program Director P.O. Box 83 Tok, AK 99780 Phone: 883-5185 Fax: 883-4332</p>	<p>Aleutian/Pribiloff Island Association Aleutian Counseling Center June Dirks, Counselor P.O. Box 1130 Unalaska, AK 99685 Phone: 581-2742 Fax: 581-2040</p>	<p>Valdez Counseling Center Virginia Rhodes, Program Director P.O. Box 1050 Valdez, AK 99686 Phone: 835-2838 Fax: 835-5927</p>
<p>Mat-Su Council Recovery Center Pam Sandvik, Director 291 E. Swanson Wasilla, AK 99654 Phone: 373-2454 Fax: 373-1135</p>	<p>Alaska Addictions Rehabilitation Services Nugen's Ranch Karen Nugen-Logan Executive Director 3701 Palmer Wasilla Way P.O. Box 871545 Wasilla, AK 99687 Phone: 376-4534 Fax: 376-2348</p>	<p>Avenue to Recovery Tom Stock, Director 406 Alaska Avenue P.O. Box 1108 Wrangell, AK 99929 Phone: 874-3338 Fax: 874-3339</p>
<p>Yakutat Tlingit Tribe Family Services Ramona Anderstrom, Program Director 716 Ocean Cape Road P.O. Box 418 Yakutat, AK 99689 Phone: 784-3375 Fax: 784-3664</p>		

**Division of Alcohol and Drug Abuse Approved Programs
Adolescent**

<p>Booth Memorial Youth & Family Services Salvation Army Julia Person, Clinical Director 3600 East 20th Avenue Anchorage, AK 99508 Phone: 279-0522 Fax: 278-5073</p>	<p>Volunteers of America of Alaska/ ASSIST Elaine Dahlgren, Executive Director 441 West 5th Avenue Suite 202 & 301 Anchorage, AK 99501 Phone: 279-9634 Fax 276-5489</p>	<p>Graf-Rheeneerhaahii Fairbanks Native Association Barb Kootuk, Acting Program Director P.O. Box 80450 Fairbanks, AK 99708 Phone: 455-4725 Fax: 455-4730</p>
<p>LifeGivers Fairbanks Native Association Valerie Naquin, Program Director 605 Hughes Avenue Fairbanks, AK 99701 Phone: 452-1274 Fax: 452-1282</p>	<p>Chemical Dependency Division/DHSS City & Borough of Juneau Christen Blackgoat, Administrator 3250 Hospital Drive Juneau, AK 99801 Phone: 586-9508 Fax: 586-5605</p>	<p>Raven's Way Paty Hefley, Director 222 Tongass Drive, Pouch R Sitka, AK 99835 Phone: 966-8726 Fax 966-8705</p>
<p>Mat-Su Council Recovery Center Pam Sandvik, Director 291 E. Swanson Wasilla, AK 99654 Phone: 373-2454 Fax: 373-1135</p>		

Appendix 3
Decision Tree for Prioritizing Populations
with Unmet HIV Prevention Needs

References

References

- Academy for Educational Development, Center for Community Based Health Strategies. (1999). *Assessing the need for HIV prevention services: A guide for community planning groups, self-assessment Tool for Community Planning Groups*. Washington, DC: Academy for Educational Development, Center for Community Based Health Strategies.
- Butler, C.T., Rothstein, A., & Rothstein, L. (1991). *On conflict and consensus: A handbook on formal consensus decision making* [online] Available: [<http://consensus.hypermart.net/ocac>]. Cambridge, MA: Food Not Bombs Publishing.
- Centers for Disease Control and Prevention, HIV/AIDS Prevention Research Synthesis Project. Compendium of HIV Prevention Interventions with Evidence of Effectiveness, November 1999.
- Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention. Evaluating CDC-Funded HIV Prevention Programs: Volume I: Guidance III-I, December 1999.
- Centers for Disease Control and Prevention. HIV Prevention Case Management Guidance. September 1997.
- Centers for Disease Control and Prevention. (2000). Adoption of protective behaviors among persons with recent HIV infection and diagnosis - Alabama, New Jersey, and Tennessee, 1997-1998. *MMWR Recommendations and Reports*, 49:512-515.
- Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention. (2000). Draft: A serostatus approach to fighting the HIV/AIDS epidemic. 1-8.
- Centers for Disease Control and Prevention. (2000). HIV/AIDS surveillance update. 1 (10), 12.
- Centers for Disease Control AIDS Community Demonstration Projects Research Group. (1999). Community-level HIV intervention in five cities: Final outcome data from the CDC AIDS Community Demonstration Projects. *American Journal of Public Health*, 89 (3), 336-345.
- Cohen, D., Dent, C., & MacKinnon, D. (1991). Condom skills education and sexually transmitted disease reinfection. *Journal of Sex Research*, 28 (1), 139-144.
- Cohen, D.A., MacKinnon, D.P., Dent, C., Mason, H., & Sullivan, E. (1992). Group counseling at STD clinics to promote use of condoms. *Public Health Reports*, 107 (6), 727-731.
- Des Jarlais, D.C., Casriel, C., Friedman, S.R., & Rosenblum, A. (1992). AIDS and the transition to illicit drug injection - Results of a randomized trial prevention program. *British Journal of Addiction*, 87 (3), 493-498.
- DiClemente, R.J. & Wingood, G.M. (1995). A randomized controlled trial of an HIV sexual risk-reduction intervention for young African-American women. *Journal of the American Medical Association*, 274 (16), 1271-1276.
- El-Bassel, N. & Schilling, R.F. (1992). 15-month follow-up of women methadone patients taught skills to reduce heterosexual HIV transmission. *Public Health Reports*, 107 (5), 500-504.
- Fenaughty, A.M., Fisher, D.G., & Cagle, H.H. (1998). Sex partners of Alaskan drug users: HIV transmission between white men and Alaska Native women. *Women, drug use, and HIV infection*, 27 (1/2), 87-103.

- Greenberg, J.B., & Neumann, M.S., (Eds.). (1991). *What we have learned from the AIDS evaluation of street outreach projects: A summary document*. Atlanta, GA: Department of Health and Human Services, Centers for Disease Control and Prevention.
- Hobfoll, S.E., Jackson, A.P., Lavin, J., Britton, P.J., & Shepherd, J.B. (1994). Reducing inner-city women's AIDS risk activities: A study of single, pregnant women. *Health Psychology*, 13 (5), 397-403.
- Jemmott, J.B., Jemmott, L.S., & Fong, G.T. (1992). Reductions in HIV risk-associated sexual behaviors among black male adolescents: Effects of an AIDS prevention intervention. *American Journal of Public Health*, 82 (3), 372-377.
- Johnson, M.E., Fisher, D.G., Davis, D.C., Cagle, H.H., Rhodes, F., Booth, R., Siegal, H., & Jones, A. (1996). Assessing reading level of drug users for HIV and AIDS prevention purposes. *AIDS Education and Prevention*, 8 (4), 323-334.
- Kamb, M.L., Fishbein, M., Douglas, J.M., Rhodes, F., Rogers, J., Bolan, G., Zenilman, J., Hoxworth, T., Malotte, C.K., Iatesta, M., Kent, C., Lentz, A., Graziano, S., Byers, R.H., & Peterman, T.A., for the Project RESPECT Study Group (1998). Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: A randomized controlled trial. *Journal of the American Medical Association*, 280 (13), 1161-1167
- Kegeles, S.M., Hays, R.B., & Coates, T.J. (1996). The Mpowerment Project: A community-level HIV prevention intervention for young gay men. *American Journal of Public Health*, 86 (8), 1129-1136.
- Kelly, J.A., Murphy, D.A., Washington, C.D., Wilson, T.S., Koob, J.J., Davis, D.R., Ledezma, G., & Davantes, B. (1994). The effects of HIV/AIDS intervention groups for high-risk women in urban clinics. *American Journal of Public Health*, 84 (12), 1918-1922.
- Kelly, J.A., St. Lawrence, J.S., Hood, H.V., & Brasfield, T.L. (1989). Behavioral intervention to reduce AIDS risk activities. *Journal of Consulting and Clinical Psychology*, 57 (1), 60-67.
- Kelly, J.A., St. Lawrence, J.S., Stevenson, Y., Hauth, A.C., Kalichman, S.C., Diaz, Y.E., Brasfield, T.L., Koob, J.J., & Morgan, M.G. (1992). Community AIDS/HIV risk reduction: The effects of endorsements by popular people in three cities. *American Journal of Public Health*, 82 (11), 1483-1489.
- Kirby, D., Barth, R.P., Leland, N., & Fetro, J.V. (1991). Reducing the risk: Impact of a new curriculum on sexual risk-taking. *Family Planning Perspectives*, 23 (6), 253-263.
- Lauby, J., Smith, P.J., Stark, M., Person, B., & Adams, J. (1998). A community-level HIV prevention intervention for inner city women: Results of the women and infants demonstration trial. Philadelphia, PA: Philadelphia Health Management Corporation.
- Magura, S., Kang, S., & Shapiro, J.L. (1994). Outcomes of intensive AIDS education for male adolescent drug users in jail. *Journal of Adolescent Health*, 15 (6), 457-463.
- Main, D.S., Iverson, D.C., McGloin, J., Banspach, S.W., Collins, J.L., Rugg, D.L., & Kolbe, L.J. (1994). Preventing HIV infection among adolescents: Evaluation of a school-based education program. *Preventive Medicine*, 23 (4), 409-417.
- McCusker, J., Stoddard, A.M., Zapka, J.G., Morrison, C.S., Zorn, M., & Lewis, B.F. (1992). AIDS education for drug abusers: Evaluation of short-term effectiveness. *American Journal of Public Health*, 82 (4), 533-540.

- National Institutes of Health Consensus Development Conference. Intervention to prevent HIV risk behavior. February 1997.
- Normand, J., Vlahov, D., & Moses, L.E., (Eds.). (1995). Preventing HIV transmission: *The role of sterile needles and bleach*. Washington, DC: National Academy Press.
- O'Donnell, C.R., O'Donnell, L., San Doval, A., Duran, R., & Labes, K. (1998). Reductions in STD infections subsequent to an STD clinic visit: Using video-based patient education to supplement provider interactions. *Sexually Transmitted Diseases*, 25 (3), 161-168.
- Prochaska, J.O. & DiClemente, C.C. (1983) Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51:390-395.
- Rotheram-Borus, M.J., Van Rossem, R., Gwadz, M., Koopman, C., & Lee, M. (1997). *Reductions in HIV risk among runaway youths*. Los Angeles, CA: University of California, Department of Psychiatry, Division of Social and Community Psychiatry.
- Sikkema, K.J., Kelly, J.A., Winett, R.A., Solomon, L.J., Cargill, V.A., Roffman, R.A., McAuliffe, T.L., Heckman, T.G., Anderson, E.A., Wagstaff, D.A., Norman, A.D., Perry, M.J., Crumble, D.A., & Mercer, M.B. (2000). Outcomes of a randomized community-level HIV prevention intervention for women living in 18 low-income housing developments. *American Journal of Public Health*, 90 (1), 57-63.
- Stanton, B.F., Li, X., Ricardo, I., Galbraith, J., Feigelman, S., & Kaljee, L. (1996). A randomized, controlled effectiveness trial of an AIDS prevention program for low-income African-American youths. *Archives of Pediatrics and Adolescent Medicine*, 150 (4), 363-372.
- St. Lawrence, J.S., Brasfield, T.L., Jefferson, K.W., Alleyne, E., O'Bannon, R.E., & Shirley, A. (1995). Cognitive-behavioral intervention to reduce African American adolescents' risk for HIV infection. *Journal of Consulting and Clinical Psychology*, 63 (2), 221-237.
- Valdiserri, R.O., Lyter, D.W., Leviton, L.C., Callahan, C.M., Kingsley, L.A., & Rinaldo, C.R. (1989). AIDS prevention in homosexual and bisexual men: Results of a randomized trial evaluating two risk reduction interventions. *AIDS*, 3 (1), 21-26.
- Varghese, B., Peterman, T.A., & Holtgrave, D.R. (1999). Cost-effectiveness of counseling and testing and partner notification: a decision analysis. *AIDS*, 13 (13): 1745-51.
- Wenger, N.S., Linn, L.S., Epstein, M., & Shapiro, M.F. (1991). Reduction of high-risk sexual behavior among heterosexuals undergoing HIV antibody testing: A randomized control trial. *American Journal of Public Health*, 81 (12), 1580-1585.
- West, G.R., & Stark, K.A. (1997). Partner notification for HIV prevention: A critical re-examination. *AIDS Education and Prevention*, 9, Supplement B: 68-78.
- Wolitski, R.J., MacGowan, R.J., Higgins, D.L., Jorgensen, C.M. (1997). The effects of HIV counseling and testing on risk-related practices and help-seeking behavior. *AIDS Education and Prevention*, suppl B, 52-67.
- Wykoff, R.F., Jones, J.L., Longshore, S.T., Hollis, S.L., Quiller, C.B., Dowda, H., & Gamble, W.B. (1991). Notification of the Sex and Needle-Sharing Partners of Individuals with HIV in Rural South Carolina: 30-Month Experience. *Sexually Transmitted Diseases*, 18(4): 217-222.

This publication (The 2001-2003 Alaska HIV Prevention Plan) was supported by Cooperative Agreement Number U62/CCU006257 from the Centers of Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.