



2004 - 2006
Alaska
HIV Prevention
Plan





Dear Alaskan Community:

The Alaska HIV Prevention Planning Group is pleased to present the *2004-2006 Alaska HIV Prevention Plan*. The recommendations and the supporting data and information are presented to help shape and sustain effective HIV prevention activities. Our goal is to prevent new HIV infections in Alaska.

Continued progress towards this goal requires contributions from all sectors. The strategies and interventions proposed in the *Plan* are a limited part of the overall effort. Ultimately, the knowledge, attitudes, and behaviors that help individuals prevent infection are promoted and supported by families, friends, churches, health care providers, tribal health organizations, social groups, schools, public policy-setting bodies, and communities.

The sexual and injection behaviors that place individuals at risk for HIV infection occur not in isolation but within the broader context of our communities. Changing social conditions that contribute to risk behavior, eliminating stigma and discrimination against those infected and affected by HIV, and supporting lifelong healthy behaviors are all critical to successful prevention efforts. Persons who are living with HIV make an important contribution to raising awareness about the epidemic. Communities can play an important, positive role in educating their members about preventing transmission of HIV/AIDS and ensuring that persons living with HIV are not silenced by fear of discrimination.

It is our sincere hope that no more Alaskans will become infected with HIV. We encourage all citizens to take part in local prevention activities, to increase awareness and understanding of HIV/AIDS, and to show compassion for those infected and affected by HIV and AIDS. Act within your own family, work place, social groups, or community organizations to make this become the reality in Alaska.

Sincerely,

Handwritten signature of Clarence Smelcer in black ink.

Clarence Smelcer

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Mary Lee

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The *2004-2006 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 copies of this document or additional information please call the Section of Epidemiology HIV/STD Program at (907) 269-8000 or visit the website at <http://www.akepi.org>.

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List of Acronyms

AAC	Alaska Administrative Code
ACDP	AIDS Community Demonstration Projects
ADA	Alcoholism and Drug Abuse Program, Alaska Division of Behavioral Health
ADAM	Arrestee Drug Abuse Monitoring Program
AESOP	AIDS Evaluation of Street Outreach Projects
AI/AN	American Indians and Alaska Natives
AIDS	Acquired Immune Deficiency Syndrome
ANHB	Alaska Native Health Board
ANHC	Anchorage Neighborhood Health Center
ANTHC	Alaska Native Tribal Health Consortium
ASD	Anchorage School District
ASO	AIDS Service Organization
AYPF	Alaska Youth and Parents Foundation
BART	Becoming a Responsible Teen
BHS	Burchell Alternative High School
BP/BR	Be Proud!/Be Responsible!
BRFSS	Behavioral Risk Factor Surveillance System
CAPS	Center for AIDS Prevention Studies
CDP	Center for Drug Problems
CAIR	Center for AIDS Intervention Research, University of Wisconsin Medical College
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
COM	Compendium of HIV Prevention Interventions with Evidence of Effectiveness
CSA	Community Services Assessment
CTS	(HIV) Counseling and Testing Sites
CY	Calendar Year
DARFS	Drug Abuse Research Field Station at University of Alaska Anchorage
DASH	Division of Adolescent and School Health
DEBI	Diffusion of Effective Behavioral Interventions Project
DEED	Department of Education and Early Development
DHSS	Department of Health and Social Services
DIS	(Public Health) Disease Intervention Specialist
DJJ	Division of Juvenile Justice
DOC	Department of Corrections
EIS	Ryan White Title III Early Intervention Services
Four A's	Alaskan AIDS Assistance Association
FPL	Federal Poverty Level
GISP	Gonococcal Isolate Surveillance Project
HCV	Hepatitis C Virus
HE/RR	Health Education and Risk Reduction
HIV	Human Immunodeficiency Virus

List of Acronyms *(cont.)*

HIVCT	HIV Counseling and Testing
HOPWA	Housing Opportunities for People with AIDS
HUD	Housing and Urban Development
HPPG	Alaska HIV Prevention Planning Group
HRSA	Health Resources and Services Administration
IAA	Interior AIDS Association
IDU	Injection Drug User
IEP	Inmate Education Program
IHS	Indian Health Service
ISAP	Inmate Substance Abuse Program
MOA	Municipality of Anchorage Health Department
MSM	Men Who Have Sex With Men
MMWR	Morbidity and Mortality Weekly Report
NCHS	National Center for Health Statistics
NIDA	National Institute on Drug Abuse
ORW	Outreach Worker
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PID	Pelvic Inflammatory Disease
PLWHA	People Living With HIV/AIDS
PRAMS	Pregnancy Risk Assessment and Monitoring Survey
POL	Popular Opinion Leader
POWER	Peer Outreach Worker Education and Referral Program
PTW	Programs That Work
RAPP	Real AIDS Prevention Project
RARE-T	Reducing AIDS Risk Effectively in Teens
REP	Replicating Effective Programs
RFP	Request for Proposals
ROTC	Reserve Office Training Corps
SAFE	Sero-status Approach to Fighting the HIV/AIDS Virus
SEP	Syringe Exchange Program
SPNS	Special Projects of National Significance
STD	Sexually Transmitted Disease
TB	Tuberculosis
YKHC	Yukon-Kuskokwim Health Corporation
YRBS	Youth Risk Behavior Survey



Chapter 1

Introduction

Chapter 1: Introduction

Comprehensive HIV Prevention Program Components

The State of Alaska HIV/STD Program receives funding for HIV Prevention activities from the Centers for Disease Control and Prevention (CDC). CDC defines a comprehensive HIV prevention program as including nine essential components:

1. HIV prevention community planning;
2. HIV prevention activities;
 - a. HIV counseling, testing and referral services;
 - b. Partner counseling and referral services;
 - c. Prevention for HIV-infected persons
 - d. Health education and risk reduction (HE/RR) activities;
 - e. Public information programs (if addressed in the jurisdiction's Prevention Plan);
 - f. Perinatal transmission prevention (for jurisdictions with ≥ 150 perinatal HIV cases);
3. Quality assurance;
4. Evaluation of major program activities, interventions, and services including data on interventions and clients served;
5. Capacity-building activities;
6. Sexually transmitted disease prevention activities;
7. Collaboration and coordination with other related programs;
8. Laboratory support; and
9. HIV/AIDS epidemiologic and behavioral surveillance.

HIV Prevention Community Planning

Since January 1994, state, territorial, and local health departments receiving HIV prevention funds through the CDC have conducted community planning activities to develop comprehensive HIV prevention plans. In Alaska, a statewide Alaska HIV Prevention Planning Group (HPPG) was organized in 1994 to guide the planning process. It is the joint responsibility of the HPPG members and the health department to implement component #1, HIV prevention community planning. This collaborative planning process aims to improve the effectiveness of HIV prevention programs through the participation of individuals who are affected by HIV/AIDS and who are knowledgeable about HIV prevention and Alaska communities. Please see *Chapter 7: Overview of the Community Planning Process* for more information about the HPPG members and the community input process. Persons who reflect the perspective of the populations most affected by HIV, as well as epidemiologists, social scientists, providers, and State HIV/STD Program staff, work together to develop a statewide prevention plan that best represents the needs of populations at risk for, or infected with HIV/AIDS. In developing the *2004-2006 Alaska HIV Prevention Plan*, the HPPG considered epidemiologic data, HIV prevention needs, resources and service gaps for the most affected populations, and the published research on, and program experience with, HIV prevention interventions. The resulting recommendations in the Plan are based on scientific evidence, local experience, and community values. The Plan guides

the health department's annual application to CDC for federal HIV prevention funds. With these and other funds, the State HIV/STD Program and its grantees and contractors carry out the nine essential components of the HIV prevention program for Alaska.

CDC HIV Prevention Strategic Plan

HIV prevention community planning plays an important role in achieving the goals of CDC's "HIV Prevention Strategic Plan Through 2005" (CDC, 2001a). CDC's *Overarching National Goal* for HIV prevention in the United States is to:

Reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by 2005, focusing particularly on eliminating racial and ethnic disparities in new HIV infections. To accomplish this goal, CDC expects:

1. By 2005, to decrease by at least 50% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained, and evidence-based HIV prevention activities.
2. By 2005, through voluntary counseling and testing increase from the current estimated 70% to 95% the proportion of HIV-infected people in the United States who know they are infected.
3. By 2005, increase from the current estimated 50% to 90% the proportion of HIV-infected people in the United States who are linked to appropriate prevention, care, and treatment services.
4. By 2005, strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs.

Advancing HIV Prevention Initiative

In April 2003, CDC announced its initiative *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. CDC is refocusing some HIV prevention activities to reduce the number of new HIV infections in the United States (CDC, 2003a). CDC is emphasizing services to on the estimated 180,000 to 280,000 persons who are unaware of their HIV infection, in particular, partner notification, counseling, and referral services, and prevention services for persons diagnosed with HIV to help prevent further transmission. CDC is also strengthening efforts to promote routine, universal HIV screening as a part of prenatal care. This will be accomplished through four strategies:

1. Making HIV screening a routine part of medical care;
2. Creating new models for diagnosing HIV infection, including the use of rapid testing;
3. Improving and expanding prevention services for People Living With HIV/AIDS (PLWHA); and
4. Further decreasing perinatal HIV transmission.

The 2004-2006 Alaska HIV Prevention Plan

The *2004-2006 Alaska HIV Prevention Plan* is the fifth comprehensive plan produced by the Alaska HPPG. It describes the epidemiology of HIV/AIDS in Alaska and related risk factors, the populations at greatest need for HIV prevention interventions, and recommendations for interventions that are most appropriate to meet these needs. 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 with the goal of preventing HIV and AIDS in Alaska.

Organization of the 2004-2006 Alaska HIV Prevention Plan

The *2004-2006 Alaska HIV Prevention Plan* includes the essential elements of a comprehensive HIV prevention program as specified by the CDC.

Chapter One offers an **Introduction** to the overarching national goal for HIV prevention in the United States, HIV prevention community planning, and the *2004-2006 Alaska HIV Prevention Plan*.

Chapter Two 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).

Chapter Three describes the **Community Services Assessment**. Data are presented on the prevention needs, funded interventions, use of prevention services, and funding sources for populations most affected by HIV in Alaska.

Chapter Four encapsulates the rationale for selecting the **Prioritized Populations** for 2004-2006. Key data from the Epidemiologic Profile and the Community Services Assessment are summarized.

Chapter Five focuses 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 Alaska HIV Prevention Planning Group (HPPG) drew upon the behavioral science and evaluation literature and local experience to select the types of interventions likely to best meet the HIV prevention needs of each of the priority populations.

Chapter Six presents the **Recommendations** of the HPPG for prevention activities statewide and for interventions specific to each prioritized population. This chapter also describes activities to be carried out by the health department in the areas of quality assurance, evaluation, capacity building, and other elements of a comprehensive HIV prevention program.

Chapter Seven is an **Overview of the Community Planning Process**. This chapter discusses the Alaska HIV Prevention Planning Group and their major goals and guidelines set by the CDC, as well as community input processes.



Chapter 2

Epidemiologic Profile

Chapter 2: Epidemiologic Profile

Overview

HIV in Alaska is currently characterized by a relatively low prevalence of infection in the state's population. Through December 31, 2002, 892 cases of HIV/AIDS were reported in Alaska. On average, 40 HIV/AIDS cases were newly diagnosed per year from 1998-2002. This represents a decline from the average of 51 cases newly diagnosed per year in the previous decade (1988-1997).

Beginning in 1996, deaths from HIV-related causes declined significantly in Alaska, as well as in the U.S., due primarily to advances in medical care and treatment. The decline in deaths, combined with a relatively constant rate of new infections has resulted in a slow but steady increase in the number of persons in the population living with HIV. Needs for medical care, supportive services, and ongoing prevention services will continue to grow as the population of persons living with HIV grows and individuals live longer, healthier lives.

A large proportion of persons with HIV infection was first diagnosed late in the course of their HIV disease. Of persons newly reported in Alaska with HIV infection from 1999-2002, 64% were first diagnosed with HIV within 12 months of their AIDS diagnosis. Such a late diagnosis limits the potential benefits from medical care and also lengthens the time during which an infected person may unknowingly transmit HIV to others. HIV screening for the general population has not effectively address this problem, given that 1-2 persons per 1,000 tested per year (0.1-0.2%) at voluntary HIV counseling and testing sites from 1998-2002 were found to be HIV-infected. This, combined with the low prevalence of HIV and the general population's low perception of risk, make effective partner notification services the most critical public health intervention, interrupting transmission of HIV by targeting intensive public health activities to those at greatest potential risk. These public health activities alert persons to their HIV exposure, offer individualized HIV counseling and testing, assure those infected access to care, and identify through disease intervention efforts others who may have been exposed.

As has been the case nationwide since the beginning of the epidemic, the number and proportion of HIV/AIDS cases in males exceeded that in females in Alaska through December 31, 2002. As the proportion of cases in males declined, the proportion of cases in females increased. In the most recent five-year period (1998-2002), an average of 28 HIV/AIDS cases (70% of total cases) per year in Alaska were in males compared to an average of 12 HIV/AIDS cases (30% of total cases) per year in females. When cases presumed infected more recently are compared to those presumed infected earlier in the epidemic, the proportion of total cases in females has increased: 38% of HIV non-AIDS cases diagnosed from 1998-2002 were in females, as compared to 16% of HIV/AIDS cases in persons presumably infected earlier in the epidemic. Although the proportion of cases in females increased, the number of cases per year in females varied little over the past decade (an average of 11 cases per year from 1993-1997 and an average of 12 cases per year from 1998-2002 were in females).

A greater proportion of female cases than male cases occurred in persons in a younger age group at the time of first HIV diagnosis. Of cumulative female HIV/AIDS cases, 18% were aged 15-24 years at first HIV diagnosis, compared to 11% of male cases occurring in males in this age group. Of cases presumed infected more recently (HIV non-AIDS cases diagnosed from 1998-2002),

61% of cases in females were 15-34 years of age while 40% of male cases diagnosed during this period were 15-34 years of age at the time of first HIV diagnosis.

HIV infection affected individuals in all racial and ethnic groups. In Alaska, as in the U.S., the proportion of HIV/AIDS cases among racial/ethnic minority persons increased over time as the proportion in Whites decreased. Compared to their proportions of the state's population, Alaska Native/American Indian, Black, and Hispanic persons were over-represented among HIV/AIDS cases, while Whites and Asian/Pacific Islanders were under-represented. Disparities for cases presumed infected more recently (HIV non-AIDS with diagnosis from 1998-2002) were greatest for Alaska Native/American Indian females and for Alaska Native/American Indian and Black males.

HIV cases were reported in all regions of Alaska. Over time, the proportion of cases residing in the urban areas of Anchorage, Fairbanks, and Juneau at the time of first diagnosis declined and the proportion residing in other areas increased. Of persons presumed infected more recently (HIV non-AIDS cases with diagnosis from 1998-2002), 64% resided in Anchorage, Fairbanks, or Juneau at the time of first HIV diagnosis (55% in Anchorage/Mat-Su alone), compared to 77% of cases presumed infected earlier in the epidemic. Among persons presumed infected more recently, the proportion of female cases (51%) living outside of these three urban areas at time of first diagnosis was greater than the proportion of males (27%) living outside of these areas.

In Alaska (and the U.S.), the greatest proportion of HIV/AIDS cases was associated with exposure through male-male sex. Singly, and in combination with injection drug use, male-male sex was a risk factor in 53% of cumulative HIV/AIDS cases (66% of cumulative cases in males) reported in Alaska through December 31, 2002. In cases where male-male sex was a risk factor, the proportion of cases among racial and ethnic minority males was greater, and the proportion in white males smaller, in cases presumed infected more recently than in cases presumed infected earlier in the epidemic.

Injection drug use (considering injection drug use as a single exposure category and in combination with male-male sex) was a risk factor in 19% of cumulative HIV/AIDS cases through December 31, 2002 (132 cases in males and 36 cases in females). IDU was a risk factor in 21% of cases in females, and IDU (singly and combined with MSM) was a risk factor in 18% of cases in males. In female cases presumed infected more recently (HIV non-AIDS cases diagnosed from 1998-2002), IDU was associated with 24% of cases, compared to 20% of female cases presumably infected earlier in the epidemic.

Of cumulative HIV/AIDS cases diagnosed through December 31, 2002, 12% were related to heterosexual contact with a person with or at increased risk of HIV infection (5% of male and 43% of female cases). The proportion of cases with this exposure category increased over time. Persons having unprotected heterosexual sex with partners who have been diagnosed with HIV or who are current/former injection drug users, and females having unprotected sex with bisexual males are at increased risk of HIV infection. Among cases presumed infected more recently (HIV non-AIDS cases with diagnosis from 1998-2002), 13% of male and 49% of female cases were related to heterosexual contact with a person with or at increased risk of HIV infection.

Exposure categories of transfusion/transplantation and hemophilia were associated with 2% (22 cases) of cumulative HIV/AIDS cases in Alaska through December 31, 2002. Risk of new HIV

infection from transfusion/transplantation has been greatly reduced nationwide, and no HIV cases associated with transfusion/transplantation and with diagnosis after 1990 were reported in Alaska through December 31, 2002. Risk from contaminated blood products for hemophilia was essentially eliminated nationwide and no case associated with hemophilia was diagnosed with HIV in Alaska after 1996.

The greatest HIV risk for children in Alaska and the U.S. was perinatal transmission from an HIV-infected mother. The number of HIV/AIDS cases in Alaska related to perinatal transmission through December 31, 2002 was small (6 cases or 1% of total cumulative cases). Antiretroviral therapy is effective in reducing HIV transmission during pregnancy and delivery and has helped reduce perinatal infection rates nationwide. The majority of pregnant women in Alaska received HIV screening as part of their prenatal care.

An exposure category was not identified for 19% (172) of cumulative HIV/AIDS cases (16% of cases in males and 32% in females). This is consistent with trends in the U.S. The number of cases classified as having Other/Unknown/Unspecified exposure and the proportion of total cases in this category has decreased steadily since 1999 when HIV first became a reportable condition in Alaska. Cases currently classified as Other/Unknown/Unspecified may be reclassified into other exposure categories as more information becomes available.

Unlike some other areas of the U.S., HIV infection was uncommon in adolescents in Alaska, although behavior placing individuals at increased risk of HIV exposure was relatively common in this population. Through December 31, 2002, there were 108 cumulative HIV/AIDS cases in persons aged 13-24 years at first HIV diagnosis (12% of the 892 cumulative HIV/AIDS cases reported in Alaska). Of these 108 cases, 79 cases (73%) were in males and 29 cases (27%) were in females. The average number of cases (5-6) newly diagnosed per year in this age group varied little over the last 15 years. For males aged 13-24 years, risk behaviors of male-male sex (66%), injection drug use (9%), or male-male sex with injection drug use (15%) were associated with 90% of HIV/AIDS cases. For females in this age group, heterosexual contact to a person with or at increased risk for HIV was associated with 62% of HIV/AIDS cases and injection drug use 7%. All races/ethnicities were represented among cases in this age group, and cases were predominantly urban.

Persons with STD are at increased risk of acquiring or transmitting HIV through sexual contact. Chlamydia and gonorrhea infections were relatively common in sexually active young adults in Alaska. Based on co-infection data, the population of persons ever reported with HIV did not overlap to a great extent with the population reported with gonorrhea from 1988-2001, and overlapped to an even smaller extent with the population reported with chlamydia from 1996-1999.

Sociodemographics of Alaska

Population. The Alaska Department of Labor and Workforce Development estimated Alaska's 2002 population to be 643,786. The Alaska Department of Labor and Workforce Development estimates of the 2002 race/ethnicity distribution of the Alaska population are provided in Table 1 for persons of one race and for persons of two or more races. Table 1 also shows the estimated proportion of the population (all races) that is of Hispanic ethnicity.

Table 1. Estimated 2002 Alaska Population by Race/Ethnicity

Racial/Ethnic Category	2002 Estimated Population					
	Male		Female		Total	
	Number	% of Male total	Number	% of Female total	Number	%
One race reported						
White	237,476	71.7%	218,868	70.0%	456,344	70.9%
Alaska Native/ American Indian	51,466	15.5%	51,057	16.3%	102,523	15.9%
Asian	12,556	3.8%	14,208	4.5%	26,764	4.2%
Black	12,702	3.8%	11,220	3.6%	23,922	3.7%
Hawaiian/ Pacific Islander	1,817	0.5%	1,790	0.6%	3,607	0.6%
2 or more races	15,315	4.6%	15,311	4.9%	30,626	4.8%
Total	331,332		312,454		643,786	100%
Of those in above categories, persons of Hispanic Ethnicity	13,717	4.1%	13,034	4.2%	26,751	4.2%

The state's population is relatively young and culturally diverse. The U.S. Census in 2000 found only Utah's median age younger than Alaska's. The median age for Alaskans in 2002 was 32.7 years and was the same for males and females. The age structure of the population varied considerably by race/ethnicity. For persons specifying a single race, the median age for Whites was 35.3 years; for Alaska Natives was 26.0 years; for Blacks (many of whom come to Alaska as young adults with the military) was 26.6 years; for Asians was 35.2 years; and for Hawaiians and Pacific Islanders was 23.6 years. For persons of two or more races, the median age was 15.6 years. For persons of Hispanic ethnicity (of any race), the median age was 23.9 years.

In the 2000 Census, 5% of Alaskans self-identified as two or more races, placing Alaska second only to Hawaii in the percentage of persons identifying themselves as multi-racial.

Demographic Methods. Allowing persons to self-identify as two or more races (as opposed to selecting a single race) is part of a recently introduced national convention for categorizing race data. Persons of Hispanic/Latino ethnicity are additionally categorized by race (rather than treating Hispanic as a race category). These new conventions were first used in the census in 2000. As a result, 2000 Census data differ from past census data and from ways in which other data (including HIV/AIDS surveillance data) were previously collected. Most data systems have adopted these new conventions. No single approach has yet been adopted nationally to make data gathered under the new format comparable to previously-gathered data, nor is any approach completely correct (for example, people of more than one race aren't in any single race category).

The National Center for Health Statistics (NCHS) has created a "bridging series" of population data that statistically reapportions persons of two or more races into four single race categories to allow comparison with earlier and other data sets using single race categories. This document uses the NCHS "Bridged Modified Race Series for April 1, 2000 based on Census 2000" (Table 2) in tables and figures where race data on HIV/AIDS cases are compared to population data broken down by race. NCHS data make age imputation corrections in a manner that tends to

underestimate young children and overestimate young teens (by less than 1,000 persons) compared to State of Alaska estimates. NCHS estimates may also attribute some persons of two or more races to Black or White race categories, while State methods would classify them as Alaska Native (fewer than 1,000 persons or less than 1% of the Alaska Native population). These relatively small figures do not significantly affect the analyses presented in this profile. Persons of Hispanic ethnicity (from 2000 Census data) are included within the various race categories in population data throughout this document.

Table 2. NCHS Bridged Modified Race Series for April 1, 2000 Based on Census 2000

Single Race Category	Male	Female	Total
	Number (% Male)	Number (% Female)	Number (%)
White	240,925 (74%)	219,857 (73%)	460,782 (73%)
Alaska Native/ American Indian	54,115 (17%)	53,600 (18%)	107,715 (17%)
Asian/Pacific Islander	15,134 (5%)	16,652 (5%)	31,786 (5%)
Black or African American	13,938 (4%)	12,711 (4%)	26,649 (4%)
Total Population	324,112 (100%)	302,820 (100%)	626,932 (100%)

Alaska Natives, Asian/Pacific Islanders, and Hispanics accounted for over half of the state's growth during the last decade. Growth occurred disproportionately in the more populated areas of the state from 1990-2000: the populations of the Municipality of Anchorage, Matanuska-Susitna Borough, and Kenai Peninsula Borough grew faster than the rest of Alaska, accounting for 59% of the state's population in 2000 (compared to 56% in 1990). These three areas also became more racially diverse during this period.

According to the 2000 Census, the Municipality of Anchorage was the state's largest population center and reflected the diversity of the state: Whites made up 77% of the Anchorage population; Alaska Natives 10%; Blacks 7%, Asians 7%, and Native Hawaiians and Pacific Islanders 1%. Of these, approximately 6% were Hispanic or Latino.

Three boroughs (Lake and Peninsula, North Slope, and Northwest Arctic) and five census areas (Bethel, Dillingham, Nome, Wade Hampton, and Yukon Koyokuk) were 72% or more Alaska Native (Alaska Department of Labor Modified Age, Race, and Sex (MARS) estimates for 2000).

Alaska has 226 federally recognized tribes. The Alaska Native population is more rural than the Alaska population at large, although 22% of all Alaska Natives live within the Municipality of Anchorage.

The White population was concentrated in the most heavily populated areas of the state. Nine boroughs (Anchorage Municipality, Matanuska-Susitna, Kenai Peninsula, Fairbanks North Star, Denali, Haines, Juneau, Ketchikan, and Sitka) and three census areas (Valdez-Cordova, Southeast Fairbanks, and Wrangell-Petersburg) were 72% or more White.

The largest proportions of Blacks lived in the Municipality of Anchorage (69%) and in the Fairbanks North Star Borough (22%). Blacks constituted 7% of the population in each area. This population is historically associated with the military; its proportionate share of the state population has declined as military bases have closed or been reduced and the populations of other racial groups have grown.

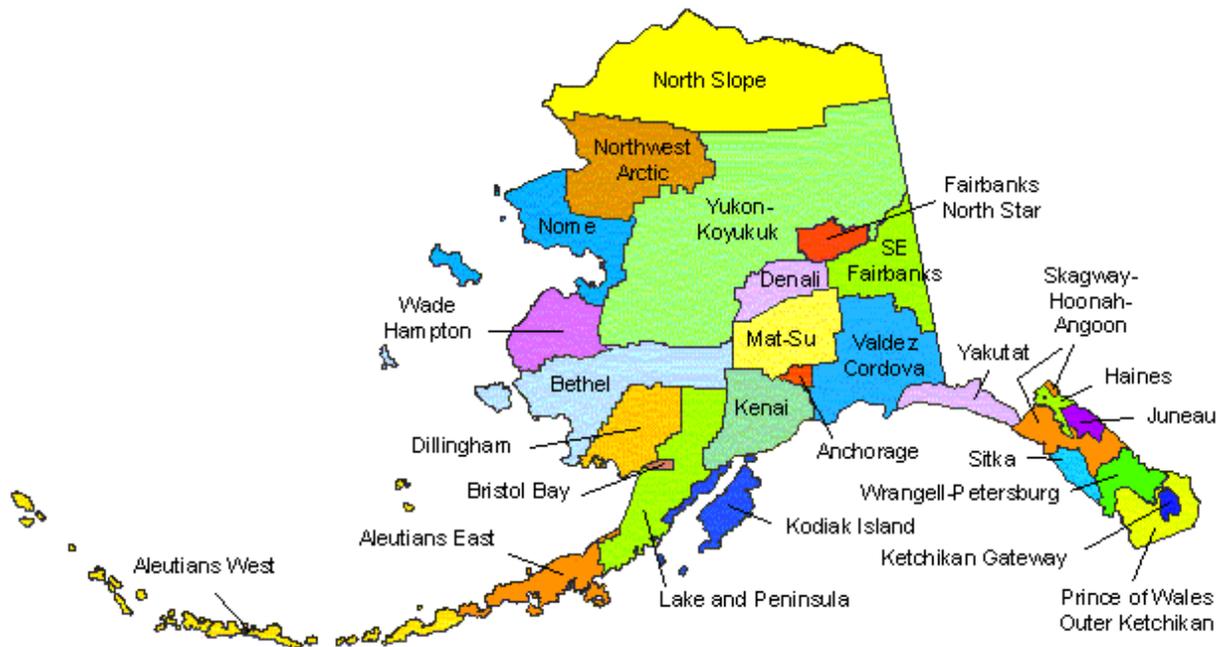
The largest proportions of Asian/Pacific Islanders lived in Anchorage and coastal areas. Of Asian/Pacific Islanders, 58% lived in the Municipality of Anchorage and 8% in Fairbanks North Star Borough. The proportion of Asian/Pacific Islanders in area populations was greatest in the Aleutians East Borough (31%), Aleutians West Census Area (30%), and Kodiak Island Borough (19% of the area population).

The Hispanic population increased substantially in the last decade in Alaska as in the United States. Largest proportions of the Hispanic population lived in the Municipality of Anchorage (57%) and Fairbanks North Star Borough (13%). The proportion of Hispanics in area populations was greatest in the Aleutians East Borough (13% of the population was Hispanic) and Aleutians West Census Area (11% were Hispanic).

Half of all Alaskans lived in Anchorage or surrounding areas and nearly three-quarters lived in the five “railbelt” boroughs served by the State-owned Alaska Railroad. The U.S. Census Bureau defines an urbanized area as densely settled territory that contains 50,000 or more people. An urban cluster consists of densely settled territory that contains at least 2,500 but fewer than 50,000 people. By Census Bureau definition, there were 30 places considered urbanized areas or to be within urban clusters in Alaska in 2000, with a total population of 411,257 (66% of the total state population). This “urban” designation obscures the geographic remoteness of so many Alaska communities with populations over 2,500.

In developing the *2004 -2006 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.

Figure 1. Map of Alaska Census Areas



For purposes of characterizing the epidemic geographically, 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.

Urban Centers

Almost two thirds (60%) of the population of Alaska or 384,842 people live within three urban census areas: the Municipality of Anchorage (population 269,070), Fairbanks North Star Borough (84,791); and the Juneau Borough (30,981).

Urban Satellites and Rural Hubs

Urban satellites and rural hubs have a combined population of 175,311 making up 18% of the total population of the state. Urban satellites refer to the communities of the Matanuska-Susitna Borough (population 65,241) and the Kenai Peninsula Borough (population 50,123) 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.

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 83,633, making up 13% of

the state total. Population figures are listed in Table 3 by Census Area, less the population of the rural hub of that census area.

Military. 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 Alaska's largest employer. The 2000 Census reported the armed forces included 17,111 persons and constituted 4% of the Alaska workforce. In 2002, uniformed military numbered 17,802 per the Alaska Department of Labor and Workforce Development. Alaska ranks first in the U.S. with 18% of the civilian population aged 18 and older being veterans, compared to 12% for the U.S., as estimated by the U.S. Census 2001 Supplementary Survey.

Education. The U.S. Census Supplementary Survey estimated that 188,175 Alaskans age 3 years and over were enrolled in preschool through graduate school in 2001. An estimated 90% of the Alaska population 25 years and over were high school or higher graduates (including high school equivalency). This compared to 82% of the U.S. population as a whole and ranked Alaska #1 among the states and District of Columbia. Of Alaskans over 25 years of age, 26% had bachelor's or higher degrees, a proportion equivalent to that for the U.S. as a whole. Of all Alaskans (in and out of school), 13% spoke a language other than English, as compared to 18% of the U.S. population (and ranking Alaska 17th highest in the country).

Employment. Oil, tourism, and fisheries drive the Alaska economy, and a growing tourism industry brings over 1.1 million visitors per year to the state. Oil revenues supply nearly 85% of the State's budget. In recent years, oil prices have been comparatively strong, and oil activity influences contractors, transporters, engineering firms, and other industries that service oil and gas firms. During the same period, fisheries and timber have been relatively soft. Partially as a result, the Northern, Anchorage/Mat-Su, and Interior Regions of the state have seen the biggest economic gains while Coastal areas have had minimal or negative economic growth.

According to the Alaska Department of Labor and Workforce Development, Alaska maintained a steady, moderate (around 2% per year) growth rate in nonfarm employment from 1990-2002. During the 1990s, this rate of growth placed Alaska 25th highest among the states, as other states experienced economic expansion. From 2001-2002, this same rate of growth in nonfarm employment ranked Alaska highest among the 50 states and District of Columbia, as these other areas were more adversely affected by the national recession.

The U.S. Census 2001 Supplementary Survey found that Alaska ranked second highest in the U.S. in the percent of the population in the labor force (this included the armed forces). Alaska was estimated to have 73% of persons 16 years and older in the labor force, as compared to 66% for the U.S. as a whole. An estimated 67% of females aged 16 years and older were in the Alaska workforce, as compared to 59% of U.S. females 16 and older. In 2001, nonresident workers comprised 18.4% of workers employed in Alaska.

Table 3. 2002 Population Estimates by Area (Alaska Department of Labor & Workforce Development)

Urban Centers			384,842	60%
Municipality of Anchorage	269,070			
Fairbanks North Star Borough	84,791			
Juneau City and Borough	30,981			
Urban Satellites and Rural Hubs			175,311	27%
Matanuska-Susitna and Kenai Peninsula Subtotal		115,364		(18%)
Matanuska-Susitna Borough	65,241			
Kenai Peninsula Borough less villages off the road system	50,123			
Rural Hubs Subtotal		59,947		(9%)
Kodiak city and Kodiak Station	8,017			
Sitka city/Borough	8,894			
Ketchikan city	7,845			
Bethel city	5,736			
Barrow city	4,434			
Valdez city	4,171			
Unalaska city	4,051			
Nome city	3,493			
Petersburg city	3,146			
Kotzebue city	3,107			
Dillingham city	2,475			
Cordova city	2,434			
Wrangell city	2,144			
Rural Areas			83,633	13%
Aleutians East Borough	2,729			
Aleutians West Census Area less Unalaska city	1,022			
Bethel Census Area less Bethel city	10,748			
Bristol Bay Borough	1,159			
Denali Borough	1,886			
Dillingham Census Area less Dillingham city	2,455			
Haines Borough	2,360			
Kenai Peninsula Borough communities not on road system- Nanwalek, Port Graham, Seldovia, Tyonic, Halibut Cove, Grouse Creek, Jakolof Bay	1,064			
Ketchikan Gateway Boro. less Ketchikan city	5,825			
Kodiak Is. Boro. less Kodiak city, Kodiak Stn.	5,835			
Lake and Peninsula Borough	1,641			
Nome Census Area less Nome city	5,849			
North Slope Borough less Barrow	2,809			
Northwest Arctic Borough less Kotzebue	4,159			
Prince of Wales/ Outer Ketchikan	5,678			
Skagway-Hoonah-Angoon Census Area	3,221			
Southeast Fairbanks Census Area	5,958			
Valdez-Cordova Census Area less Valdez and Cordova cities	3,695			
Wade Hampton Census Area	7,294			
Wrangell-Petersburg Census Area less Wrangell and Petersburg cities	1,154			
Yakutat City/Borough	724			
Yukon-Koyukuk Census Area	6,368			
TOTAL			643,786	100%

Income and Poverty. Income is measured in a number of different ways. Common measurements include average or mean (the total population income divided by the number of persons in the population) and median income (half of the income earned in the population falls above the median figure and half falls below it). Income is also measured for different populations. Examples include per capita income (total income divided by all persons in the population; these persons may not all be wage earners), family income (total income divided by the number of families; families may include multiple wage earners), and household income (total income divided by the number of households; households may include people beyond those in a family). These different measures may vary a great deal, and each may change over time with economic conditions. Different surveys use different population samples, methods, and definitions, and these influence results. Data from several of surveys are reflected in Table 4 and the text below.

Table 4. Economic Characteristics, Alaska and the U.S., 1999

Economic Characteristic	Alaska	United States
Per capita income	\$22,660	\$21,587
Median earnings, male full-time year-round workers	\$41,257	\$37,057
Median earnings, female full-time year-round workers	\$31,151	\$27,194
Median household income	\$51,571	\$41,994
Median family income	\$59,036	\$50,046
Individuals below poverty	9%	12%
Families below poverty	7%	9%

The U.S. Census Bureau estimated these same characteristics two years later in its 2001 Supplementary Survey. The estimated per capita income in Alaska increased to \$24,327 in 2001 as compared to \$22,457 for the U.S. as a whole. Alaska's median household income was \$55,938 as compared to the U.S. median household income of \$42,317, and ranked Alaska 3rd highest in the country. Alaska's median family income was \$62,013 as compared to the U.S. median family income of \$50,844, ranking Alaska 6th highest in the country.

Consistent with the income data, the U.S. Census Bureau's 2001 Supplementary Survey estimated a smaller percentage of Alaskans living in poverty than in most other states. The estimated percentage of Alaskans below poverty in the preceding 12 months was 7% (8,192 families, 43,836 individuals) as compared to 12% for the U.S. as a whole. This ranked Alaska 50th among the 51 states and District of Columbia on this indicator, with only New Hampshire having a smaller proportion of people falling below poverty.

Federal (DHHS) poverty guidelines are used to determine eligibility for certain programs, and are updated annually. The guidelines' income levels for Alaska (and Hawaii) individuals and families are higher than those for the contiguous 48 states and District of Columbia, apparently recognizing the higher cost of living in these two states. In 2003, the federal poverty guideline for a family of one in Alaska is \$11,210 and \$23,000 for a family of four. The percentage of Alaskans below poverty in 2001 was 7% as compared to 12% for the U.S., per the Census 2002 Supplementary Survey. The percentage of persons below the poverty level varies considerably in different areas of the state. Generally, a smaller percentage of people are living below poverty in more urban areas such as Anchorage, Fairbanks North Star Borough, and Juneau than in rural

areas of the state. Barrow, Valdez, Kodiak, and most hub cities in Southeast Alaska have relatively small percentages of people living in poverty.

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.

Insurance Coverage. Insurance coverage, whether private or provided through programs such as Medicaid, can facilitate access to medical care. A slightly larger percentage of adults are uninsured in Alaska than in the U.S. as a whole, as shown in Table 5. Additional data from the Kaiser Family Foundation show that a slightly higher percentage of women 19-64 have employer, individual, or Medicaid insurance coverage than do men within the same age group.

Table 5. Distribution of Adults 19-64 by Insurance Status, Alaska (2000-2001) and U.S. (2001) (Source: Kaiser Family Foundation State Health Facts Online)

Source of Coverage	Alaska Percent Covered	United States Percent Covered
Employer	66%	67%
Individual	5%	6%
Medicaid	7%	6%
Medicare	1%	2%
Uninsured	22%	19%
Total	100%	100%

Uninsured nonelderly persons in Alaska are more likely to have higher incomes than is the case in the U.S. as a whole (52% of the uninsured nonelderly in Alaska have incomes at 200% or more of the U.S. poverty threshold as compared to 35% in the U.S. as a whole). Conversely, a smaller proportion (48%) of low income, nonelderly adults is without insurance coverage in Alaska than is the case nationally (65%).

In state fiscal year 2002, 124,925 Alaskans enrolled in the Medicaid program. The largest proportion resided in the Anchorage area (33.6%), with 7.1% in Fairbanks and 6.5% in Wasilla.

The Alaska Area Native Health Service reports that in a 36 month period from 1999 and 2002, 121,009 Alaska Native individuals utilized IHS or tribal health facilities at least once.

Characteristics of Persons with HIV and AIDS in Alaska

This Profile provides data on cases of HIV (with and without AIDS) reported in Alaska with diagnosis on or before December 31, 2002. Alaska case numbers are relatively small and these data must be interpreted in the context of cumulative scientific knowledge about HIV/AIDS.

AIDS became a condition reportable to the Alaska Division of Public Health in 1985. HIV became reportable in February 1999. Under Alaska Administrative Code (7 AAC 27.005. and 7 AAC 27.007.), medical providers and laboratories are required to report suspected and diagnosed cases of HIV infection and AIDS to the Division of Public Health.

After HIV reporting was introduced in February 1999, cases were reported in persons who had

been diagnosed with HIV many years earlier as well as persons who were recently infected or recently diagnosed for the first time. Reports on “older” HIV cases are more likely to have incomplete data than reports on more recently diagnosed cases. Since 1999, it has been possible to gather more complete data on some, but not all, of these cases. Unless otherwise specified, the data that follow are for all HIV and AIDS cases reported in Alaska, whether they were first diagnosed in Alaska or elsewhere. Unless otherwise noted, data presented by year are presented by year of diagnosis (to estimate onset of HIV infection) rather than by year of report.

People with HIV and AIDS undergo the same kinds of life events as people without HIV infection — they move into or out of Alaska, they may or may not interact with medical providers while they live here, and they may die of HIV or other causes in Alaska or elsewhere. Multiple types of surveillance activities are necessary to provide an accurate picture of HIV infection in Alaska. The following sections present available data in different ways to depict cumulative and current aspects of the HIV epidemic in Alaska. For surveillance purposes, each HIV and AIDS case is counted only once (rather than once as an HIV case and a second time when the individual develops AIDS).

Of HIV cases reported to the Division of Public Health in a given year, some were infected in past years and others were recently infected or recently diagnosed for the first time. Because it is usually difficult to know the true date of HIV infection, precise HIV incidence data are lacking. First HIV diagnosis is used as a substitute for HIV infection incidence, realizing that individual cases are diagnosed at different times, ranging from months to years after infection. Similarly, clinical detection of AIDS-defining conditions occurs at different points in time for different individuals.

In many sections of this report, data are presented as proportions. It is important to recognize that proportions represented by each of the constituent elements must add up to the whole (100%). Therefore, when one proportion decreases, one or more of the others must increase. A proportionate increase does not necessarily mean that rates have changed. It is important to consider the actual number of cases or events involved and rates, along with any changes in proportions, before drawing conclusions.

Cumulative Data on HIV and AIDS in Alaska

A total of 892 cases of HIV infection, with and without AIDS, were reported to the Alaska Division of Public Health with a diagnosis on or before December 31, 2002, as shown in Table 6.

Table 6. Cumulative HIV and AIDS cases reported to the Alaska Division of Public Health through December 31, 2002

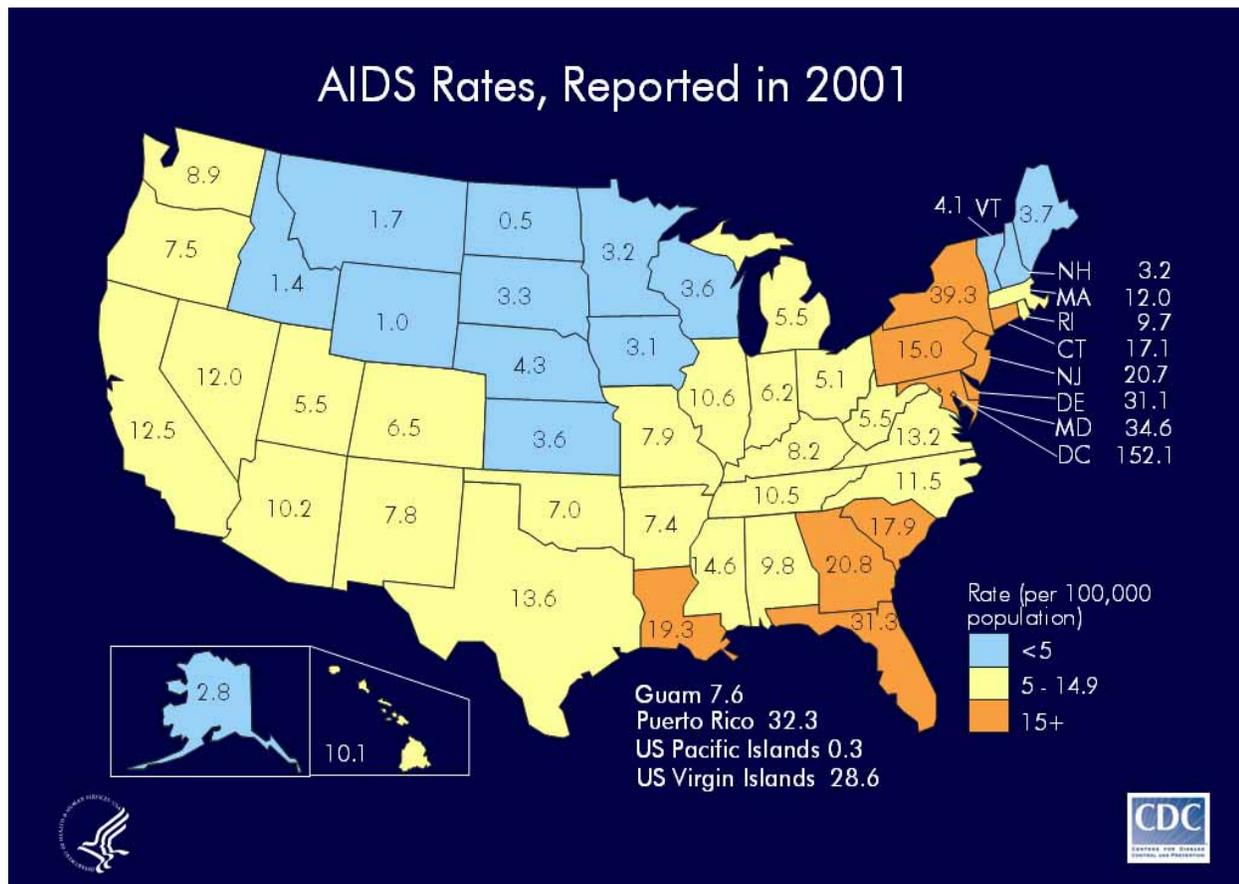
	Total HIV & AIDS Cases Reported	HIV & AIDS Cases Not Known to Have Died	HIV & AIDS Cases Known to Have Died
HIV Cases with AIDS	616	318	298
Alaska Residents at First AIDS Diagnosis (Onset)	524	239	285
Not Alaska Residents at First AIDS Diagnosis (Onset)	92	79	13
HIV Cases without AIDS	276	252	24
Total	892*	570*	322*

* Case numbers presented in this Profile may differ from data presented in other Section of Epidemiology reports since HIV/AIDS case data are updated as new information is available.

The mean annual rate of AIDS cases first diagnosed in Alaska residents from 1998-2002 (mean annual AIDS incidence rate) was 3.1 cases per 100,000 population. A mean annual rate over a five-year period is presented here to offer a more stable estimate of the actual AIDS incidence rate in Alaska, because the numbers of diagnosed cases are small and fluctuate from year to year. This Alaska mean annual rate compares to an annual 2001 AIDS incidence rate in the U.S. of 14.9 AIDS cases per 100,000 population (source: CDC, *HIV/AIDS Surveillance Report, 2001 Year-end Edition*.13:2). Annual AIDS incidence rates for other states are provided in Figure 2, below, based on cases reported to CDC in 2001.

The 2001 AIDS incidence rate shown for Alaska in the CDC diagram below (2.8 cases per 100,000 population) and the AIDS incidence rate shown above for the period ending in 2002 (3.1 cases per 100,000 population), even though the figures are relatively similar, differ in two important ways. First, the Alaska case rate above (3.1/100,000) is the mean (average) annual AIDS incidence rate for a five-year period through 2002, while the CDC rate (2.8/100,000) is for the twelve months in 2001. Second, the Alaska rate considers all Alaska cases reported to the State as *diagnosed* during the time period in question. The CDC rate below is calculated on Alaska cases the State *reported* to CDC during 2001 (regardless of when the cases were diagnosed). The two rates do not measure comparable things.

Figure 2. AIDS Rates (cases reported per 100,000 population), 2001 – United States
 (source: Centers for Disease Control and Prevention, HIV/AIDS Surveillance General Epidemiology Slide Series through 2001)



The mean annual HIV incidence rate (cases with and without AIDS) among cases reported in Alaska as diagnosed in the period from 1998-2002 was 6.4 cases per 100,000 population. Using CDC’s national estimate of 40,000 new HIV cases occurring per year, the comparable annual rate for new HIV cases for the United States as a whole in 2002 was 13.9 cases per 100,000 population.

The figures we used in calculating Alaska’s mean annual rates are presented in Table 7, below. In Table 7, column headings are abbreviated as follows: (1) AIDS cases first diagnosed in persons who were Alaska residents at the time of their AIDS diagnosis are labeled “Alaska AIDS cases” and (2) HIV cases (with and without AIDS) are labeled “HIV/AIDS Cases.” (Note that the number of cases is shown by date of first known AIDS diagnosis in the column labeled “Alaska AIDS cases” and by date of first known HIV diagnosis in the column labeled “HIV/AIDS cases.”)

Table 7. HIV Cases Diagnosed by Year and Population, 1998-2002, Alaska

Year	Alaska AIDS Cases	HIV/AIDS Cases Ever Reported in Alaska	Alaska Population*
1998	28	45	617,082
1999	7	42	622,000
2000	28	47	626,932
2001	18	35	634,892
2002	16	31	643,786
Total	97	200	

*Population figures are estimates from the Alaska Department of Labor and Workforce Development for 1997-1999 and 2001-2002, and from the 2000 Census for 2000

Cumulative HIV cases and deaths due to any cause by year are shown in Figure 3 and illustrate the growing number of individuals in the population living with HIV, as new individuals become infected and previously infected individuals live longer. HIV cases and known deaths due to any cause among those cases by year of first known HIV diagnosis are presented in Table 8.

Figure 3. Cumulative HIV Cases and Known Deaths by Year of First Known HIV Diagnosis, Onset through December 31, 2002, Alaska N=892 (the 37 cases and 4 deaths for which date of diagnosis is unknown are not shown in the graph below)

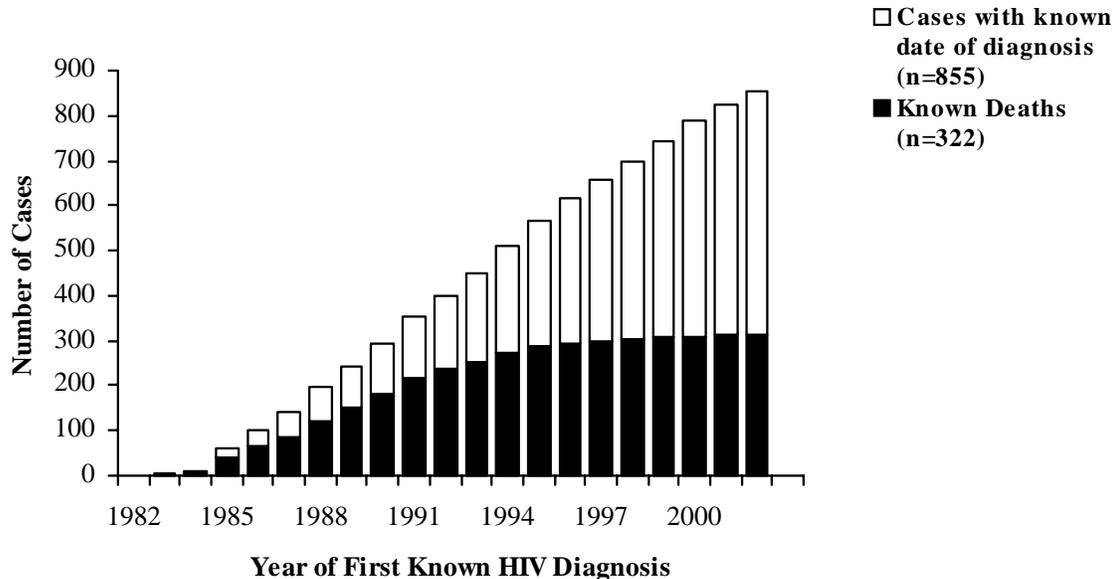


Table 8. HIV Cases and Known Deaths by Year of First Known HIV Diagnosis by Year, Onset through December 31, 2002, Alaska N=892

Year	Cases by Year of First Known HIV Diagnosis	Known Deaths Among Persons Diagnosed with HIV in that Year
1982	1	1
1983	5	3
1984	6	4
1985	48	30
1986	42	27
1987	42	22
1988	52	36
1989	45	27
1990	51	30
1991	60	37
1992	48	19
1993	49	17
1994	62	19
1995	57	15
1996	49	8
1997	38	5
1998	45	5
1999	42	4
2000	47	1
2001	35	3
2002	31	3
Unknown	37	6
Total	892	322

Gender

Female - Of 892 cumulative Alaska HIV cases, 168 cases (19%) were in females. The number and proportion of HIV cases among females in Alaska increased over time, although both remain smaller than in males. This is similar to the national trend.

Male - Of 892 cumulative Alaska HIV cases, 724 cases (81%) were in males. The number of HIV/AIDS cases newly diagnosed in males per year has decreased over time.

The average number of HIV/AIDS cases diagnosed per year in females has changed little in the last ten years (1993-2002), although the proportion of cases in females has increased considerably as the number of cases in males has declined.

Table 9. Average Number of HIV/AIDS Cases Newly Diagnosed per Year in Time Periods from 1982-2002 by Gender, Alaska N=892 (date of first diagnosis is unknown for 28 males and 9 females)

Time Period	Average Number of Cases Diagnosed per Year		
	Males	Females	Total, Males & Females
1982-1987	22	2	24
1988-1992	44	7	51
1993-1997	40	11	51
1998-2002	28	12	40

Age

Of HIV cases reported in Alaska, 618 (69%) were first diagnosed in individuals aged 25 to 44 years. Unlike the situation in some other areas of the U.S., HIV cases reported among younger people in Alaska were relatively few (19 cases or 2% of the total were aged 10-19 years at first HIV diagnosis). (Figure 9, Table 10) Characteristics of persons diagnosed with HIV while adolescents/young adult are discussed later in this document.

Figure 4. Cumulative HIV Cases with Onset through December 31, 2002 (with and without AIDS) by Age at First Known HIV Diagnosis, Alaska N=892 (the 36 cases for which age is unknown are not shown in the graph below)

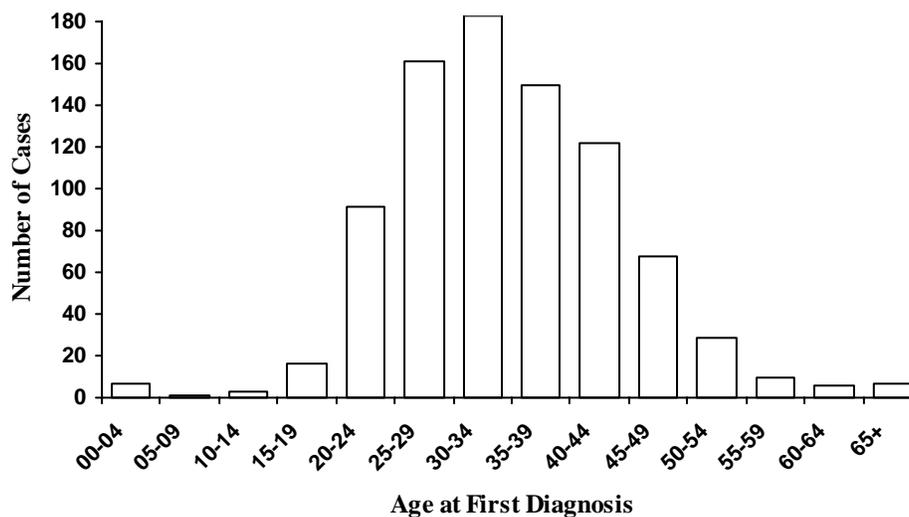


Table 10. Cumulative HIV Cases (with and without AIDS) by Gender and Age at First Known HIV Diagnosis through December 31, 2002, Alaska N=892

Age Group	Males	Females	Total
	Number (column %)	Number (column %)	Number (column %)
00-04	4 (1%)	3 (2%)	7 (1%)
05-09	1 (<1%)	0 (0%)	1 (<1%)
10-14	3 (<1%)	0 (0%)	3 (<1%)
15-19	10 (1%)	6 (4%)	16 (2%)
20-24	68 (9%)	23 (14%)	91 (10%)
25-29	130 (18%)	31 (18%)	161 (18%)
30-34	152 (21%)	33 (20%)	185 (21%)
35-39	128 (18%)	22 (13%)	150 (17%)
40-44	104 (14%)	18 (11%)	122 (14%)
45-49	54 (7%)	14 (8%)	68 (8%)
50-54	23 (3%)	6 (4%)	29 (3%)
55-59	9 (1%)	1 (1%)	10 (1%)
60-64	6 (1%)	0 (0%)	6 (1%)
65+	5 (1%)	2 (1%)	7 (1%)
Unknown	27 (4%)	9 (5%)	36 (4%)
Total	724 (100%)	168 (100%)	892 (100%)

Among total cumulative HIV cases, a greater proportion of adult female cases than adult male cases occurred in persons in a younger age group at the time of first HIV diagnosis. (Table 11) Of cases with known dates of diagnosis, 18% of females, compared to 11% of males, were diagnosed between the ages of 15-24 years while, of those diagnosed between the ages of 35-44 years, males accounted for 33% and females 25%.

Table 11. Age at First Known HIV Diagnosis by Gender for Selected Age Groups, Cumulative HIV/AIDS Cases through December 31, 2002, Alaska

Age Group	Males Number (%)	Females Number (%)
15-24 years	78 (11%)	29 (18%)
25-34 years	282 (40%)	64 (40%)
35-44 years	232 (33%)	40 (25%)
All Other Age Groups	105 (15%)	26 (16%)
Total Number of Cases with Known Date of Diagnosis	697 (100%)	159 (100%)

Exposure Category

In order to have consistent national data across geographic areas, the mode of HIV exposure is categorized according to specific national definitions in a hierarchy established by the CDC. Each HIV or AIDS case is counted only once. Individuals who have more than one mode of exposure are counted in only one exposure category determined by the CDC hierarchy, except that men who report both sexual contact with other men and injection drug use make up a separate CDC exposure category. CDC exposure category titles are straight-forward, with two

exceptions:

Heterosexual contact cases include only those cases reporting heterosexual contact with a person with, or at increased risk for, HIV infection (for example, an injection drug user). Cases where contact was not with an infected person or a person known to be at increased risk are classified as *Other (no risk reported or identified)*.

Other (no risk reported or identified) cases are in individuals with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. This case classification also includes:

- persons who are currently under investigation by the health department;
- persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow up; and
- persons who were interviewed or for whom other follow-up information was available and no (defined) exposure mode was identified.

Exposure data are presented below for cumulative HIV and AIDS cases diagnosed through December 2002.

Figure 5. Cumulative HIV Cases (with and without AIDS) by Exposure Category through December 31, 2002, Alaska (N=892)

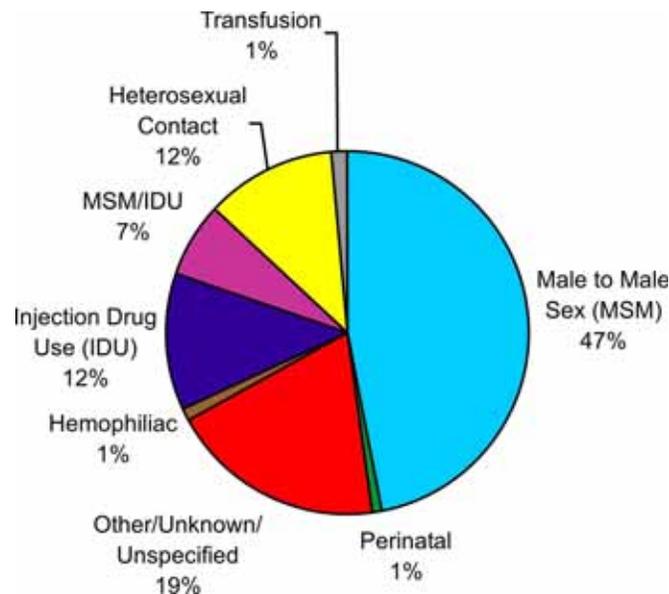


Table 12. Cumulative HIV Cases (with and without AIDS) by Exposure Category by Gender through December 31, 2002, Alaska (N=892)

Exposure Category	Males	Females	Total
	Number (column %)	Number (column %)	Number (column %)
Male-Male Sex (MSM)	419 (58%)	Not Applicable	419 (47%)
Injection Drug Use (IDU)	74 (10%)	36 (21%)	110 (12%)
MSM and IDU	58 (8%)	Not Applicable	58 (7%)
Heterosexual Contact to at-risk Person	33 (5%)	72 (43%)	105 (12%)
Transfusion/Transplant	8 (1%)	4 (2%)	12 (1%)
Hemophilia	10 (1%)	0 (0%)	10 (1%)
Perinatal Transmission	3 (<1%)	3 (2%)	6 (1%)
Other/Unknown/Unspecified	119 (16%)	53 (32%)	172 (19%)
Total	724 (100%)	168 (100%)	892 (100%)

The exposure category of male-male sex was the largest single risk for infection. This was true both for the total population of persons with HIV infection in Alaska (47% of all cumulative cases plus an additional 7% of cumulative cases in combination with injection drug use) and for the population of males only, where male-male sex was associated with 66% of cases. Injection drug use as a single exposure category accounted for 12% of cumulative cases and, when MSM-IDU cases were additionally considered, injection drug use was associated with 19% of cumulative cases (IDU was associated with 18% of cases in males and 21% of cases in females). Heterosexual contact to a person at increased risk for HIV (for example, a known HIV positive, IDU, or, for females, a bisexual male) accounted for 12% of total cumulative cases (5% of cases in males and 43% of cases in females). The proportions of cumulative cases related to perinatal transmission, transfusion or transplantation, or receipt of blood products for hemophilia remained low at 1%, each.

A relatively large proportion of cumulative cases (172 cases or 19%) were classified in the Other/Unknown/Unspecified exposure category. This is consistent with national trends. Some of these cases (particularly more recent cases) will be reclassified to other exposure categories as more case information becomes available. The proportion of cumulative cases classified as Other/Unknown/Unspecified in Alaska decreased in 2002 compared to 2001. At the national level, CDC statistically redistributes data on persons with no reported risk into specific risk categories. Because of the state's small case numbers and validity concerns, Alaska data have not been statistically redistributed in any of the presentations in this document.

Race/Ethnicity

HIV affects individuals in all racial and ethnic groups in Alaska. Although individuals are not at risk of HIV infection due to their race/ethnicity, it is sometimes considered an indicator of other social factors that may influence risk of exposure to HIV.

Several studies in other areas of the country have cited misidentification of American Indians and Alaska Natives (AI/AN) in disease surveillance databases and on death certificates as evidence that HIV/AIDS cases among AI/AN were underreported. A 1992 study by the Section of Epidemiology found no underreporting among AI/AN cases of AIDS in Alaska at that time. In 2002, the Section of Epidemiology again undertook an assessment of the accuracy of the race/ethnicity data recorded for HIV/AIDS cases, in collaboration with the Centers for Disease Control and Prevention and the Indian Health Service. The IHS National Patient Information and Reporting System served as the best available source for AI/AN status. Of the 847 HIV/AIDS cases reported in Alaska through June 2002, 182 were AI/AN; six (3.3% of the total) were found to have been inappropriately coded as White or Hispanic. These cases included four American Indian and two Alaska Native cases. Coding was corrected on these cases (and these changes are reflected throughout this report) in the Alaska data. An additional 15 cases classified in the Alaska database as AI/AN were not found in the IHS database. These cases were retained as AI/AN cases in Alaska's database on the basis of other evidence.

Data on all cumulative HIV cases by race/ethnicity are presented in Figure 6 and Table 13. (Table 13 presents Alaska population data for 2000, reapportioned into single race categories as discussed at the beginning of this Chapter.) Please note that the HIV *case* data classify individuals of Hispanic ethnicity as a separate race/ethnicity category while the *population* data include individuals of Hispanic ethnicity within the other (race) categories. Table 14 presents cumulative case data by race/ethnicity and gender.

Figure 6. Cumulative HIV Cases (with and without AIDS) by Race/Ethnicity through December 31, 2002, Alaska N=892 (22 cases have unknown race/ethnicity and are not shown in the graph below)

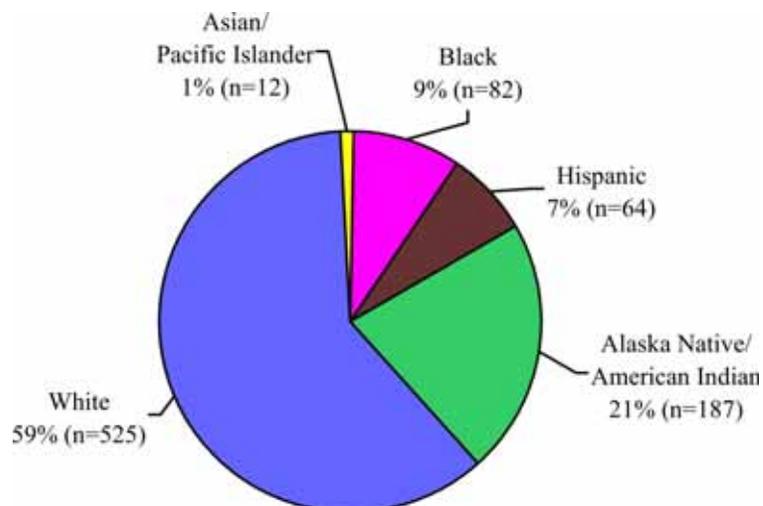


Table 13. Cumulative HIV Cases (with and without AIDS) Diagnosed through December 31, 2002 by Race/Ethnicity, Compared to Alaska Population

Race/Ethnicity	HIV Cases	Population Data from 2000 Census Reapportioned into Four Races*
	Number (% Total)	Number (% Total)
White	525 (59%)	460,782 (73%)
Alaska Native/ American Indian	187 (21%)	107,715 (17%)
Black	82 (9%)	26,649 (4%)
Asian/Pacific Islander	12 (1%)	31,786 (5%)
Hispanic Ethnicity	64 (7%)	25,852 (4%)*
Other/Unknown/Unspecified	22 (2%)	---
Total	892 (100%)	626,932 (100%)

*Alaska population data by race are drawn from the National Center for Health Statistics' Bridged Modified Race Series for April 1, 2000 based on Census 2000, Using Four Race Categories

**Persons of Hispanic origin may be of any race and are included within the race categories in the population figures

Table 14. Cumulative HIV Cases (with and without AIDS) Diagnosed through December 31, 2002 by Gender and Race/Ethnicity, Alaska (N=892)

Race/Ethnicity	Males	Females	Total
	Number (column %)	Number (column %)	Number (column %)
White	451 (62%)	74 (44%)	525 (59%)
Alaska Native/ American Indian	128 (18%)	59 (35%)	187 (21%)
Black	62 (9%)	20 (12%)	82 (9%)
Hispanic Ethnicity	56 (8%)	8 (5%)	64 (7%)
Asian/Pacific Islander	9 (1%)	3 (2%)	12 (1%)
Unknown	18 (2%)	4 (2%)	22 (2%)
Total	724 (100%)	168 (100%)	892 (100%)

For adult/adolescent males and females, HIV affected Whites and Asian/Pacific Islanders in proportions less than their representation in the state's population while HIV affected Alaska Native/American Indians, Blacks, and Hispanics in proportions greater than their representation in the population. These trends are similar to trends for the U.S. as a whole.

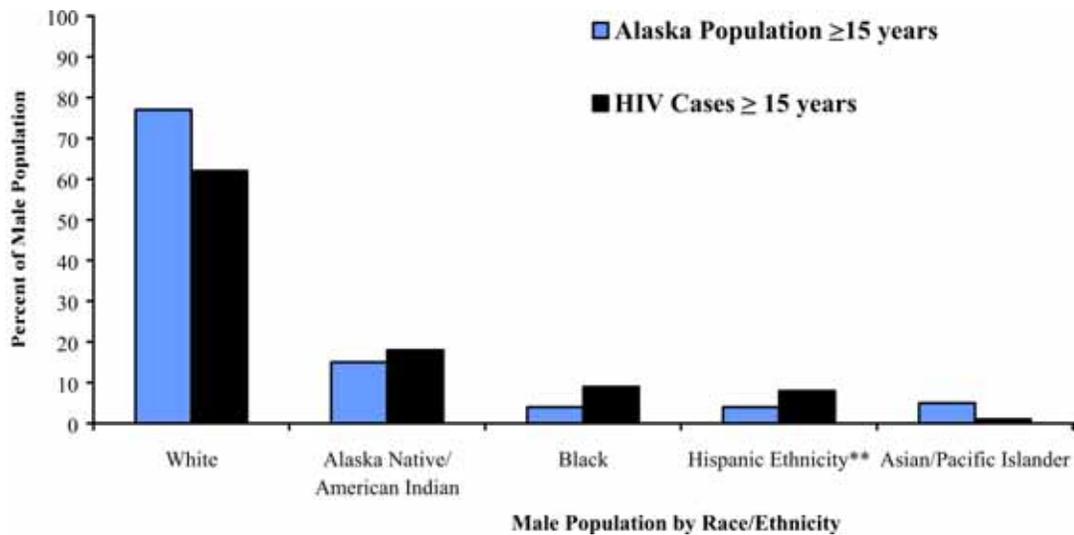
Table 15. Cumulative HIV Cases (with and without AIDS) in Males Aged 15 Years and Older, Onset through December 31, 2002, Compared to Alaska Male Population by Race/Ethnicity

Race/Ethnicity	Males \geq 15 Years of Age, Alaska Population*	HIV Cases first Diagnosed in Males \geq 15 Years of Age
White	187,034 (77%)	445 (62%)
Alaska Native/American Indian	35,623 (15%)	127 (18%)
Black	9,425 (4%)	61 (9%)
Asian/ Pacific Islander	11,028 (5%)	9 (1%)
Hispanic Ethnicity	[8,835 (4%)]**	56 (8%)
Other/Unknown/Unspecified	---	18 (3%)
Total	243,110 (100%)	716 (100%)

* Alaska population data by race are drawn from the National Center for Health Statistics' Bridged Modified Race Series for April 1, 2000 based on Census 2000, using four race categories. The Hispanic male population data are from the 2000 Census (total population Hispanic/Latino males = 13,268)

**Males \geq 15 years of Hispanic/Latino ethnicity are included within the racial categories in the population data

Figure 7. Cumulative HIV/AIDS Cases First Diagnosed in Males >15 Years through December 31, 2002 Compared to Males >15 Years in the Alaska Population by Race/Ethnicity N=716 (race/ethnicity is unknown for 18 HIV cases)



* Alaska population data by race are drawn from the National Center for Health Statistics' Bridged Modified Race Series for April 1, 2000 based on Census 2000, using four race categories. The Hispanic male population data are from the 2000 Census (total population Hispanic/Latino males = 13,268)

**Males > 15 years of Hispanic/Latino ethnicity are included within the racial categories in the population data

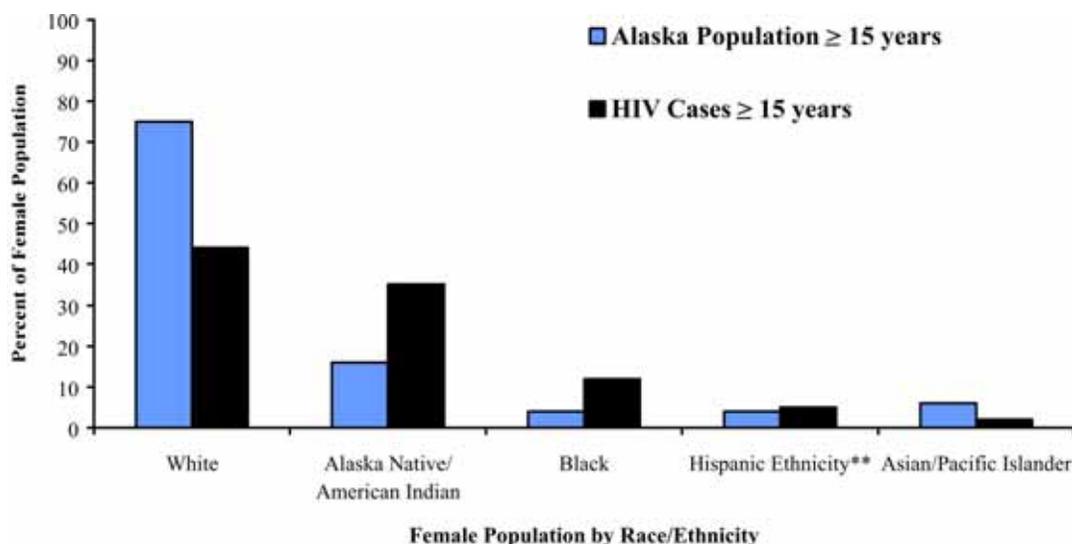
Table 16. Cumulative HIV Cases (with and without AIDS) in Females Aged 15 Years and Older, Onset through December 31, 2002, Compared to Alaska Female Population by Race/Ethnicity

Race/Ethnicity	Females \geq 15 Years of Age, Alaska Population*	HIV Cases first Diagnosed in Females \geq 15 Years of Age
White	168,710 (75%)	73 (44%)
Alaska Native/American Indian	36,217 (16%)	58 (35%)
Black	8,157 (4%)	19 (12%)
Asian/Pacific Islander	12,715 (6%)	3 (2%)
Other/Unknown/Unspecified	---	4 (2%)
Hispanic Ethnicity	[8,187 (4%)]**	8 (5%)
Total	225,779 (100%)	165 (100%)

* Alaska population data by race are drawn from the National Center for Health Statistics' Bridged Modified Race Series for April 1, 2000 based on Census 2000, using four race categories. The Hispanic female population data are from the 2000 Census (total population Hispanic/Latino females = 12,584)

**Females \geq 15 years of Hispanic/Latino ethnicity are included within the racial categories in the population data

Figure 8. Cumulative HIV Cases First Diagnosed in Females >15 Years through December 31, 2002 Compared to Females >15 Years in the Alaska Population* by Race/Ethnicity N=165 (race/ethnicity is unknown for 4 cases)



* Alaska population data by race are drawn from the National Center for Health Statistics' Bridged Modified Race Series for April 1, 2000 based on Census 2000, using four race categories. The Hispanic female population data are from the 2000 Census (total population Hispanic/Latino females = 12,584)

**Females > 15 years of Hispanic/Latino ethnicity are included within the racial categories in the population data

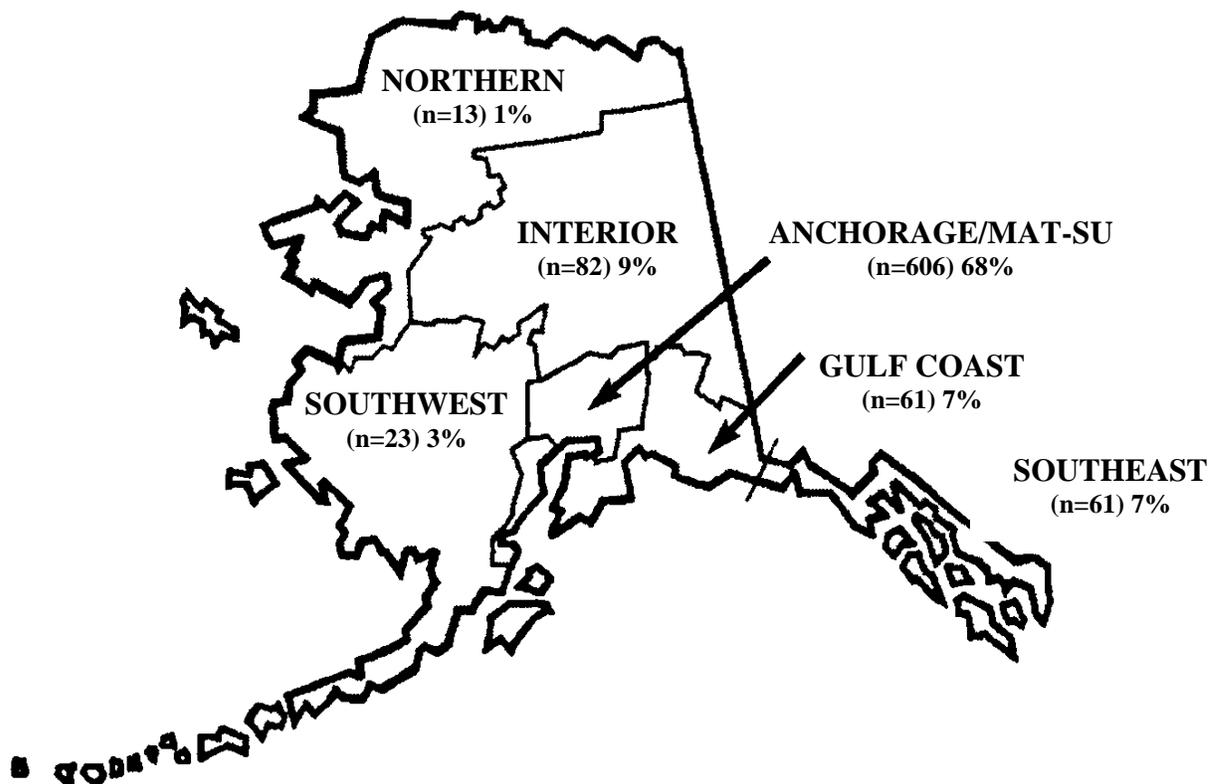
Geographic Region of Residence at First Known HIV Diagnosis

Geographic region of residence at the time of first known HIV diagnosis is shown in Figure 9 and Table 17 for cumulative cases of HIV infection reported in Alaska through December 31, 2002. The region of residence is the region where the case resided at the time of first known HIV

diagnosis, when known. If this is not known, residence is defined as the region of residence at the time of first AIDS diagnosis. If neither of these is known, residence is defined as the region from which the earliest case report was received. The geographic areas identified represent the state's economic regions.

HIV cases have been reported from all regions of the state. At the time of first known HIV diagnosis, the largest proportion of cases resided in the most populous area of the state, with 70% (574) reporting residence in Anchorage/Mat Su. It should be noted that residence at first known HIV diagnosis does not necessarily reflect the area where infection occurred, where the infected individual currently resides, or where the individual currently seeks care.

Figure 9. Region of Residence at Time of First Known HIV Diagnosis, Cumulative Cases Reported through December 31, 2002 Alaska* N=892 (35 with out-of-state residence and 11 with unknown residence)



*Note: Region of residence is defined as region of residence at first HIV diagnosis, when known, the region of residence at first AIDS diagnosis when the residence at HIV diagnosis is unknown, and the region of first case report when residence at HIV and AIDS diagnosis are unknown

Table 17. Estimated Population by Geographic Region* and Number of Cases by Region of Residence at First Known HIV Diagnosis, Cumulative Cases with Onset through December 31, 2002, Alaska (N=892)

Region	Population*		HIV Cases	
	Number	% Total	Number	% Total
Southwest	39,310	(6%)	23	(3%)
Northern	23,851	(4%)	13	(1%)
Interior	99,003	(15%)	82	(9%)
Anchorage/Mat-Su	334,311	(52%)	606	(68%)
Gulf Coast	75,339	(12%)	61	(7%)
Southeast	71,972	(11%)	61	(7%)
Out of State			35	(4%)
Unknown			11	(1%)
Total	643,786	(100%)	892	(100%)

*Population estimates by the Alaska Department of Labor and Workforce Development as of July 1, 2002

Deaths Among Persons with HIV/AIDS

Data on deaths in Alaska with an underlying cause of HIV infection are shown in Table 18. 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 18. Alaska Resident Deaths with an Underlying Cause of HIV Infection by Year of Death, 1982-2002, Section of Vital Statistics (N=227)

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
2000	11
2001	7
2002	11*
Total	227*

*preliminary data

Unlike the Vital Statistics data in Table 18 above, data on deaths among HIV/AIDS cases shown earlier in this Profile (Figure 3 and Table 8) 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. (Information on deaths occurring in persons who were no longer Alaska residents is likely incomplete.) Figure 3 and Table 8 also differ from Table 18 in that for those cases known to have died, Figure 3 and Table 8 show the death in the year the case was first diagnosed (rather than in the year the death occurred) in order to reflect case mortality.

HIV/AIDS ranked within the top 15 leading causes of death in Alaska from 1991 through 1995, but has not ranked within the top 15 causes of death since 1995. HIV/AIDS was among the top 10 causes of death in 1996 for the population of Alaskans aged 25-44 years, but has not been since that time. HIV-related deaths have declined in Alaska and the U.S. as a whole since 1996, primarily due to advances in treatment and medical care.

To help place deaths related to HIV in context, the top five causes of death for Alaskans in 1999 (and the number of deaths) included malignant neoplasms or cancer (621), heart disease (560), unintentional injuries (293), cerebrovascular disease (172), and chronic lower respiratory disease (145). These top five causes were the same for males and females although their order was different.

HIV/AIDS in Adolescents and Young Adults

CDC selects the age group of 13-24 years to characterize HIV infection in adolescents and young adults in the U.S. epidemic. Through December 31, 2002, a cumulative total of 108 cases of HIV/AIDS were diagnosed in Alaska in persons aged 13-24 years at first HIV diagnosis. These cases were diagnosed from 1983 through 2002. An average of 5 cases per year in this age group were diagnosed in the period from 1998-2002, slightly less than the average of 6 cases per year throughout the preceding decade (1988-1997).

Of the 108 total cumulative cases in persons aged 13-24 years at first HIV diagnosis, 79 (73%) cases were in males and 29 (27%) cases in females.

For males aged 13-24 years, male-male-sex, injection drug use, and male-male sex combined with injection drug use accounted for 90% of cases through December 2002. For females aged 13-24 years, heterosexual contact to a person with or at increased risk of HIV infection was the most significant identified risk category (62% of cases), followed by injection drug use (7%). As with the total cumulative population of persons with HIV/AIDS, all races and ethnicities were represented in persons aged 13-24 years at first HIV diagnosis. The largest proportion of cases resided in urban areas at time of first HIV diagnosis with most in Anchorage/Mat-Su.

Table 19. Cumulative HIV Cases (with and without AIDS) in Persons Aged 13-24 Years at First HIV Diagnosis by Exposure Category by Gender through December 31, 2002, Alaska (N=108)

Exposure Category	Males	Females	Total
	Number (column %)	Number (column %)	Number (column %)
Male-Male Sex (MSM)	52 (66%)	Not Applicable	52 (48%)
Injection Drug Use (IDU)	7 (9%)	2 (7%)	9 (8%)
MSM and IDU	12 (15%)	Not Applicable	12 (11%)
Heterosexual Contact to at-risk Person	1 (1%)	18 (62%)	19 (18%)
Transfusion/Transplant	0 (0%)	0 (0%)	0 (0%)
Hemophilia	0 (0%)	0 (0%)	0 (0%)
Perinatal Transmission	0 (0%)	0 (0%)	0 (0%)
Other/Unknown/Unspecified	7 (9%)	9 (31%)	16 (15%)
Total	79 (100%)	29 (100%)	108 (100%)

Table 20. Cumulative HIV Cases (with and without AIDS) in Persons Aged 13-24 Years at First HIV Diagnosis through December 31, 2002 by Gender and Race/Ethnicity, Alaska (N=108)

Race/Ethnicity	Males	Females	Total
	Number (column %)	Number (column %)	Number (column %)
White	54 (68%)	12 (41%)	66 (61%)
Alaska Native/ American Indian	14 (18%)	10 (34%)	24 (22%)
Black	4 (5%)	5 (17%)	9 (8%)
Hispanic Ethnicity	6 (8%)	1 (3%)	7 (6%)
Asian/Pacific Islander	0 (0%)	1 (3%)	1 (1%)
Unknown	1 (1%)	0 (0%)	1 (1%)
Total	79 (100%)	29 (100%)	108 (100%)

Table 21. Economic Region of Residence at First Known HIV Diagnosis, Cumulative HIV Cases (with and without AIDS) in Persons Aged 13-24 Years at First HIV Diagnosis through December 31, 2002, Alaska (N=108)

Economic Region	Total Number (Column %)
Anchorage/Mat-Su	72 (67%)
Gulf Coast	4 (4%)
Southeast	6 (6%)
Southwest	3 (3%)
Northern	1 (1%)
Interior	11 (10%)
Out of State	9 (8%)
Unknown	2 (2%)
Total	108 (100%)

Table 22. Urban/Rural Region of Residence at First Known HIV Diagnosis, Cumulative HIV Cases (with and without AIDS) in Persons Aged 13-24 Years at First HIV Diagnosis through December 31, 2002, Alaska (N=108)

Region	Total Number (Column %)
Urban	80 (74%)
Sub-Urban	8 (7%)
Rural Hub	2 (2%)
Rural Community	7 (6%)
Out of State	9 (8%)
Unknown Residence	2 (2%)
Total	108 (100%)

Persons Diagnosed Late in the Course of their HIV Disease

Diagnosis of HIV late in the course of infection precludes the benefits of early treatment and prolongs the time during which an infected person may unknowingly expose others. One indicator of late HIV diagnosis is rapid progression to AIDS after first HIV diagnosis. For purposes of comparison to national data, “late testers” are defined as cases with a reported AIDS diagnosis within 12 months of first HIV diagnosis.

HIV infection was made a condition reportable to the Division of Public Health in February 1999. In the period that followed, HIV cases diagnosed prior to this time were also reported, a number of which had been diagnosed many years earlier. Comprehensive record reviews with large providers additionally identified AIDS cases that had inadvertently not yet been reported, some of which were in persons who had moved to Alaska from other geographic areas.

During the four-year period from 1999 to 2002, 120 cases (97 males and 23 females) first reported with AIDS also had their first known HIV diagnosis within 12 months of their AIDS diagnosis. These 120 cases included persons diagnosed with AIDS as long ago as 1983. Persons of all races/ethnicities were included. Most (69% of male and 83% of female cases) resided in

Anchorage/Mat Su at the time of AIDS diagnosis. Male cases were reported from all economic regions of the state, and 12% of male cases were from out of state. Cases in females were concentrated in Anchorage/Mat-Su with a very small number of cases in two other regions.

Of the 120 cases reported to the Division of Public Health in this group, 61 cases received their first AIDS diagnosis in the period from 1999-2002. These 61 persons represented 64% of the 96 persons reported in Alaska as first diagnosed with AIDS from 1999-2002.

For comparison, CDC recently reported an analysis of HIV/AIDS surveillance data from the 25 states having both HIV and AIDS named reporting since 1994. Of 104,780 persons aged 13 years and older diagnosed with HIV from 1994-1999, 41% had an AIDS diagnosis within one year of a positive HIV test (*MMWR* 2003; 52(15):330). In a second CDC analysis of data from an ongoing, cross-sectional, multisite interview study in 16 higher prevalence health departments, 45% of 4,127 persons with AIDS aged 18 years or older were identified as having AIDS diagnosed within one year of HIV diagnosis. In an additional 336 persons (8%), it was not possible to determine the relationship between HIV testing and AIDS diagnosis dates (*MMWR* 2003; 52(25):582).

Further analysis of the characteristics of persons diagnosed late (and those diagnosed earlier) will be more feasible as additional Alaska HIV data become available over time.

HIV Cases Newly Reported in Alaska in 2002

Seventy-four (74) unduplicated cases of HIV were newly reported to the Alaska Division of Public Health in 2002 (Table 23). Of these, 30 cases (41%) had their first known HIV diagnosis in 2002. Of the 74 cases, 44 (59%) had a diagnosis of HIV without AIDS and 30 (41%) had an AIDS diagnosis. (Note: these data represent cases newly *reported* to the Division in 2002 and are not necessarily the same cases shown in Tables 7 and 8 as being first *diagnosed* in 2002. These two sets of case numbers are expected to differ.)

Of the 44 cases of HIV without AIDS, 21 were first diagnosed in 2002 and an additional 23 were first diagnosed prior to 2002. Of the 30 cases first reported with AIDS, 13 had their first AIDS diagnosis in 2002 (9 of which were diagnosed with both HIV and AIDS in 2002), 16 were diagnosed with AIDS prior to 2002, and the date of AIDS diagnosis was unknown for one case.

The number and proportion of cases reported for the first time in 2002 with an HIV diagnosis in an earlier year was much smaller than in 2001 or 2000 (4 or 5% of 74 cases reported in 2002 as compared to 16 or 31% of cases reported in 2001 and 37 or 48% of 77 cases reported in 2000). This decline indicates that “catch up” reporting on older, previously diagnosed Alaska cases has essentially been completed. Some previously diagnosed HIV cases will continue to be newly reported in Alaska since individuals will relocate to Alaska from other states (just as persons from Alaska relocate to other states).

Table 23. Cases First Reported with HIV and/or AIDS in 2002, Alaska (N=74)

Total reported with HIV and/or AIDS					74
Diagnosis of HIV only (without AIDS)				44	
In 2002			21		
Before 2002			23		
Diagnosis date unknown			0		
Diagnosis of AIDS				30	
AIDS diagnosis also in 2002			13		
HIV diagnosis also in 2002		9			
HIV & AIDS diagnosed at same time	7				
HIV diagnosed prior to AIDS onset but both in 2002	2				
HIV diagnosis date unknown		0			
HIV diagnosis before 2002		4			
AIDS diagnosis before 2002			16		
AIDS diagnosis date unknown			1		

Persons Presumed Living with HIV

Data on the number of persons living with HIV, or the *prevalence* of HIV infection, provide one indicator of potential service needs. The true number and characteristics of persons living with HIV in Alaska can only be approximated, primarily due to individuals' mobility but also because not all infected persons have yet been diagnosed. The most straightforward approximation of HIV prevalence is provided by the number of persons reported with HIV in Alaska and who are not known to have died. Some persons included in these figures very likely left the state and died at some later date without their deaths being reflected in the Alaska data. (Of the 570 persons reported with HIV/AIDS in Alaska since 1982 and who are not known to have died, 286 were diagnosed prior to 1990.) For comparison purposes, data on persons not known to have died (referred to as "presumed living") are contrasted with data on those known to have died in all tables except Table 25.

Table 24. Cumulative HIV Cases by Gender, Cases Presumed Living and Cases Known to Have Died, through 12/31/02, Alaska (N=892)

Gender	Cases Presumed Living Number (column %)	Cases Known to Have Died Number (column %)	Total (column %)
Male	443 (78%)	281 (87%)	724 (81%)
Female	127 (22%)	41 (13%)	168 (19%)
Total	570 (100%)	322 (100%)	892 (100%)

The age data in Table 25, below differ from data presented earlier in this report (Figure 4, Tables 10 and 11) in that each case's age has been calculated as of July 2002 rather than using age at first HIV diagnosis, in order to better represent the (presumed living) population's current characteristics.

Table 25. Cumulative HIV Cases by Age on July 2002, Cases Presumed Living, through 12/31/02, Alaska (N=570)

Age as of July 2002	Cases Presumed Living, Number (column %)
0-4	0 (0%)
5-9	0 (0%)
10-14	2 (<1%)
15-19	1 (<1%)
20-24	15 (3%)
25-29	35 (6%)
30-34	66 (12%)
35-39	133 (23%)
40-44	132 (23%)
45-49	97 (17%)
50-54	49 (9%)
55-59	24 (4%)
60-64	8 (1%)
65+	8 (1%)
Unknown	0 (0%)
Total	570 (100%)

Table 26. Cumulative HIV Cases by Exposure Category, Cases Presumed Living and Cases Known to Have Died, through 12/31/02, Alaska (N=892)

Exposure Category	Cases Presumed Living Number (column %)	Cases Known to Have Died Number (column %)	Total Number (column %)
Male-Male Sex (MSM)	236 (41%)	183 (57%)	419 (47%)
Injection Drug Use (IDU)	77 (14%)	33 (10%)	110 (12%)
MSM and IDU	37 (6%)	21 (7%)	58 (7%)
Heterosexual Contact to at-risk Person	83 (15%)	22 (7%)	105 (12%)
Transfusion/Transplant	1 (<1%)	11 (3%)	12 (1%)
Hemophilia	4 (1%)	6 (2%)	10 (1%)
Perinatal Transmission	1 (<1%)	5 (2%)	6 (1%)
Other/Unknown/Unspecified	131 (23%)	41 (13%)	172 (19%)
Total	570 (100%)	322 (100%)	892 (100%)

Table 27. Cumulative HIV Cases by Race/Ethnicity, Cases Presumed Living and Known to Have Died, Onset through December 31, 2002, Alaska (N=892)

Race/Ethnicity	Cases Presumed Living Number (column %)	Cases Known to Have Died Number (column %)	Total Number (column %)
White	324 (57%)	201 (62%)	525 (59%)
Alaska Native/ American Indian	114 (20%)	73 (23%)	187 (21%)
Black	57 (10%)	25 (8%)	82 (9%)
Hispanic Ethnicity	44 (8%)	20 (6%)	64 (7%)
Asian/Pacific Islander	10 (2%)	2 (1%)	12 (1%)
Unknown	21 (4%)	1 (<1%)	22 (2%)
Total	570 (100%)	322 (100%)	892 (100%)

Persons Infected More Recently

Comparing information about persons with more recently acquired HIV infection to those infected earlier in the epidemic may help guide HIV prevention and care activities. This is somewhat difficult to do in places like Alaska where small case numbers make it difficult to accurately identify patterns and trends. In order to include a reasonably large number of cases, cases within the most recent five-year period (1998-2002) were selected to represent “recent” cases. To approximate more recent infections, those cases with their first known HIV diagnosis within this five-year period and without progression to AIDS through December 31, 2002 were selected. This population is referred to below as “Recent (HIV, Non-AIDS).” This population is contrasted to the population of all other persons reported in Alaska with HIV and AIDS, in order to highlight characteristics of recent cases that may differ from those presumably infected during earlier time periods.

Table 28. HIV Cases by Gender, Recent (HIV, Non-AIDS) Cases and All Other HIV/AIDS Cases, Onset through 12/31/02, Alaska (N=892)

Gender	Recent HIV Cases Number (column %)	All Other HIV/AIDS Cases Number (column %)	Total Number (column %)
Male	67 (62%)	657 (84%)	724 (81%)
Female	41 (38%)	127 (16%)	168 (19%)
Total	108 (100%)	784 (100%)	892 (100%)

In cases presumed infected more recently, the proportion of females as compared to males is considerably greater than was the case in cases presumed infected earlier in the epidemic.

Figure 10. HIV Cases by Gender, Recent (HIV, Non-AIDS) Cases and All Other HIV/AIDS Cases, Onset through 12/31/02, Alaska (N=892; 108 Recent, 784 All Other)

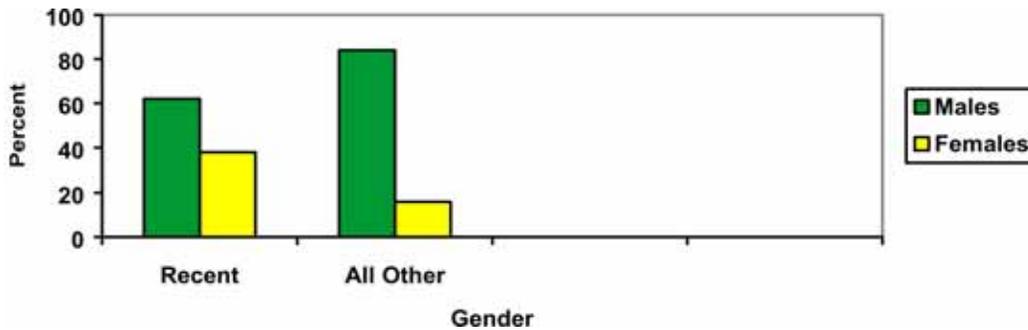
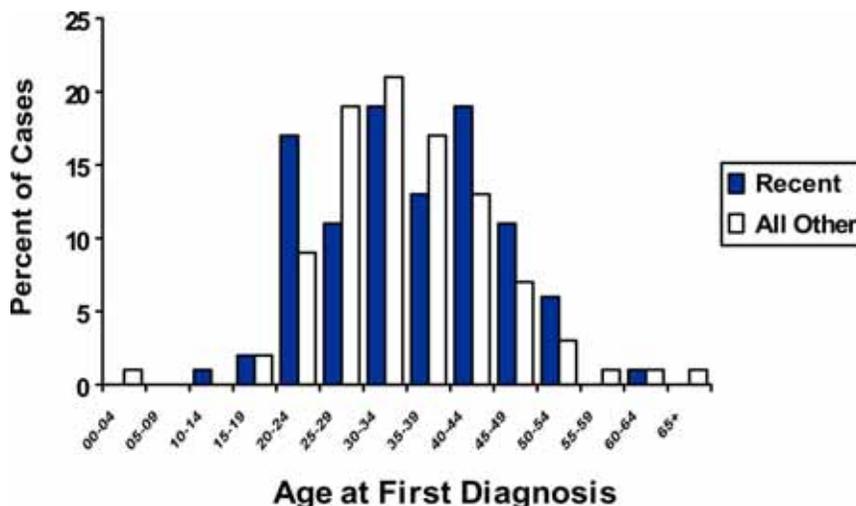


Table 29. HIV Cases by Age at First HIV Diagnosis, Recent (HIV, Non-AIDS) and All Other HIV/AIDS Cases, Onset through 12/31/02, Alaska (N=892)

Age at First HIV Diagnosis	Recent HIV Cases Number (column %)	All Other HIV/AIDS Cases Number (column %)	Total Number (column %)
0-4	0 (0%)	7 (1%)	7 (1%)
5-9	0 (0%)	1 (<1%)	1 (<1%)
10-14	1 (1%)	2 (<1%)	3 (<1%)
15-19	2 (2%)	14 (2%)	16 (2%)
20-24	18 (17%)	73 (9%)	91 (10%)
25-29	12 (11%)	149 (19%)	161 (18%)
30-34	20 (19%)	165 (21%)	185 (21%)
35-39	14 (13%)	136 (17%)	150 (17%)
40-44	21 (19%)	101 (13%)	122 (14%)
45-49	12 (11%)	56 (7%)	68 (8%)
50-54	7 (6%)	22 (3%)	29 (3%)
55-59	0 (0%)	10 (1%)	10 (1%)
60-64	1 (1%)	5 (1%)	6 (1%)
65+	0 (0%)	7 (1%)	7 (1%)
Unknown	0 (0%)	36 (5%)	36 (4%)
Total	108 (100%)	784 (100%)	892 (100%)

Figure 11. HIV Cases by Age at First HIV Diagnosis, Recent (HIV, Non-AIDS) and All Other HIV/AIDS Cases, Onset through 12/31/02, Alaska (N=892; 108 Recent and 784 All Other) (the 36 cases for which age is unknown are not shown in the graph below)



Recent adult (ages 15 years and older) cases tended to be younger at age of first HIV diagnosis than was the case in persons presumed infected earlier in the epidemic. In cases with known dates of diagnosis, 19% of recent (HIV, non-AIDS) cases were aged 15-24 years at first HIV diagnosis as compared to 12% of all other cases. A higher proportion of recent female cases (24%) were aged 15-24 years at first HIV diagnosis than was the case for males (15%).

Figure 12. Age at First Known HIV Diagnosis by Gender, Recent (HIV, Non-AIDS) Cases by Selected Age Group, Diagnosis 1998-2002, Alaska N=108, 67 Males and 41 Females (of these, 21 cases including 12 males and 9 females are in other age groups and are not shown below.)

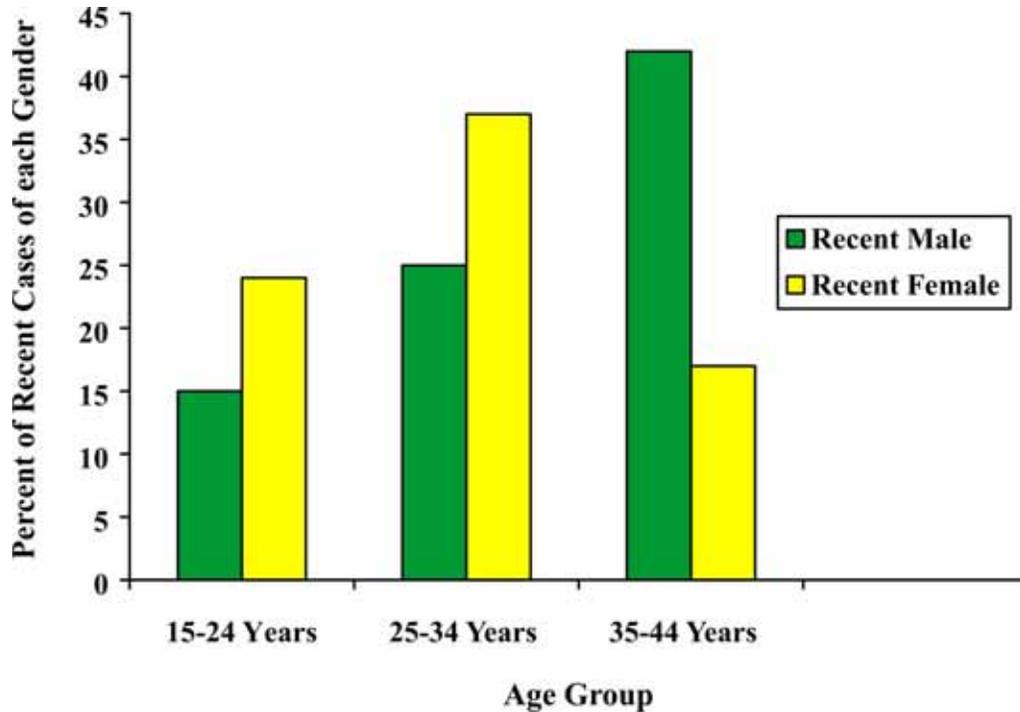


Table 30. Age at First Known HIV Diagnosis by Gender, Recent (HIV, non-AIDS) Cases by Selected Age Group, Diagnosis 1998-2002, Alaska N=108

Age Group	Males Number (Column %)	Females Number (Column %)	Total Number (Column %)
15-24 years	10 (15%)	10 (24%)	20 (19%)
25-34 years	17 (25%)	15 (37%)	32 (30%)
35-44 years	28 (42%)	7 (17%)	35 (32%)
All Other Ages	12 (18%)	9 (22%)	21 (19%)
Total	67 (100%)	41 (100%)	108 (100%)

Table 31. Male HIV Cases by Exposure Category, Recent (HIV, Non-AIDS) and All Other Male HIV/AIDS Cases with Onset through 12/31/02, Alaska (N=724)

Exposure Category	Recent HIV Cases Number (column %)	All Other HIV/AIDS Cases Number (column %)	Total Number (column %)
Male-Male Sex (MSM)	33 (49%)	386 (59%)	419 (58%)
Injection Drug Use (IDU)	6 (9%)	68 (10%)	74 (10%)
MSM and IDU	1 (1%)	57 (9%)	58 (8%)
Heterosexual Contact to at-risk Person	9 (13%)	24 (4%)	33 (5%)
Transfusion/Transplant	0 (0%)	8 (1%)	8 (1%)
Hemophilia	0 (0%)	10 (2%)	10 (1%)
Perinatal Transmission	0 (0%)	3 (<1%)	3 (<1%)
Other/Unknown/Unspecified	18 (27%)	101 (15%)	119 (16%)
Total	67 (100%)	657 (100%)	724 (100%)

Figure 13. Male HIV Cases by Exposure Category, Recent (HIV, Non-AIDS) and All Other Male HIV/AIDS Cases with Onset through 12/31/02, Alaska (N=724; 67Recent and 657 All Other)

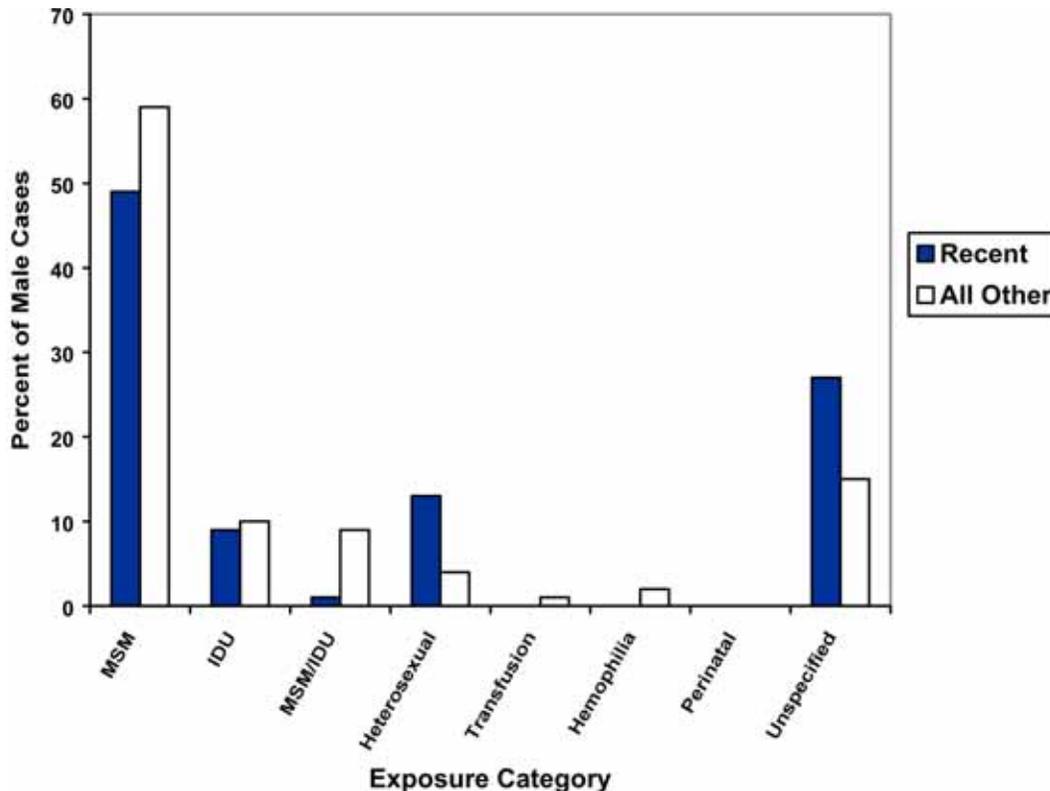
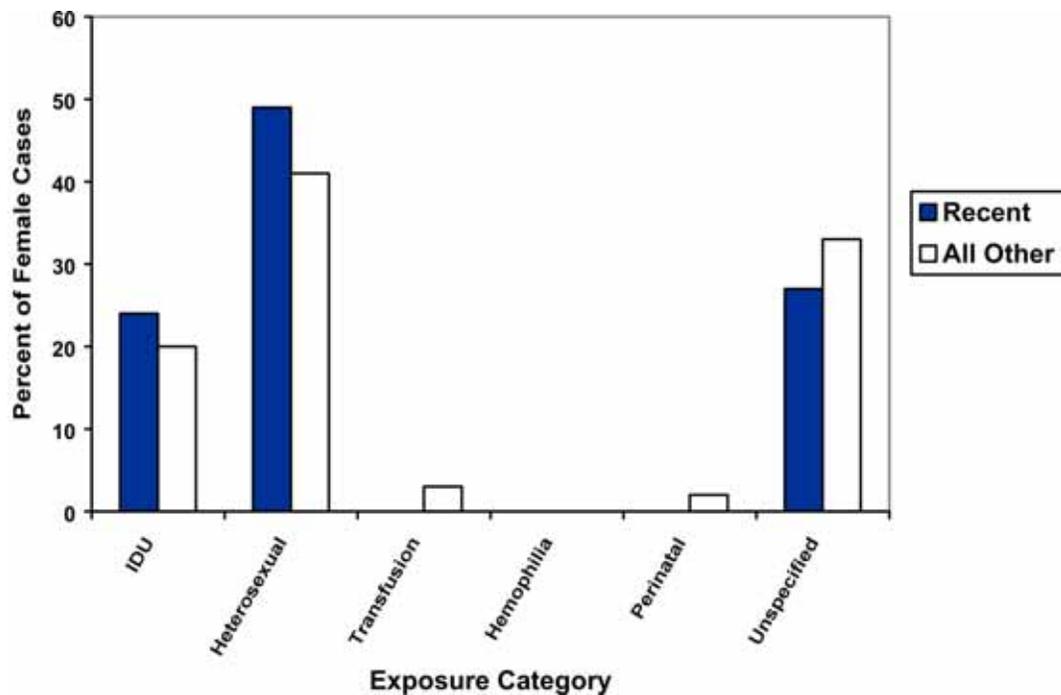


Table 32. Female HIV Cases by Exposure Category, Recent (HIV, Non-AIDS) and All Other Female HIV/AIDS Cases with Onset through 12/31/02, Alaska (N=168)

Exposure Category	Recent HIV Cases Number (column %)	All Other HIV/AIDS Cases Number (column %)	Total Number (column %)
Male-Male Sex (MSM)	Not Applicable	Not Applicable	Not Applicable
Injection Drug Use (IDU)	10 (24%)	26 (20%)	36 (21%)
MSM and IDU	Not Applicable	Not Applicable	Not Applicable
Heterosexual Contact to at-risk Person	20 (49%)	52 (41%)	72 (43%)
Transfusion/Transplant	0 (0%)	4 (3%)	4 (2%)
Hemophilia	0 (0%)	0 (0%)	0 (0%)
Perinatal Transmission	0 (0%)	3 (2%)	3 (2%)
Other/Unknown/Unspecified	11 (27%)	42 (33%)	53 (32%)
Total	41 (100%)	127 (100%)	168 (100%)

Figure 14. Female HIV Cases by Exposure Category, Recent (HIV, Non-AIDS) and All Other Female HIV/AIDS Cases with Onset through 12/31/02, Alaska (N=168; 41 Recent and 127 All Other)



The single exposure category of male-male sex remained the largest for male cases, although the proportion of cases with this exposure was smaller in recent cases (49%) than in cases presumably infected earlier in the epidemic (59%). The proportion of male cases with injection drug use exposure was similar in recent cases (9%) and those infected earlier (10%). The proportion of cases with the exposure category male-male sex and injection drug use was much smaller in recent (1%) than in earlier cases (9%). The proportion of male cases with the exposure category of heterosexual contact to a person with/at increased risk of HIV was larger in recent cases (13%) as compared to cases presumably infected earlier in the epidemic (4%). There were no recent male cases with exposure categories of transfusion/transplant, hemophilia, or perinatal transmission.

For females, the exposure category of heterosexual contact to a person with or at increased risk of HIV was larger in recent cases (49%) as compared to cases presumably infected earlier in the epidemic (41%). The proportion of female cases with injection drug use exposure was also larger in recent cases (24%) than in those presumably infected earlier (20%). There were no recent female cases with exposure categories of transfusion/transplant, hemophilia, or perinatal transmission.

The proportion of cases with other/unknown/unspecified exposure category is large (27%) for recent cases in both males and females. This exposure category is larger for recent than earlier male cases, and is smaller for recent than earlier female cases. (Recent cases numbers are relatively small for cases of both genders and proportions in some exposure categories are therefore likely to be unstable.)

Individuals presumed to have been infected more recently also differ in race/ethnicity from those presumably infected earlier in the epidemic.

Table 33. Male HIV Cases by Race/Ethnicity, Recent (HIV, Non-AIDS) and All Other Male HIV/AIDS Cases with Onset through 12/31/02, Alaska (N=724)

Race/Ethnicity	Recent HIV Cases Number (column %)	All Other HIV/AIDS Cases Number (column %)	Total Number (column %)
White	31 (46%)	420 (64%)	451 (62%)
Alaska Native/ American Indian	19 (28%)	109 (17%)	128 (18%)
Black	9 (13%)	53 (8%)	62 (9%)
Hispanic Ethnicity	2 (3%)	54 (8%)	56 (8%)
Asian/Pacific Islander	3 (4%)	6 (1%)	9 (1%)
Unknown	3 (4%)	15 (2%)	18 (2%)
Total	67 (100%)	657 (100%)	724 (100%)

Figure 15. Male HIV Cases by Race/Ethnicity, Recent (HIV, Non-AIDS) and All Other Male HIV/AIDS Cases with Onset through 12/31/02, Alaska (N=724; 67 Recent and 657 All Other) (Race/ethnicity is unknown for 3 recent and 15 “all other” cases)

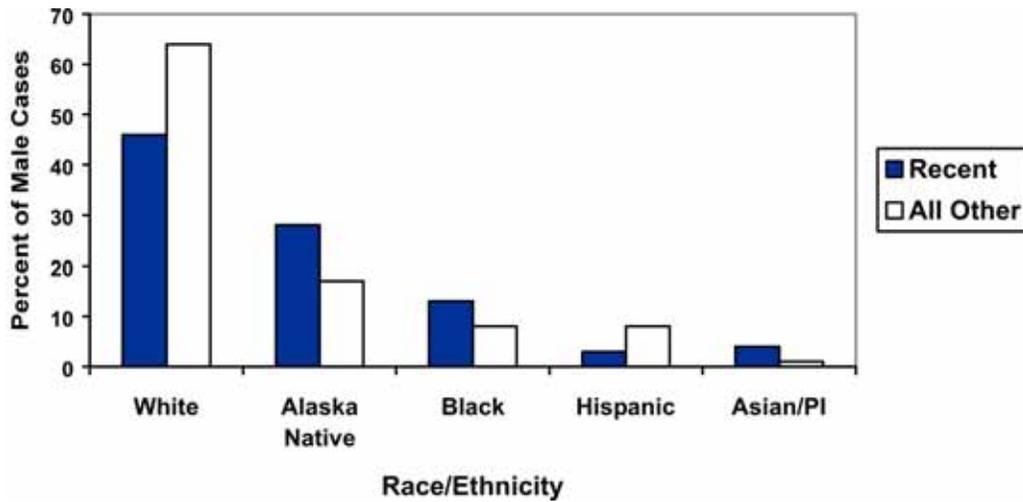
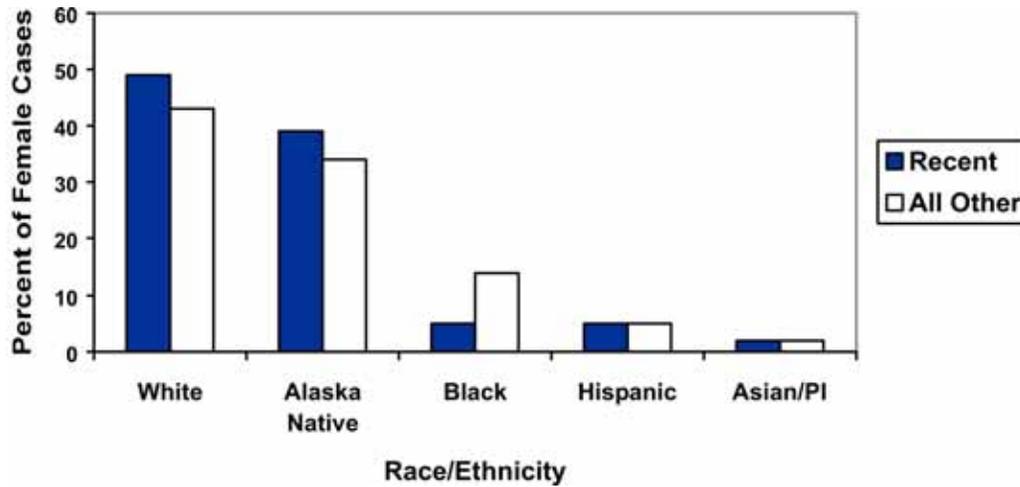


Table 34. Female HIV Cases by Race/Ethnicity, Recent (HIV, Non-AIDS) and All Other Female HIV/AIDS Cases with Onset through 12/31/02, Alaska (N=168)

Race/Ethnicity	Recent HIV Cases Number (column %)	All Other HIV/AIDS Cases Number (column %)	Total Number (column %)
White	20 (49%)	54 (43%)	74 (44%)
Alaska Native/ American Indian	16 (39%)	43 (34%)	59 (35%)
Black	2 (5%)	18 (14%)	20 (12%)
Hispanic Ethnicity	2 (5%)	6 (5%)	8 (5%)
Asian/Pacific Islander	1 (2%)	2 (2%)	3 (2%)
Unknown	0 (0%)	4 (3%)	4 (2%)
Total	41 (100%)	127 (100%)	168 (100%)

Figure 16. Female HIV Cases by Race/Ethnicity, Recent (HIV, Non-AIDS) and All Other Female HIV/AIDS Cases with Onset through 12/31/02, Alaska (N=168; 41 Recent and 127 All Other) (Race/ethnicity is unknown for 4 “all other” cases)



Although the small number of cases of HIV (non-AIDS) in MSM and MSM/IDU make the proportions unstable, data in Table 35, below indicate the burden of HIV disease among men of minority race/ethnicity has increased in recent (1998-2002) years as compared to that in white MSM and MSM/IDU.

Table 35. Recent (HIV, Non-AIDS) and All Other Male HIV/AIDS Cases with Exposure Categories of Male-Male Sex and Male-Male Sex/Injection Drug Use by Race Ethnicity, with Onset through 12/31/02, Alaska (N=477)

Race/Ethnicity	Recent HIV Cases in MSM & MSM/IDU Number (column %)	All Other HIV/AIDS Cases in MSM & MSM/IDU Number (column %)	Total HIV/AIDS Cases in MSM & MSM/IDU Number (column %)
White	18 (53%)	310 (70%)	328 (69%)
Alaska Native/ American Indian	9 (26%)	71 (16%)	80 (17%)
Black	4 (12%)	27 (6%)	31 (6%)
Hispanic Ethnicity	2 (6%)	29 (7%)	31 (6%)
Asian/Pacific Islander	1 (3%)	3 (1%)	4 (1%)
Unknown	0 (0%)	3 (1%)	3 (1%)
Total	34 (100%)	443 (100%)	477 (100%)

Figure 17. Recent (HIV, Non-AIDS) and All Other Male HIV/AIDS Cases with Exposure Categories of Male-Male Sex and Male-Male Sex/Injection Drug Use by Race Ethnicity, with Onset through 12/31/02, Alaska (N=477; 34 Recent and 443 All Other)

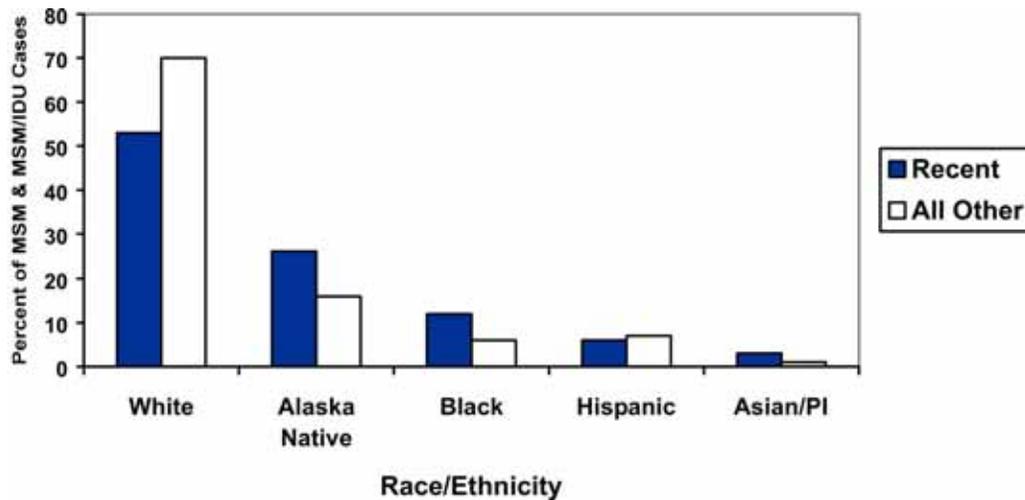


Table 36. Urban/Rural Region of Residence at First Known HIV Diagnosis, Recent (HIV, non-AIDS) Cases and All Other HIV/AIDS Cases, Onset through 12/31/02, Alaska (N=892)

Region	Recent Number (Column %)	All Other Number (Column %)	Total Number (Column %)
Urban	69 (64%)	603 (77%)	672 (75%)
Sub-Urban	9 (8%)	71 (9%)	80 (9%)
Rural Hub	9 (8%)	40 (5%)	49 (5%)
Rural Community	12 (11%)	33 (4%)	45 (5%)
Out of State	8 (7%)	27 (3%)	35 (4%)
Unknown Residence	1 (1%)	10 (1%)	11 (1%)
Total	108 (100%)	784 (100%)	892 (100%)

Figure 18. Urban/Rural Region of Residence at First Known HIV Diagnosis, Recent (HIV, non-AIDS) Cases and All Other HIV/AIDS Cases, Onset through 12/31/02, Alaska (N= 892; 108 Recent and 784 All Other) (1 recent HIV and 10 other HIV/AIDS cases have unknown region of residence)

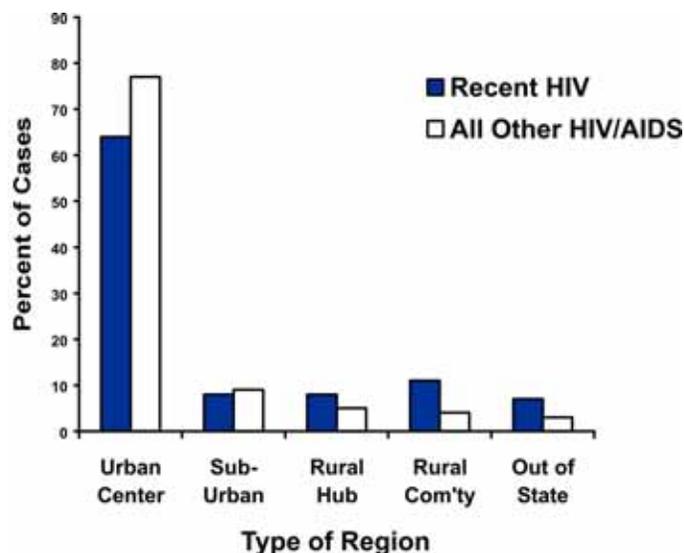


Table 37. Region of Residence at First HIV Diagnosis by Gender, Recent (HIV, non-AIDS) Cases with Onset 1998-2002, Alaska (N=108)

Region	Male Number (Column %)	Female Number (Column %)	Total Number (Column %)
Urban	49 (73%)	20 (49%)	69 (64%)
Sub-Urban	5 (7%)	4 (10%)	9 (8%)
Rural Hub	3 (4%)	6 (15%)	9 (8%)
Rural Community	6 (9%)	6 (15%)	12 (11%)
Out of State	4 (6%)	4 (10%)	8 (7%)
Unknown Residence	0 (0%)	1 (2%)	1 (1%)
Total	67 (100%)	41 (100%)	108 (100%)

Figure 19. Urban/Rural Region of Residence at First Known HIV Diagnosis by Gender, Recent (HIV, Non-AIDS) Cases with Onset 1998-2002, Alaska (N= 108; 67 Males and 41 Females) (1 recent female case with unknown region of residence)

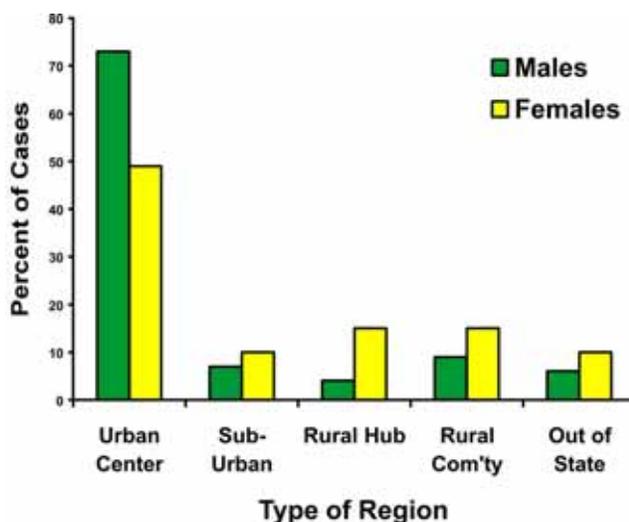
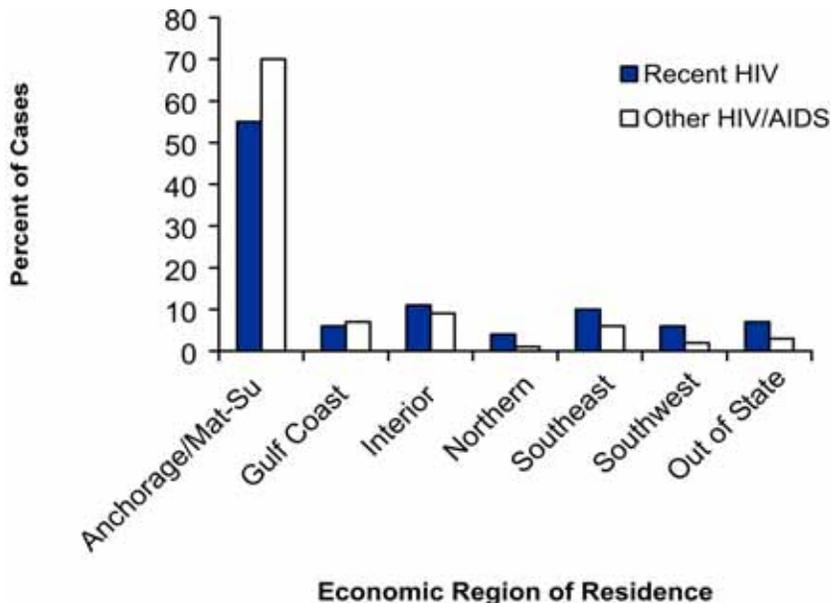


Table 38. Economic Region of Residence at First Known HIV Diagnosis, Recent (HIV, non-AIDS) Cases and All Other HIV/AIDS Cases, Onset through 12/31/02, Alaska (N=892)

Economic Region	Recent Number (Column %)	All Other Number (Column %)	Total Number (Column %)
Anchorage/Mat-Su	59 (55%)	547 (70%)	606 (68%)
Gulf Coast	6 (6%)	55 (7%)	61 (7%)
Southeast	12 (11%)	70 (9%)	82 (9%)
Southwest	4 (4%)	9 (1%)	13 (1%)
Northern	11 (10%)	50 (6%)	61 (7%)
Interior	7 (6%)	16 (2%)	23 (3%)
Out of State	8 (7%)	27 (3%)	35 (4%)
Unknown	1 (1%)	10 (1%)	11 (1%)
Total	108 (100%)	784 (100%)	892 (100%)

Figure 20. Economic Region of Residence at First Known HIV Diagnosis, Recent (HIV, non-AIDS) Cases and All Other HIV/AIDS Cases, Onset through 12/31/02, Alaska (N= 892; 108 Recent and 784 All Other) (residence unknown for 1 recent and 10 other cases)

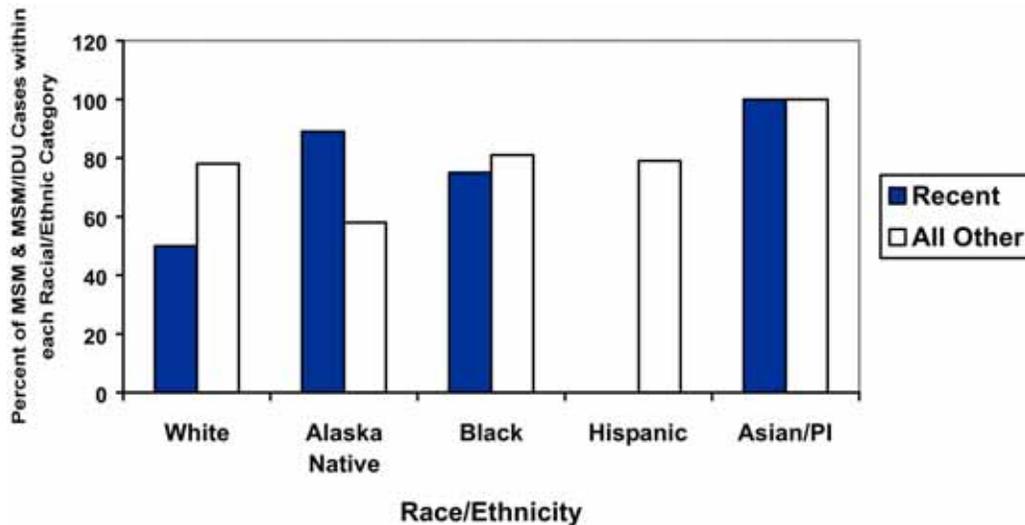


The majority (62%) of all recent HIV (non-AIDS) cases in persons whose exposure category is identified as MSM or MSM/IDU are in men whose residence was Anchorage/Mat-Su at the time of first known HIV diagnosis (Table 39). This proportion is smaller than the proportion of such men (75%) presumably infected earlier in the epidemic. The proportion of MSM and MSM/IDU cases whose residence was Anchorage/Mat-Su at the time of first known HIV diagnosis varies by race/ethnicity, as well as in recent as compared to all other HIV/AIDS cases, as shown below. Half of recent HIV (non-AIDS) cases in White males and considerably more than half of recent cases in Alaska Native/American Indian, Black, and Asian MSM and MSM/IDU are among men who resided in Anchorage/Mat-Su at time of first HIV diagnosis.

Table 39. Among Males with Exposure Categories of Male-Male Sex or Male-Male Sex/Injection Drug Use, Proportions of Recent (HIV, non-AIDS) and All Other HIV/AIDS Cases within each Racial/Ethnic Category with Residence in Anchorage/Mat-Su at First HIV Diagnosis, Alaska (N=477)

Race/Ethnicity	Recent HIV Cases in MSM & MSM/IDU	All Other HIV/AIDS Cases in MSM & MSM/IDU	All Cumulative Cases in MSM & MSM/IDU
White	50% (9 of 18 cases)	78% (243 of 310 cases)	77% (252 of 328 cases)
Alaska Native/ American Indian	89% (8 of 9 cases)	58% (41 of 71 cases)	61% (49 of 80 cases)
Black	75% (3 of 4 cases)	81% (22 of 27 cases)	81% (25 of 31 cases)
Hispanic Ethnicity	0% (0 of 2 cases)	79% (23 of 29 cases)	74% (23 of 31 cases)
Asian/Pacific Islander	100% (1 of 1 case)	100% (3 of 3 cases)	100% (4 of 4 cases)
Unknown Race/Ethnicity	0% (0 of 0 cases)	67% (2 of 3 cases)	67% (2 of 3 cases)
Total	62% (21 of 34 cases)	75% (334 of 443 cases)	74% (355 of 477 cases)

Figure 21. Among Males with Exposure Categories of Male-Male Sex or Male-Male Sex/ Injection Drug Use, Proportions of Recent (HIV, non-AIDS) and All Other HIV/AIDS Cases within each Racial/Ethnic Category with Residence in Anchorage/Mat-Su at First HIV Diagnosis, Alaska (N=477; 34 Recent and 433 All Other)



Partner Notification Activities

Partner notification is a voluntary service conducted in cooperation with the HIV infected person to confidentially advise his/her sexual and injecting partners of their exposure to HIV and offer them testing, prevention counseling, and referrals for other services. Multiple interactions over a period of time may be involved, depending on the circumstances. In Alaska, partner services are generally conducted by specialized public health personnel. Persons with risk behavior and HIV exposure are those at greatest risk of infection. Partner notification reaches these individuals more reliably than any other approach and facilitates provision of focused, individualized services to them.

In 2002, 39 cases were assigned to public health personnel for partner notification services. At the time of this summary, 37 cases had been contacted, with the following results:

- 24 cases named 57 partners
- 7 cases named no partners
- 5 cases refused to participate
- 1 case was pending

Of the 57 partners named:

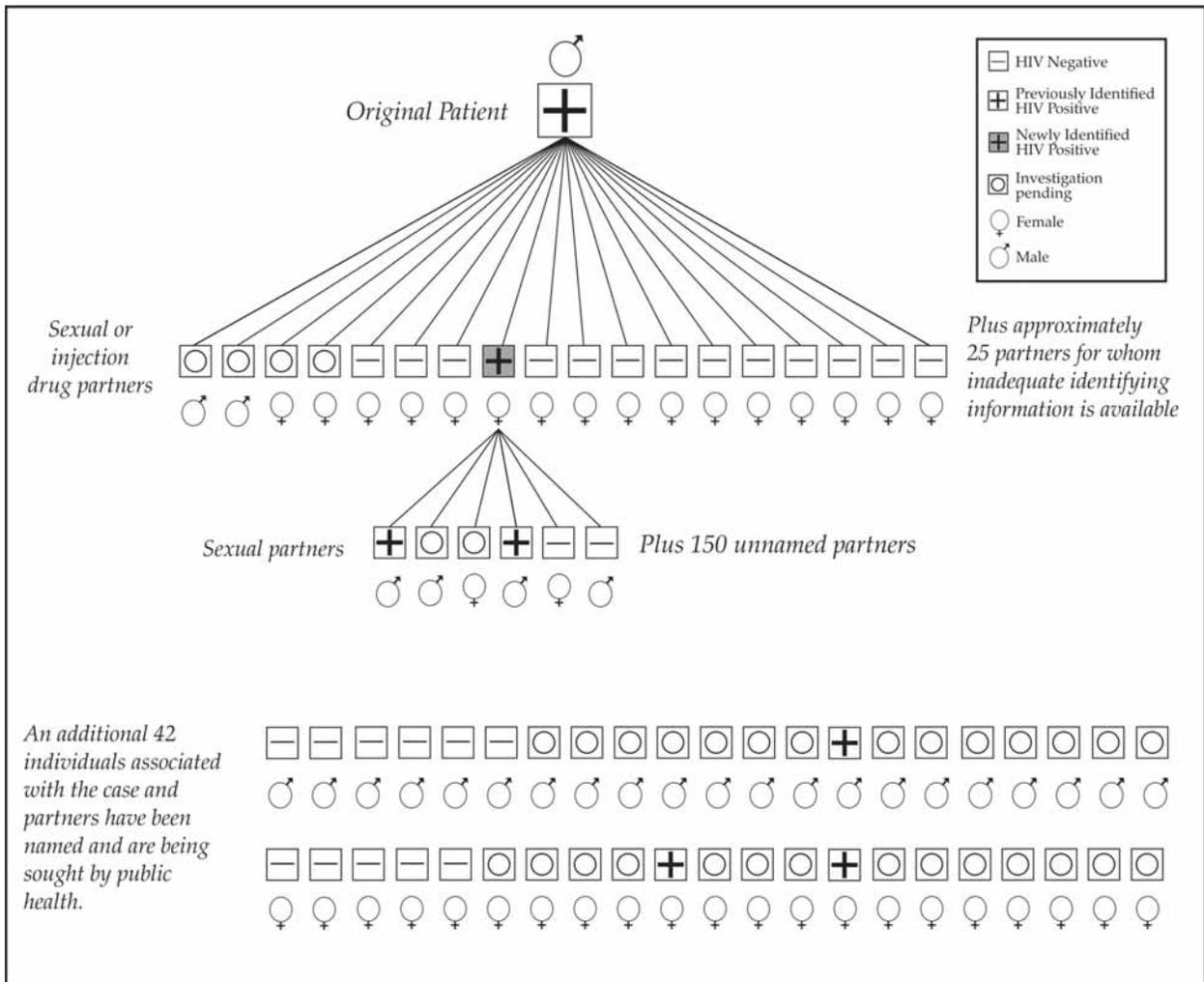
- 11 were HIV positive and were aware of their HIV status
- 38 were notified of their exposure, and 35 of these partners were tested
- 2 partners were newly found to be HIV positive

Some partner notification and disease intervention activities are relatively uncomplicated but many others are not. As an example, State HIV/STD Program staff were conducting an extensive public health investigation of an HIV case with many sexual and injection drug partners (Figure 22) at the time this document was published. Risk factors in this investigation included crack cocaine and injection drug use, unprotected sex, pregnancy, multiple partners and group sexual

activity, predilection for anal sex, and incarceration. Specialized public health activities conducted included interviewing cases and partners (more than 60 interviews); many hours of partner evaluation, education, risk reduction counseling, and referral for medical care; identification of source (prior infection) and new HIV infection in partners; ensuring evaluation for HIV infection of six female partners who were pregnant at the time of this investigation, and ensuring evaluation/follow up for their infants after birth.

This investigation illustrates some of the reasons such an investigation could not be accomplished by a non-public-health provider. Public health staff are able to access locating and medical records, contact many providers, ensure appropriate medical referrals, network with other State agencies, and interview individuals under statutory authority. Public health staff are able to prioritize the necessary activities and devote the time they demand. Other health care providers or outside agencies would not be able to do all of these things.

Figure 22. A Case Investigation and Associated Partner Notification Activities, in Progress, Alaska, 2003



Voluntary HIV Testing in HIV Counseling and Testing Sites

Twenty-one sites in urban and hub cities around the state are considered HIV Counseling and Testing Sites (CTS). These sites are State-funded or funded with federal HIV prevention funds through the HIV/STD Program, and use the State Virology Laboratory to process their HIV tests. Data are gathered from these sites on characteristics of persons tested as well as on pre- and post-test counseling activities. (HIV testing is also available at a number of other sites around the state, including in all correctional institutions.)

Over the five-year period from 1998-2002, the number of individuals tested per year at CTS has increased nearly 9% (from 5,467 in 1998 to 5,935 in 2002), while the number of individuals tested in all other sites using the State Virology Lab has decreased by 8% (to 11,493 individuals in 2002). CTS also accounted for an increasing proportion of the number of persons testing HIV positive at the end as compared to the beginning of this five-year period (from 13 positive individuals in 1998 or 59% of all individuals testing positive through the State Lab, to 10 positive individuals in 2002 or 83% of all individuals testing positive through the State Lab). Individuals of all races/ethnicities are represented among the individuals using the CTS (and those testing HIV positive).

Table 40. Individuals Receiving HIV Testing through the State Virology Laboratory, HIV Counseling and Testing (CTS) and Other Sites by Year, 1998-2002, Alaska (N=60,481)

Year	Individuals Tested at Counseling & Testing Sites (CTS) (No., % HIV Positive)	Individuals Tested at Other Sites Using State Lab (No., % HIV Positive)	Total Individuals Tested through State Lab (No., % HIV Positive)
1998	5,467 (13+, 0.2%)	7,077 (9+, 0.1%)	12,544 (22+, 0.2%)
1999	5,445 (14+, 0.3%)	6,918 (10+, 0.1%)	12,363 (24+, 0.2%)
2000	5,385 (10+, 0.2%)	6,811 (14+, 0.2%)	12,196 (24+, 0.2%)
2001	5,758 (13+, 0.2%)	6,127 (3+, <0.1%)	11,885 (16+, 0.1%)
2002	5,935 (10+, 0.2%)	5,558 (2+, <0.1%)	11,493 (12+, 0.1%)
Total	27,990 (60+, 0.2%)	32,491 (38+, 0.1%)	60,481 (98+, 0.2%)

If the 10 individuals testing HIV positive at CTS in 2002 were all diagnosed for the first time through these interactions (this may or may not be the case), then individuals diagnosed at CTS would comprise 48% of the 21 individuals reported as first diagnosed with HIV in 2002 (see also Table 23).

Individuals testing at CTS are interviewed for their HIV-related risks in order to guide HIV prevention counseling. Individuals' willingness to voluntarily disclose risks, as well as interviewer skills, affect data validity, and the resulting data are best considered indicators. The four most significant HIV risk categories identified through these interactions are male-male sex (MSM), injection drug use (IDU), and heterosexual contact with a partner (1) at increased risk or (2) with no known risk. Over the five-year period from 1998 to 2002, those stating their risk as MSM consistently had the greatest proportion testing HIV positive, and this risk category was the only one to show a trend, declining from 3% positive in 1998 to 1% positive in 2002.

Table 41. Cumulative Proportion of Individuals Testing HIV Positive in CTS by Selected Risk Category, 1998-2002

Risk Category	Number of Individuals Tested	Individuals with This Risk Testing HIV Positive Number (%)
Male-Male Sex	1,424	28 (2.0%)
Heterosexual Partner, Increased Risk	681	5 (0.7%)
Injection Drug Use	869	2 (0.2%)
Heterosexual Partner, No Known Risk	18,866	17 (0.1%)

CTS staff documented post-test counseling for 60.5% of persons tested at their sites in 2002 as compared to 55.4% in 2001. All (100%) persons with HIV positive test results in CTS received their test results and post-test counseling.

HIV Testing During Prenatal Care

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. The first question on counseling was dropped from the survey after 1999.

In 1996, 8,198 Alaska-resident women with live births were represented by the PRAMS, 9,820 in 1997, 9,793 in 1998, 9,819 in 1999, and 9,766 in 2000. Survey results through 2000 (the most recent available PRAMS data) for the HIV-related questions follow in Tables 42 and 43.

Table 42. Percent of Women Giving Birth to Live Infants Whose Prenatal Health Care Providers Counseled Them About HIV Prevention, Alaska

Response	2000	1999	1998	1997	1996
Yes	(question not asked)	46.8%	46.7%	42.9%	43.9%
No		49.7%	50.3%	54.0%	52.4%
Skipped (no prenatal care)		0.9%	0.8%	1.7%	1.4%
No response		2.6%	2.2%	1.3%	2.3%

Table 43. Percent of Women Giving Birth to Live Infants Whose Prenatal Health Care Providers Discussed HIV Testing With Them, Alaska

Response	2000	1999	1998	1997	1996
Yes	80.9%	76.1%	73.7%	74.5%	76.6%
No	16.8%	19.9%	23.6%	22.3%	20.0%
Skipped (no prenatal care)	0.6%	0.9%	0.8%	1.7%	1.4%
No response	1.8%	3.1%	1.9%	1.5%	2.0%

Alaska currently has a low incidence of perinatal HIV transmission. The number of HIV-infected women of childbearing age is small but is increasing. PRAMS data show a relatively large and growing proportion of women giving birth report discussion of (and likely testing for) HIV during pregnancy.

HIV Care Service Utilization

The State of Alaska receives federal funding under Title II of the Ryan White CARE Act to support HIV care services for persons with HIV and their families. (Other in-state organizations including the Alaska Native Tribal Health Consortium, Anchorage Neighborhood Health Center, and the Yukon-Kuskokwim Health Corporation also receive federal funding under different titles of the CARE Act.) Funds to the State are allocated through regional consortia, predominantly to purchase case management to facilitate individuals' access to existing medical and social services and to meet needs for "gap" services. Funds are also allocated for the statewide AIDS Drug Assistance Program (ADAP) that purchases HIV-related medications or individual health insurance to cover such medications.

In 2002, a total of 362 HIV positive individuals received one or more services provided or purchased with CARE Act funds by one of the two State grantee organizations. These organizations have offices in Anchorage, Fairbanks, and Juneau and also serve individuals in other areas of the state. Of these 362 individuals, 43 (12%) were new clients to the service organization during 2002. Males constituted 76% (274 individuals), females 24% (87 individuals), and transgender persons 1% (1 individual) of the client population. Sixty-one individuals participated in the AIDS Drug Assistance Program.

Characteristics of individuals served with CARE Act services may be contrasted with characteristics of those presumed living to estimate service reach. Table 44 indicates the characteristics of both populations are very similar. Attempting to draw any broader conclusions from these data about individuals with HIV diagnoses who are not in primary medical care may be unproductive. Caveats about the data on persons reported in Alaska with HIV and who are not known to have died are discussed earlier in this document. Individuals using CARE Act services may opt out of medical care, regardless of how they are counseled. Additionally, HIV positive persons with access to insurance and other financial resources may be receiving care but not accessing CARE Act services, which serve predominantly low income persons.

Data in Table 44 below are for Title II CARE Act services only (those funded through the State HIV/STD Program). The two sets of race/ethnicity data are not fully comparable because Hispanic ethnicity is treated as an exclusive race category for presumed living cases while for CARE Act clients, persons are classified in one of the four race categories and also as to whether or not they are of Hispanic ethnicity.

Table 44. Demographic Characteristics of HIV/AIDS Cases Presumed Living through 12/31/02 and Title II CARE Act Clients in 2002, Alaska

Characteristic	HIV/AIDS Cases Presumed Living through 12/31/02 (N=570)	Clients of Title II CARE Act Services in 2002 (N=362)
Gender		
Male	78%	76%
Female	22%	24%
Transgender	--	<1%
Race/Ethnicity		
White	57%	70%
Alaska Native/Am. Indian	20%	22%
Black	10%	7%
Asian/Pacific Islander	2%	1%
Hispanic Ethnicity*	8%*	[10%]*
Age Range (age in 2002)		
0-12 years	<1%	0%
13-24 years	3%	2%
25-44 years	64%	68%
45+ years	33%	31%

*CARE Act clients of Hispanic ethnicity are included in the four race categories listed, unlike HIV/AIDS cases presumed living where Hispanic ethnicity is treated as if it were a (fifth) race category

Prevalence of HIV Infection in Specific Populations

Civilian Applicants for Military Service. All civilian applicants for military service are screened for HIV infection. This includes individuals applying for active duty or reserve military service (including the National Guard), the service academies, and the Reserve Officers Training Corps (ROTC). From October 1985 through December 2001, 21,974 (17,985 male and 3,989 female) individual applicants for military service in Alaska were tested. Of these, 3 (0.01%) had test results showing HIV infection. All three were males, including one aged 20-24 years and two 30 years or older, with one White, one Black, and one of unspecified race.

Job Corps. 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. More recent data are not available from CDC.

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). This survey was discontinued in 1997.

Indicators of Risk

Sexually Transmitted Diseases (STD). Infection with a sexually transmitted disease indicates sexual risk behavior. Three STD with potentially serious health effects and effective treatments are reportable in Alaska: syphilis, gonorrhea and chlamydia. Alaska data do not show a high degree of overlap at this time between populations reported with gonorrhea, chlamydia, or syphilis infections and populations with HIV infection.

All STD case reports are reviewed by Division of Public Health personnel to assure appropriate treatment. When feasible, individuals reported with STD in Alaska are interviewed, asked to name their sexual partners, and asked for locating information. (As case numbers have continued to increase, prioritization of follow-up activities has been necessary.) Partners are located, if possible, notified of their exposure, and offered testing and treatment. If a partner is found to be infected with STD, he/she is then considered a case and interviewed for sexual partners, and the chain of partner identification, notification, testing, and treatment continues. This intensive follow-up leads to identification and treatment of infected individuals more effectively than any other case-finding activity.

Syphilis. Syphilis is caused by infection with the spirochete, *Treponema pallidum*. The disease, especially in its infectious stages, is relatively rare in Alaska. In 2001, 10 syphilis cases were reported in Alaska and 9 cases were reported in 2002. None of these cases was primary or secondary (infectious) syphilis.

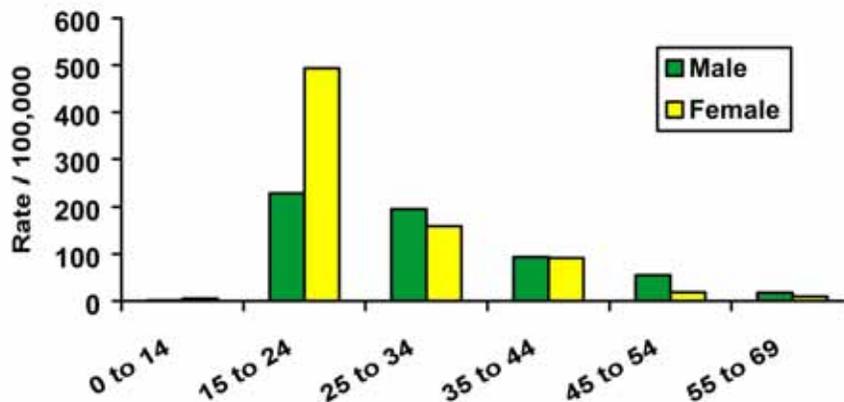
Gonorrhea. Gonorrhea infection is caused by the bacterium, *Neisseria gonorrhoeae*. Although gonorrhea rates in Alaska have declined dramatically since the late 1970s, the 642 cases reported in 2002 constituted a 41% increase over the 455 cases reported in 2001 and marked the third year of an upward trend (Table 45). Reported cases in males increased 36% (from 213 in 2001 to 289 in 2002) and cases in females increased 46% (from 242 in 2001 to 353 in 2002). There were 14 cases of gonorrhea pelvic inflammatory disease (PID). Female case rates remained higher than male case rates in most age categories (Figure 14). Approximately 36% of reported gonorrhea cases reported in 2002 also were infected with chlamydia and most were treated for both infections. The increase in gonorrhea cases from 2000 to 2002 is likely attributable to rising disease incidence, primarily in Anchorage, providers' increased and targeted STD screening in adolescents and young adults, and expanded partner notification activities throughout the state.

Table 45. Gonorrhea Cases, Alaska, 1993-2002

Year	Reported Cases	Case Rate* (per 100,000)
2002	642	100
2001	455	72
2000	357	57
1999	302	49
1998	331	53
1997	383	63
1996	466	76
1995	660	107
1994	920	152
1993	676	113

*Annual population estimates by the Alaska Department of Labor and Workforce Development.

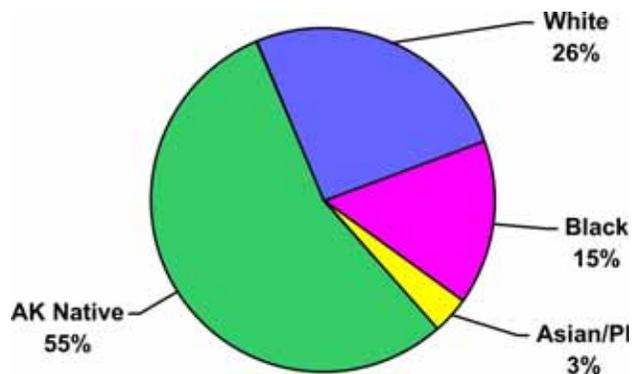
Figure 23. Gonorrhea Rates by Age Group and Gender, 2002 (N=642)



In January 2002, the State Public Health Laboratory implemented a test that detects both gonorrhea and chlamydia infections, has increased sensitivity over earlier methods, and raises the acceptability of testing, especially to male clients, because it can be performed on a urine specimen as well as a cervical or urethral swab. Providers' increased use of this test for routine chlamydia screening had the indirect benefit of increasing gonorrhea detection in young at-risk individuals.

Gonorrhea was reported among persons of every race. Case rates were highest in Black males (634/100,000) and Alaska Native females (465/100,000). Alaska Natives comprised 55% of gonorrhea cases and 17% of the population, and Blacks comprised 15% of gonorrhea cases and 4% of the population. This is consistent with the data in previous years.

Figure 24. Gonorrhea in Alaska, 2002, by Race (N=642)



Gonococcal Isolate Surveillance Project (GISP). Alaska is one of a number of sentinel surveillance sites around the country in a national project to monitor resistance trends in the organism that causes gonorrhea. In addition to testing laboratory specimens (urethral cultures from symptomatic males in Anchorage), the Alaska GISP collects data on demographics and sexual orientation of males whose specimens are included. In 2001, 3 (6%) of 54 participating males with gonorrhea self-identified as homosexual.

Partner Notification. In 2002, 246 people with gonorrhea infection were interviewed by a Public Health Disease Intervention Specialist (DIS) or nurse from the HIV/STD Program, the Municipality of Anchorage, Southcentral Foundation, and Fairbanks, Mat-Su, and Bethel Public Health Nursing Centers. These cases named 345 sexual partners, often multiple times or reciprocally. Of these partners, 68 (20%) were already treated, 200 (58%) were found and notified of their exposure, and 77 (22%) could not be followed up. Treatment was provided to 181 (90%) of those contacted, which is 72% of all partners named. Of 169 partners tested in these settings, 58 (34%) tested positive for gonorrhea. (Cases and partners interviewed in other settings are not represented in these numbers.)

Co-infection with HIV and Gonorrhea. All cases of gonorrhea (9,626) reported in Alaska from January 1, 1988 through December 31, 2001 were matched against all cases of HIV infection ever reported in Alaska (840 cases reported through June 2002). Forty-two (42) individuals reported with gonorrhea were ever reported with HIV. Of these 42 persons:

- 23 had gonorrhea only prior to HIV diagnosis;
- 15 had gonorrhea only after HIV diagnosis;
- 3 had gonorrhea before and after HIV diagnosis; and
- 1 had an unknown HIV diagnosis date.

Fewer than 1% of persons ever reported with gonorrhea during this period were reported with HIV, indicating that gonorrhea is not necessarily a good predictor of HIV in Alaska. Five percent of persons reported with HIV had ever been reported with gonorrhea.

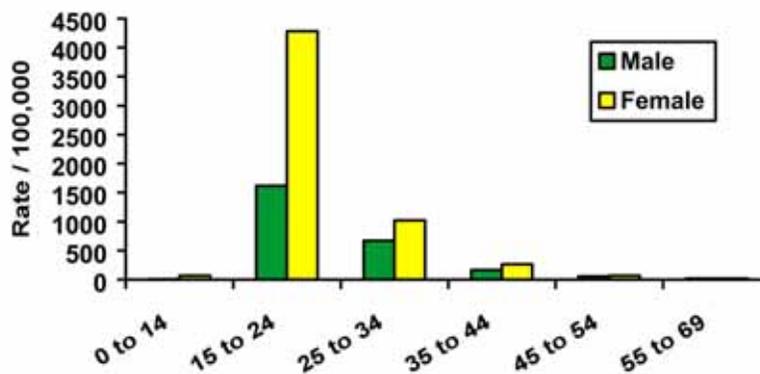
Chlamydia. In 2001 and 2002, Alaska reported the highest case rates of urogenital *Chlamydia trachomatis* infection in the United States. A total of 3,805 cases of chlamydia infection were reported in Alaska in 2002, a 40% increase from cases in 2001 (Table 46). The annual number of

reported cases in females increased 31% (from 1,968 in 2001 to 2,576 in 2002) and cases in males increased 63% (from 753 in 2001 to 1,229 in 2002). Chlamydia rates were higher for females than males (Figure 16), reflecting a much higher incidence of screening and testing in females than males. There were 48 reported cases of chlamydia pelvic inflammatory disease (PID). Peak infection rates occurred at ages 15 to 24 years for both genders. Approximately 5% of chlamydia cases reported in 2002 were simultaneously reported with gonorrhea. The increase in chlamydia case reports reflects broader use of noninvasive screening technology and adherence to national screening recommendations, intensified case finding through partner notification activities statewide, and a high rate of disease incidence.

Table 46. Chlamydia in Alaska, 1996-2002

Year	Reported Cases	Case Rate* (per 100,000)
2002	3805	591
2001	2721	429
2000	2549	406
1999	1888	304
1998	1906	307
1997	1601	262
1996	1358	221

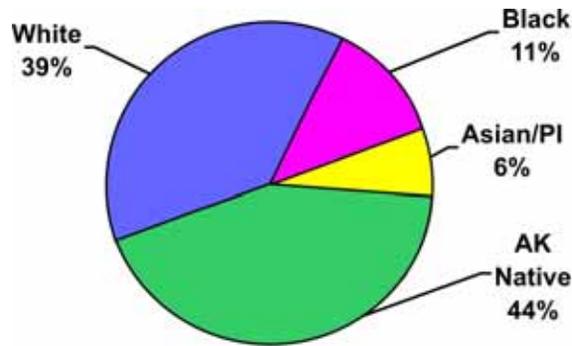
Figure 25. Chlamydia Rates by Age Group and Gender, 2002 (N=3,805)



As discussed in the section above on gonorrhea, in January 2002, the State Public Health Laboratory implemented a dual chlamydia/gonorrhea test that can be conducted on cervical swabs, urethral swabs, or urine. The use of urine specimens has increased males' acceptance of testing and facilitated screening for women who are not undergoing a pelvic exam.

While chlamydia can infect anyone, case rates were highest among Alaska Native females (2,527/100,000) and Black males (1,961/100,000). Partly this represents detection bias: minority populations are more likely to seek care through publicly funded institutions, and these sites are very compliant with screening and testing recommendations. Alaska Natives comprised 17% of Alaska's population and 44% of reported chlamydia cases, and Blacks comprised 4% of the State's population and 11% of reported cases. This pattern is consistent with previous years.

Figure 26. Chlamydia Cases by Race, 2002, Alaska (N=3,805)



Partner Notification Activities. In 2002, 1,599 people with chlamydia infection were interviewed by a Public Health Disease Intervention Specialist (DIS) or nurse from the HIV/STD Program, the Municipality of Anchorage, Southcentral Foundation, or Fairbanks, Mat-Su, or Bethel Public Health Nursing Centers. These cases named 2,461 sexual partners, often multiple times or reciprocally. Of these partners, 505 (21%) had already been treated, 1,422 (58%) were found and notified of their exposure to chlamydia, and 534 (22%) could not be followed up. Treatment was provided for 1,350 (95%) of those contacted, which is 75% of all partners named. Of, 1,219 partners tested, 525 (43%) tested positive for chlamydia. (Cases and partners interviewed in other settings are not represented in these numbers.)

Co-infection with HIV and Chlamydia. Cases of HIV and chlamydia were cross-matched in 2000, and results are presented below. Because the number of chlamydia cases is large (nearly 4,000 cases in 2002) and the overlap between the HIV and chlamydia was found to be quite small in the 2000 cross-match, a similar match has not subsequently been conducted.

All cases of chlamydia (6,726) reported in Alaska from January 1, 1989 through December 31, 1999 were matched against all cases of HIV infection ever reported in Alaska through December 31, 1999 (717). Four individuals ever reported with HIV were reported with five cases of chlamydia. None of these individuals was reported with chlamydia after the reported date of HIV onset.

Tuberculosis. In Alaska, tuberculosis (TB) occurs predominantly among Alaska Native and Asian/Pacific Island populations and is equally distributed between males and females. State TB Control Program staff determine whether HIV testing has been offered and document HIV test results for confirmed TB cases aged 25-44 years. The TB Control Program documented that HIV testing was offered to 7 of 9 (80%) active TB cases aged 25-44 years in 2002.

Co-infection with HIV and TB. HIV/AIDS and TB case records are matched periodically to identify shared cases. HIV infection in persons with tuberculosis continues to be uncommon in Alaska. Of the 734 cases of TB reported from 1993 through 2002, 10 (1.4%) were also infected with HIV.

Hepatitis C Virus Infection. Hepatitis C infection, particularly in recent years, is often related to sharing equipment and/or drugs for injection, which is also a risk behavior for HIV infection.

From 1996, when hepatitis C virus (HCV) infection first became a condition reportable to the Section of Epidemiology, through December 2002, a cumulative total of approximately 5,500 HCV cases were reported. The majority of reported cases were between the ages of 40-49 years of age at the time of first report. Slightly more than 50% of females were less than 40 years old at time of report, as compared to 30% of males. Males comprised the majority of cases. Although race was not specified for over 60% of cases, Alaska Natives comprised the largest identified race group with 23% of cases. Of cases for which residence was known, most resided in Anchorage or the Matanuska-Susitna Borough.

Co-infection with HIV and hepatitis C. A cross match conducted early in 2001 found that, through December 31, 2000, 74 individuals were reported with both HIV and hepatitis C: 74 (9%) of 781 HIV cases were also reported with HCV; and 74 (2%) of 3,889 HCV cases were reported with HIV. A similar match has not been conducted since this time but will be done in the future.

Substance Use and Abuse. The National Household Survey on Drug Abuse (NHSDA) is conducted annually by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The survey is administered to a probability sample of the U.S. civilian population and a computer-assisted interview asks persons aged 12 years and older about their use of illicit drugs, alcohol, and other substances. From these data, SAMHSA develops statistical estimates of national and state substance abuse levels. The survey population is limited to persons living in households, noninstitutional group quarters (such as shelters, rooming houses, and dormitories), and civilians living on military bases, and excludes homeless persons not living in shelters, active duty military, and residents of institutional group quarters such as jails and hospitals.

Survey data indicate that a large proportion of Alaskans uses alcohol, a smaller proportion uses marijuana, and a much smaller proportion uses other illicit substances. The proportion of the population reporting substance use constituting dependence or abuse is even smaller, although higher than in the U.S. as a whole. Substance use data reported below are annual averages based on the 1999 and 2000 surveys. The data reported below on dependence and abuse are from the 2000 NHSDA survey.

An estimated 8.8% of the Alaska population over 12 years of age used any illicit drug during the past month (as compared to 6.3% of the U.S. population), ranking Alaska in the group of states with highest estimated usage. This group also included California, Colorado, Delaware, Hawaii, Massachusetts, Oregon, Rhode Island, Vermont, and Washington. The estimated proportion of Alaskans using any illicit drug other than marijuana in the past month was 3.2% (as compared to 2.7% in the U.S.), with the highest proportion of Alaska users aged 18-25 years. The proportion of Alaskans estimated to have used cocaine in the past year was 2.2% (compared to 1.6% for the U.S.)

The proportion of Alaskans reporting alcohol use in the past month was 52.9% (compared to 46.3% in the U.S.), with 21.5% reporting binge alcohol use in the past month (compared to 20.4% for the U.S.). Seven percent of Alaskans reported alcohol dependence or abuse in the past year (compared to 5.5% of the U.S. population). Compared to the U.S. at 2.0%, 2.6% of Alaskans reported any illicit drug dependence or abuse in the past year (highest in those aged 18-25 years at 7.2%).

Alcohol- and Drug-Induced Mortality. Although they are not single-cause and rankable causes of death, the Alaska Section of Vital Statistics calculates the numbers of alcohol- and drug-induced deaths. Alcohol-induced deaths include deaths due to alcohol psychoses, alcohol dependence syndrome, non-dependent abuse of alcohol, alcohol-induced chronic liver disease and cirrhosis, and alcohol poisoning. They do not include deaths due to traumatic injury, such as motor vehicle crashes. Alaskans experienced 90 alcohol-induced deaths in 1999 (compared to 621 from cancer, 560 from heart disease, and 13 HIV-related deaths in 1999). This figure would have made alcohol-induced death the seventh leading cause of death in Alaska if it were a rankable cause of death (and the fourth leading cause for Alaska Natives). Males were more likely than females to die from alcohol-induced deaths.

Drug-induced mortality includes deaths from dependent and nondependent use of drugs (legal and illicit use) and poisoning from medically prescribed and other drugs. It excludes accidents, homicides, and other causes indirectly related to drug use, as well as deaths in newborns related to the mother's drug use. There were 55 drug-induced deaths in 1999, making it the eighth leading cause of death if it were a rankable cause. The age-adjusted death rate has more than doubled during the past decade. Natives were more likely than whites to die of drug-induced deaths. Females were more likely than males to die of a drug-induced cause in 1999, but this has not been a consistent trend in the past decade.

Substance Abuse Treatment. From 7/1/01 – 6/30/02, 4,537 individuals were substance abuse treatment clients of the Alaska Division of Alcoholism and Drug Abuse or ADA. Approximately 16% of these individuals were ADA clients more than once during this period. The 2001-2002 figure represents a 17% decrease from the 5,460 unduplicated ADA clients treated during the period from 7/1/00 – 6/30/01. Of the 2001-2002 clients, 26% were in detox, 3% in inpatient settings, 20% in residential settings, and 44% in outpatient treatment settings. Eight percent of clients were in correctional settings.

Sixty-one percent of ADA treatment clients were aged 21-44 years, with most (53%) aged 25-44 years. Eighteen percent were younger than 18 years. Males made up 62% of unduplicated clients. Four percent of females whose status was known were pregnant. Client racial/ethnic distribution was:

White	46%
Alaska Native	46%
Black	3%
Hispanic	3%
Asian/Pacific Is.	1%
Other/Unknown	1%

Fewer than 10% of clients (359) in ADA treatment in 2001-2002 identified heroin or other opiates, cocaine/crack, or methamphetamines as their primary substance problem. Of clients identifying a problem on admission (4,303), primary problems were:

Alcohol	74%
Marijuana/hashish	44%
Cocaine/crack	5%
Heroin	<1%

Other opiates	2%
Methamphetamines	1%
Polydrugs	1%

Those identifying secondary substance problems (2,059 clients) identified the following substances:

Alcohol	22%
Marijuana/hashish	47%
Cocaine/crack	17%
Heroin	1%
Other opiates	3%
Methamphetamines	1%
Polydrugs	1%

Unique clients in treatment were geographically distributed as follows:

Southeast	22%
Southcentral	36%
Kenai Peninsula	16%
Northwest	5%
Bristol Bay/Aleutians	2%
Yukon Delta	4%
Central	14%
North Central	1%
North Slope	<1%

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 statewide BRFSS included a Sexual Behavior Module to gain additional information about sexual activity and perception of risk for HIV.

Over time, the questions included on the BRFSS have changed. Some questions have been deleted from the survey and new questions have been added. Data provided cover different periods of time for different questions, and the applicable periods are noted in each case. The following sections summarize results of selected questions from the 1994 to 2002 Alaska BRFSS.

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. Data from the 1999 and 2000 BRFSS are shown in Table 47.

Table 47. Support for AIDS Education in the Schools, 1999 and 2000, Alaska

Survey Response	1999	2000
Begin in Elementary School	69%	73%
Begin in Kindergarten	8%	6%
Opposed	3%	2%

Condom Effectiveness. The number of Alaskans who thought that a properly used condom is “very effective” for preventing HIV infection increased annually: 29% in 1994, 36% in 1995, and 47% in 1997 (not asked on the BRFSS in 1998 and after). In 1996, a higher percent of Alaskans thought condoms are “very effective” for preventing HIV compared to the nation (Alaska 39%, nationwide 38%). The number of Alaskans who thought that a properly used condom was “not at all effective” decreased each year.

Consistent with national opinion, the majority of Alaskans would encourage a sexually active teenager to use condoms. In 2000 (as in 1998 and 1999), 90% of Alaskans said they would encourage condom use; nationwide in 2000, 89% would endorse condom use for sexually active teenagers. Endorsement for condom use for sexually active teenagers was slightly higher in Alaska in 1995 (91%).

HIV Testing Experience. The percentage of Alaskans who reported that they had ever had an HIV test (excluding for blood donation):

- increased from 40% in 1993 to 53% in 2002;
- was consistently higher than the national median (33% in 2001 nationally, the most recent available year); and
- was higher in 2002 for females (58%) than males (50%) in Alaska;
- was higher in females aged 18-44 years than females of other ages, and higher in males aged 25-44 years than in males of other ages.

In 2002, a higher percentage of Alaskans who self-identified as Black, or Hispanic, reported having ever been tested for HIV than did Whites or persons of other races/ethnicities. Those reporting ever having been tested for HIV were:

- 78% of Blacks;
- 53% of Whites;
- 53% of Alaska Natives/American Indians;
- 24% of Asians;
- 52% of Native Hawaiians or Other Pacific Islanders; and
- 69% Other races.

Of those included in the races above, 69% of Hispanic ethnicity reported having ever been tested for HIV.

Nationally, also (based on 2001 data), a higher percentage of Blacks (56%) and Hispanics (46%) reported ever having been tested than Whites (38%). (Alaska HIV testing data confirm that higher percentages of the state’s population of Alaska Natives and African-Americans have been tested for HIV as compared to Whites.)

In 2002, individuals most often reported their reasons for testing as:

- it was required (18%);
- they wanted to find out (24%); or

it was part of a routine exam (26%).

For females only, pregnancy was a commonly cited reason for testing, as well (28%).

Most frequently cited sites for testing were:

private doctor or HMO (33%);
hospital (27%); or
clinic (28%).

Importance of knowing HIV status. In 2002, the BRFSS asked how important it was for people to know their HIV status by getting tested. Eighty-eight percent (88%) of Alaskans thought it was “very important.” Females (91%), especially those aged 18-44, were more likely than males (85%) to think this. A higher proportion of Alaska Natives/American Indians (92%), Asians (96%), and Native Hawaiians/Pacific Islanders (98%) and those of Hispanic ethnicity (91%) believed it was “very important” than did Whites (87%) or Blacks (79%).

Knowledge about treatment for HIV. In 2002, 71% of Alaskans (83% of females and 77% of males) believed that a pregnant woman with HIV could get treatment to help reduce the chances that she would pass the virus on to her baby.

Also in 2002, 96% of Alaskans (96% of males and 97% of females) believed there were medical treatments available that were intended to help a person who was infected with HIV to live longer.

Talked with a professional about STDs and condom use. In 2002, 52% of Alaskans reported having talked with a health professional within the past 12 months about preventing sexually transmitted diseases through condom use (39% of males and 61% of females).

Risk Perception. The majority of Alaskans did not consider themselves at risk for HIV infection. Between 1995 and 2000, the percentage of Alaskans reporting no chance of getting infected with HIV was between 60 and 67%. In 2000, the percentage of Alaskans with a perception of no risk was 64% compared to the nationwide median of 68%.

In Alaska in 2000, a higher percentage of Blacks (74%) and Alaska Natives (66%) rated their risk of HIV as “none” compared to White (64%), and Hispanic (52%).

Comparing responses from Alaskan men to those from women shows that a higher percentage of women (68%) perceived themselves at no risk for HIV infection than did men (61%). Two percent (2%) of women assessed their risk as high, compared to 1% of men who perceived themselves to be at high risk.

Risk Behavior. The 2002 BRFSS included the following question about risk behaviors. “I’m going to read you a list. When I’m done, please tell me if any of the situations apply to you. You don’t need to tell me which one.

- You have used intravenous drugs in the past year
- You have been treated for a sexually transmitted or venereal disease in the past year
- You have been given or received money or drugs in exchange for sex in the past year
- You had anal sex without a condom in the past year.”

Consistent with low perception of risk (see above), 96% of Alaskans reported in 2002 that none of the list of the HIV-related risk behaviors applied to them. Only 5% said that any of the stated risk situations applied. A risk situation applied to slightly more males (5%) than females (4%). A higher percentage of 18 to 24 year olds (12%) and 25 to 34 year olds (6%) than older respondents (range 1% to 3%) reported that a risk situation applied to themselves. Report of risk behavior declined with education from 13% among persons with 8th grade education or less to 3% among college graduates, and was higher among never married persons (10%) and members of an unmarried couple (9%) than among married persons (3%).

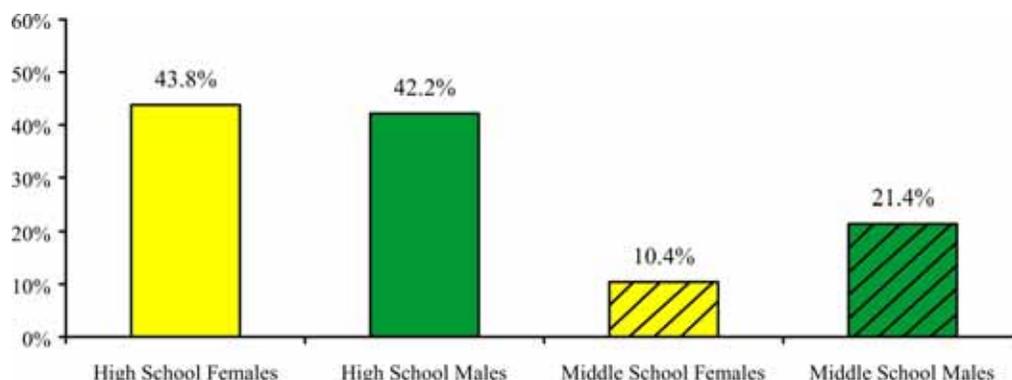
Youth Risk Behavior Survey. The Youth Risk Behavior Survey (YRBS) is part of a national surveillance system implemented in 1988 by the Centers for Disease Control and Prevention (CDC). The YRBS is intended to monitor the prevalence of behaviors that influence adolescent health and also put youth at risk 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.

The YRBS was conducted in Alaska schools in 1997, 1999, 2001, and 2003. In the period between the 1999 and 2001 surveys, the State Legislature passed a law requiring active parental consent for student participation. School districts had insufficient time before the 2001 YRBS to address the greatly increased burden posed by this active parental consent requirement. As a result, the 2001 statewide return rate for school and student participation was only 28%, far below the 60% level required for weighting the data to generalize results to the entire student population. School districts, with help from the Departments of Education and Early Development and Health & Social Services, were able to successfully assist schools in getting necessary consents for the 2003 YRBS, achieving a 62% return rate for school and student participation. Results from the 2003 YRBS will be available late in the Fall of 2003.

Data below are therefore from the 1999 Alaska YRBS. A total of 254 schools in 55 school districts statewide participated in 1999. (The Anchorage School District, the largest in the state, was not one of the participating districts and no Anchorage data are included below.)

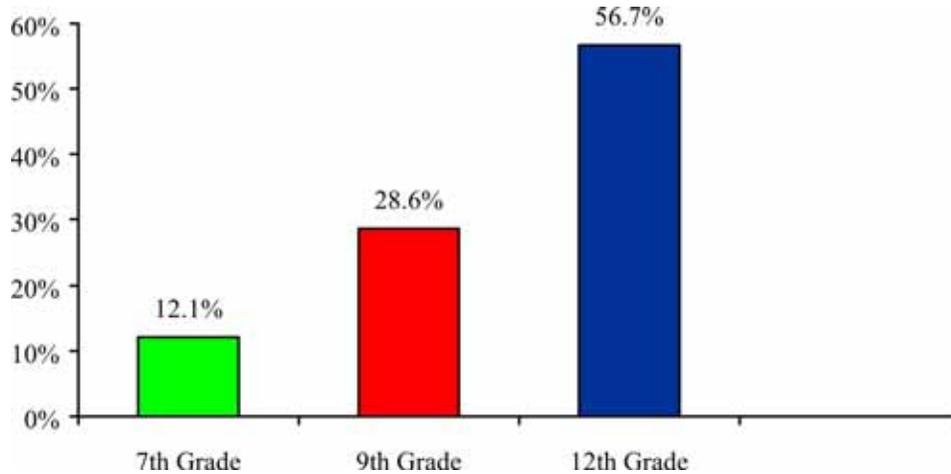
Among high school students, 42.2% of boys and 43.8% of girls report ever having sexual intercourse. Among middle school students (7th and 8th graders), 21.4% of boys and 10.4% of girls report ever having sexual intercourse (Figure 27).

Figure 27. 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 19). These rates are slightly lower than U.S. rates overall.

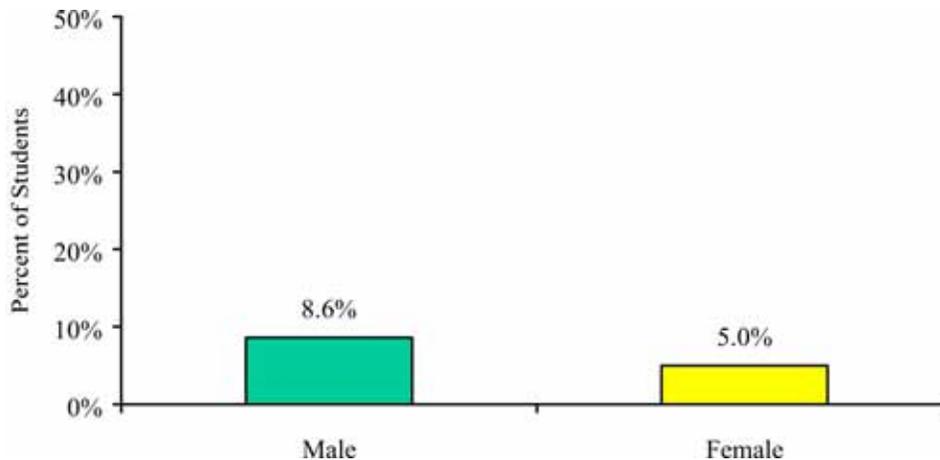
Figure 28. Percentage of high school students who report having sexual intercourse within the past three months.



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

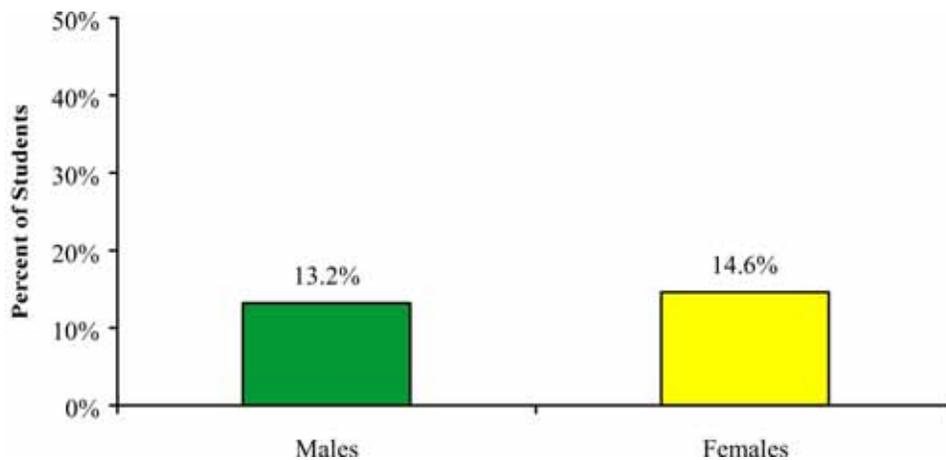
First sexual intercourse prior to age 13 was reported by 8.6% of high school boys and 5.0% of high school girls (Figure 20).

Figure 29. Percentage of high school students who report having sexual 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 21).

Figure 30. 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 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 2001, 1,056 females age 15-19 years gave birth in Alaska, a rate of 42.7 per 1,000 females aged 15-19. Females of all races aged 15-17 years in Alaska had a birth rate of 19.1/1,000, considerably lower than the U.S. rate (27.5/1,000) in 2000 for the same age group. Females aged 18-19 years in Alaska had a birth rate of 84.4/1,000 in 2001, slightly higher than the U.S. rate (79.5/1,000) in 2000 for the same age group. (U.S. data from the 2000 Census as presented in CDC's *National Vital Statistics Reports 2001*; 49(5) are the most recent available national data.)

The 2000 Alaska live birth rate for teens aged 15-19 (49.4 per 1,000) bettered the Healthy Alaskans 2000 goal (50 per 1,000 aged 15-19). The 2000 national birth rate for teens of all races aged 15-19 was 48.7/1000. Data from the CDC indicated that the 22% decline in births from 1991 to 2000 was not due to an increase in abortion, as abortion rates also declined.

Data from the Alaska Section of Vital Statistics on teen births in Alaska from 1998-2001 for the total population and for the two largest racial populations are shown in Table 48.

Table 48. Births to Alaska Teens Aged 15-19, 1998-2001

Year	Age Group	Mother's Race	Number of Births	Rate per 1,000**
1998	15-19	All Races	1,103	48.4
		Native	415	86.0
		White	586	36.8
	15-17	All Races	386	26.4
		Native	163	53.7
		White	180	17.4
	18-19	All Races	717	88.3
		Native	252	141.0
		White	406	72.7
1999	15-19	All Races	1,122	47.8
		Native	433	85.5
		White	551	33.8
	15-17	All Races	395	26.5
		Native	172	54.0
		White	175	16.8
	18-19	All Races	727	85.0
		Native	261	138.8
		White	376	64.1
2000	15-19	All Races	1,163	49.4
		Native	459	N/A*
		White	556	N/A*
	15-17	All Races	381	24.6
		Native	177	N/A*
		White	142	N/A*
	18-19	All Races	782	97.3
		Native	282	N/A*
		White	414	N/A*
2001	15-19	All Races	1,056	42.7
		Native	457	N/A*
		White	473	N/A*
	15-17	All Races	301	19.1
		Native	158	N/A*
		White	110	N/A*
	18-19	All Races	755	84.4
		Native	299	N/A*
		White	363	N/A*

*Rates for 2000 and 2001 are not currently available due to changes in census race categorization

**Rates are calculated using Alaska Department of Labor and Workforce Development population estimates



Chapter 3

Community Services Assessment

Chapter 3: Community Services Assessment

Community Services Assessment (CSA) is both a *process* and a *document*. The CSA *document*, presented in this chapter, is a compilation of data that the HPPG considered over the course of two years in their *process* of assessing the HIV prevention needs and services of the populations most affected by HIV in Alaska. Focusing on the populations most at risk for transmitting or acquiring HIV infection as indicated by data in the Epidemiologic Profile, the CSA describes: (a) the prevention needs of these populations, (b) the prevention activities/interventions implemented to address these needs, and (c) service gaps. Data on **prevention needs** include: (a) information on knowledge, skills, attitudes, behaviors or community norms that indicate whether or not members of the population engage in behaviors contributing to HIV infection; and (b) information on what prevention services are needed or wanted by members of the population. Information on **prevention activities** or **interventions** in place to meet these needs include programs specifically funded for HIV prevention interventions, as well as programs not expressly funded for HIV prevention but that reach these populations with services that contribute to risk reduction, such as substance abuse treatment programs. By comparing needs against the activities and services available to meet those needs and the funding sources of those activities and services, the HPPG determined what **service gaps** would exist in the 2004 to 2006 period if HIV prevention funds were not available for those activities and services.

Community Services Assessment Process

A number of activities were conducted throughout 2001 and 2002 to help the Alaska HPPG gain a greater understanding of the needs of populations at risk for HIV infection and the resources that exist around the state to meet these needs. Based on a needs assessment data plan developed by an HPPG subcommittee in 2000, the HIV/STD Program carried out consumer needs assessments including interviews with gay men in Anchorage and Fairbanks, and focus groups with injection drug users in Anchorage.

Following a multi-year work plan, each of the HPPG meetings between December 2001 and October 2002 focused on needs assessment and resource data specific to one or more of the behavioral risk populations prioritized in the *2001-2003 HIV Prevention Plan*. The HPPG heard from community-based organizations that were funded to conduct prevention interventions and from representatives of other agencies serving priority populations. The HPPG received presentations and/or reports about: behavioral science research projects involving injection drug users and incarcerated populations in Alaska; the findings of the interviews and focus groups conducted by the HIV/STD Program; data from interventions funded by the State under the CDC HIV prevention cooperative agreement; and HIV prevention interventions that had been evaluated and shown to be effective. Data included population size, geographic distribution of services and needs, and characteristics of persons reached by prevention interventions in calendar year 2002.

At the January 2003 meeting, the HPPG reviewed the CSA summary (Table 50, located at the end of Chapter 3) of data on needs and resources that they had considered over the preceding 13 months. The CSA summary identifies, by funding source, the HIV-specific resources and other supportive services reaching priority populations by geographic area. Prevention activities funded through June 2004 by the State HIV/STD Program under the HIV prevention cooperative

agreement from CDC are highlighted to emphasize the prevention interventions and other services that would be future gaps that could be anticipated when the current funding period ends. The HPPG members also brought to the consideration of future gaps, their extensive knowledge of their respective communities and the availability, accessibility, and suitability of services.

Community Services Assessment Data

Data follow on needs (indications of need and identified preferences) and services reviewed by the HPPG for each of the populations prioritized in the *2001 to 2003 Alaska HIV Prevention Plan*. The populations are not listed in any particular order. Although not a priority population in the 2001 to 2003 Plan, incarcerated persons were included in the CSA out of recognition of the higher prevalence of HIV related risk factors among incarcerated persons and higher prevalence of HIV in the prison population nationally.

Prevention services are organized into four categories according to funding source. (1) *State-funded Interventions Under the CDC HIV Prevention Cooperative Agreement* are administered by the HIV/STD Program and are funded through the end of the State fiscal year 2004 (June 30, 2004). (2) *HIV-specific Services Directly Funded by Federal Agencies* refer to HIV prevention or care programs funded directly to an agency or organization by a federal agency such as the CDC or the Health Resources and Services Administration (HRSA) which funds Ryan White CARE grants and Special Projects of National Significance (SPNS) for research on HIV prevention and care services. (3) *State-funded Services* refer to prevention related activities that are incorporated into programs of state agencies, but that are not funded specifically for HIV prevention under the CDC HIV prevention cooperative agreement, such as substance abuse treatment programs, Department of Corrections programming for inmates, and most Public Health Nursing Centers (4) *Non-public Funding Sources* refer to private foundations and fund raising activities by community-based organizations. Non-publicly funded HIV prevention services are very limited in Alaska. Notable examples include those supported in part or full through donations and fundraising activities at the Alaskan AIDS Assistance Association (Four A's), Interior AIDS Association (IAA), and Shanti of Southeast Alaska. Private foundation grants have also assisted the Four A's with certain activities related to the "Adam & Steve" program and for Pridefest, and to the IAA for the syringe exchange program.

Following the services summary for each population is a section on **service gaps**. Those services currently funded by the State under the CDC HIV prevention cooperative agreement will become service gaps as of mid-2004 unless newly funded by State grants from federal HIV prevention funds. Please see the Community Services Assessment (CSA) table for an abbreviated summary of the following information.

Injection Drug Users

Indication of Need

In February 2002, three consumer input groups were conducted in Anchorage with persons knowledgeable of injection drug use. Input from IDU in Anchorage was sought because there has not been a syringe exchange program operating successfully in Anchorage since a NIDA-funded

research project involving syringe exchange ended in 2001. The topic of each consumer input group was the HIV and hepatitis B and C prevention needs and preferences of IDUs in Anchorage. Participants indicated support for a variety of HIV and hepatitis prevention activities such as needle exchange and outreach. In addition, group members discussed potential barriers to implementing and sustaining risk reduction activities for IDU, including the stigma associated with injection drug use. Participants provided specific suggestions about locations, times, and methods for delivery of HIV prevention services. This information can assist the HIV/STD Program staff and providers of prevention services to plan for appropriate interventions and other services for IDUs at risk for HIV infection. Most participants agreed that paraphernalia sale laws were not a major obstacle to purchasing needles and syringes. Rather, stigma and individual pharmacy policies and practices discouraged purchase at pharmacies, leading participants to express interest in a syringe exchange program.

Interviews and focus groups with female drug users were conducted between 2001 and 2002 in conjunction with a five year National Institute on Drug Abuse (NIDA) study of drug users in Anchorage (Fenaughty, 2002). Women were asked questions about their beliefs and behaviors regarding condom use, relationship status, exchange of money for sex, and their ability to control sexual situations. Women reported infrequent use of condoms with casual partners or when exchanging sex for money or goods. Women were even less likely to use condoms with their main male partners, even knowing of their male partner's drug use. Women also indicated a relationship between their partner's substance abuse and coercive sex. Implications of this study are that interventions should help women to understand their risk in main relationships and to acknowledge their main partner's risk behaviors. The research concluded that there is a need to increase the availability of HIV testing, condoms and educational material, and awareness-raising interventions for women drug users and women with drug-using partners.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement conducted between 2001-2003

A community-based organization (CBO) in Juneau was funded to provide targeted outreach, single session group Health Education/Risk Reduction (HE/RR) at substance abuse treatment programs and homeless shelters, and individual HE/RR counseling at substance abuse treatment programs. In 2002, there were 270 outreach contacts, 324 individuals attended group HE/RR sessions, and 75 residents of substance abuse treatment programs received individual risk reduction counseling.

A CBO in Fairbanks was funded to provide targeted outreach with outreach workers, multi-session group HE/RR at substance abuse treatment programs, and HIV counseling and testing in non-clinic settings. In 2002, there were 2,112 outreach contacts made, 124 men and women participated in group HE/RR sessions, and three persons received HIV counseling and testing.

State-funded Services

The Division of Alcoholism and Drug Abuse (ADA) requires that all individuals entering substance abuse treatment have access to infectious disease screening, risk reduction education, counseling, and medical services, including diagnosis and treatment for HIV. Since 1997, ADA Notices of Grant Awards have contained the following HIV-related requirements: (a) referrals for counseling, testing, and treatment; (b) staff member trained in risk reduction; and (c) HIV issues addressed in client education and treatment plans. Furthermore, there were requirements within

the ADA FY 2000 Request for Proposals that were specific to IDUs and future requirements will likely remain the same. For example, IDUs have priority access to treatment, must be admitted no later than 120 days after requesting treatment, and must receive interim services (e.g., counseling and education about HIV and TB, referrals for HIV and TB testing, referrals for prenatal care for IDUs who are pregnant) while awaiting treatment.

The ADA-funded Center for Drug Problems (CDP) is a methadone treatment program in Anchorage. The STOP AIDS Program within CDP offers individual risk reduction counseling to all CDP clients, provides anonymous HIV counseling and testing to the public, conducts active street outreach targeting drug users, and supplies condoms, educational materials, and safer injecting supplies (not needles or syringes) at drop sites frequented by drug users.

Non-public Funding

Northern Exchange, a syringe exchange program funded by a private foundation and donations, provides sterile needles and syringes, condoms, and referral information to HIV prevention and drug treatment resources in Fairbanks and, formerly, in Juneau.

Service Gaps

IDU-specific interventions are most feasible in the larger cities –Anchorage, Fairbanks, Juneau. A privately funded syringe exchange program is operating successfully in Fairbanks, the syringe exchange in Juneau is currently inactive, and there is no syringe exchange program in Anchorage. There are methadone maintenance programs only in Anchorage and Fairbanks.

Outreach to IDU in Fairbanks is funded only through mid-2004 by the state under the CDC cooperative agreement. Previously conducted IDU outreach in Juneau became inactive in 2003 due to staff changes. Limited (30 hours/month) outreach to IDU and sex partners in Anchorage provided by the ADA-funded Center for Drug Problems, STOP AIDS Project, is intermittent depending on staff and peer outreach worker availability.

Group health education/risk reduction sessions at substance abuse treatment programs conducted by CBOs in Anchorage, Fairbanks, and Juneau and by Public Health Nursing in Bethel are funded only through mid-2004 by the State under the CDC cooperative agreement.

Men Who Have Sex With Men

Indication of Need

In 2001, interviews were conducted in Fairbanks and Anchorage with adult men who self-identified as men who have sex with men (MSM). Information was gathered about MSM's perception of community norms related to HIV risk and risk reduction, and men's ideas and preferences about HIV prevention activities. The interviews also sought to learn about venues of social interaction as points for potential prevention interventions. Findings related to prevention needs include:

- Perception of the prevalence of HIV is strongly influenced by the visibility of HIV-positive persons in the community.
- There was generally a low level of concern about HIV.

- Participants in both Anchorage and Fairbanks agreed that HIV prevention has very low visibility and more prevention activities are needed.
- Condom use, talking to partners about condoms, and talking to partners about HIV status are not the community norm in either Anchorage or Fairbanks.
- Both older and younger men perceive that it is the younger men who are engaging in high-risk behaviors and are therefore most at risk of HIV infection.
- Despite men's concerns about discrimination against homosexuality and persons with HIV, their preferences for HIV prevention activities lean heavily toward group and community interventions rather than private, individual interventions.
- Peer outreach through social networks, such as the POL model, was generally acceptable to the men who were interviewed. However, recruiting volunteers to do peer outreach may be very challenging.
- Age was the most salient characteristic defining social interaction in the MSM community. Prevention activities need to be geared to different age groups.
- The Internet has become a high traffic, virtual cruising area. Prevention efforts should increase the use of Internet chat rooms for placement of prevention messages, information on HIV testing, and for recruitment of MSM to other prevention interventions.
- Male prostitution does not appear to warrant specific outreach for HIV prevention with the possible exception of outreach for high-risk youth who engage in survival sex.
- HIV counseling and testing options are adequate to meet demand in Anchorage. More HIV counseling and testing in non-clinic settings would be welcomed in Fairbanks.
- The prominent barriers to HIV testing in Anchorage and Fairbanks appear to be psychological factors (e.g., fear of knowing status, denial of risk) rather than structural factors (reporting requirements, cost, availability). Interventions to motivate men to know their HIV status are needed.
- Stigma and discrimination against MSM persist. Fear of disclosure and self-esteem problems contribute to high risk, covert sexual behavior, are a barrier to testing for some, and prevent men from participating in prevention efforts or from being role models and spokesmen for the gay communities. It is appropriate for comprehensive HIV prevention programs for MSM to help create safe environments for coming out and for socializing in healthy ways, and to promote tolerance of sexual diversity and protection against discrimination.

In 2002, a focus group of gay and bi-sexual men under age 30 was conducted in Anchorage. Participants were from the MPower Core Group with Alaskan AIDS Assistance Association. When asked about their needs related to HIV prevention, participants identified leadership and creative options as the greatest challenge. Needs for a social community, recreational places, self-esteem and skills to negotiate safer sex, and political activism were also mentioned. When asked about the issues facing young gay and bi-sexual men under 30 in Anchorage, responses included acceptance, self-esteem, homophobia, sexuality, addiction, as well as relationship, legal, and political issues.

Partner notification activities conducted by the HIV/STD Program indicate that a number of HIV-positive men and the men they name as sex partners do not identify as gay. Such individuals would not view messages or interventions aimed at gay men as relevant to themselves.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement conducted between 2001-2003
A CBO in Anchorage provided HIV prevention to young adult MSM in Anchorage through an intervention based on the MPowerment model developed by the Center for AIDS Prevention Studies (listed in the *CDC Compendium of Interventions with Evidence of Effectiveness*).

MPOWERment is a peer-led program that seeks to address the needs of young gay and bisexual men by providing HIV prevention within the context of social activities, formal and informal outreach, a safe community center or gathering spot, and small group sessions. The model relies on diffusion of HIV prevention information through social networks, and support from the broader gay/lesbian/bisexual/transgender community. In 2002, MPOWERment project made 15,284 outreach contacts; 47 young men participated in groups; and social marketing materials were widely distributed in venues frequented by young MSM. In conjunction with the MPOWERment Project, the Municipality of Anchorage conducted targeted HIV counseling and testing in non-clinic settings.

The Anchorage CBO also provided targeted outreach in adult bookstores, public sex environments, and through Internet chat rooms, reaching MSM including those who do not identify as gay men. In 2002, there were 1,239 outreach contacts in adult book stores and public sex environments and 8,257 contacts via Internet chat rooms.

A CBO in Fairbanks provided outreach based on the Popular Opinion Leader (POL) model and HIV counseling and testing in non-clinic settings to young adult MSM. In 2002, they made 272 outreach contacts and five men availed themselves of HIV testing.

An Anchorage-based Alaska Native organization was funded to provide outreach to ethnic minority MSM using the POL model; this intervention reached Alaska Native MSM in Anchorage and rural MSM in selected regional hub communities. There were 346 outreach contacts in 2002.

Service Gaps

MSM-specific interventions are only available in Anchorage and Fairbanks, and through POL outreach to a few rural hub communities. With the exception of limited private funding to an Anchorage CBO, all funding for these interventions is from the State under the CDC cooperative agreement and ends in mid-2004. The Planning Group has identified ethnic minority MSM/gay men of color as a priority population since development of the 1997-2000 HIV Prevention Plan. State Requests for Proposals (RFPs) for grants to conduct interventions for minority MSM have stimulated proposals that have reached minority MSM. One Alaska Native organization has applied for and been awarded a grant to address this population, but no African American or Hispanic organization with 501(c) 3 designation has done so. This has been the case even though, with Planning Group support, State HIV/STD Program staff has sought to develop involvement by such organizations. In 2002-2003, one African American organization responded to a special solicitation for professional services and received a capacity-building contract to conduct a one-time community mobilization workshop for African American MSM.

Incarcerated Persons

Indication of Need

According to the Alaska Department of Corrections (DOC), the average daily population of incarcerated persons in Alaska in 2002 was 4,240 males and 431 females. Alaska Natives and African-Americans were over-represented in the incarcerated population as compared to their

representation in the state's population. While Alaska Natives are approximately 19% of the population, they accounted for 38% of males and 36% of females in correctional centers and community release facilities. African-Americans are approximately 4% of the population of Alaska yet they accounted for 11% of incarcerated men and 10% of incarcerated women. In 2002, ten percent (10%) of the incarcerated population was convicted of a controlled substance related charge (9.7% of males and 16% of females).

The Arrestee Drug Abuse Monitoring Program (ADAM) study, funded by the National Institute of Justice, conducts voluntary, anonymous drug testing and interviews with arrestees. Data reported on study participants from DOC facilities in Anchorage indicate that 52% of male and 56% of female arrestees in 2000 tested positive for drugs (cocaine, marijuana, methamphetamine, opiates, and PCP). Injection drug use was self-reported by 5.7% of males surveyed (National Institute of Justice, 2003).

Nationally, the Department of Justice reports that, as of the end of 2000, 2.2% of state prison inmates and 0.8% of federal prison inmates were known to be infected with HIV. Persons in correctional institutions are assumed to be at increased risk for HIV based on the large proportion whose offenses are drug related. Additionally, situational male-to-male sex and sharing injection, piercing or tattooing equipment may occur in prison.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement conducted between 2001-2003
CBOs were funded to conduct group Health Education/Risk Reduction (HE/RR) sessions in DOC correctional centers, jails, and community release centers in Anchorage and in correctional centers and jails in the Mat-Su and Kenai Peninsula boroughs. In 2002, almost 1,000 incarcerated men attended these groups. Approximately 340 women attended group HE/RR sessions at the Highland Mountain Correctional Center in Eagle River. CBOs conducted group HE/RR sessions in community release centers in Fairbanks and Juneau. Public Health Nursing personnel, funded by the State under the CDC cooperative agreement, conducted group HE/RR sessions at the DOC facility, community release center, and juvenile detention facility in Bethel. CBOs in Anchorage, Fairbanks and Juneau provided group HE/RR sessions at juvenile detention facilities. CBOs identified structural impediments to conducting group HE/RR sessions in correctional centers and community release centers including cancellations due to security procedures, room limitations, disinterested participants due to mandatory attendance policies in some settings, low attendance in other settings, high drop-out rates from multi-session interventions due to release or transfer, presence of correctional officers, and restrictions on distributing condoms for skill building exercises.

A grantee CBO assembled materials for DOC facilities to distribute to HIV-positive inmates at the time of their release. These were backpacks containing toiletries, HIV prevention materials, and resource information about AIDS service organizations (ASOs). The goal was to link HIV-positive inmates to case management and other care and prevention services upon release to the community. Where possible, ASO case managers began to meet with inmates prior to their release.

HIV-specific Services Directly Funded by Federal Agencies

In 2002, the Health Resources and Services Administration (HRSA) funded the Alaska Native Tribal Health Consortium (ANTHC) to conduct a five-year demonstration project, "Healthy

Transitions,” for inmates being released from a correctional facility in a northwestern Alaska region. The project will provide health assessments and HIV education, and encourage HIV testing for all inmates upon their release. For persons testing HIV-positive, the project will provide case management and linkage to care and prevention services.

State-funded Services

Various HIV prevention activities are carried out in DOC institutions (Anchorage, Bethel, Eagle River, Fairbanks, Juneau, Kenai, Ketchikan, Nome, Palmer, and Seward) by different programs within DOC. The DOC Inmate Substance Abuse Program (ISAP) and the Inmate Education Program (IEP) incorporate HIV prevention activities in their programming. Some of the facilities cover HIV prevention education within a life skills class every third week of the month. Other facilities cover HIV prevention education within parenting classes and a weekly orientation class. Some DOC Education Coordinators deliver group HE/RR using the *Be Proud/Be Responsible* (BP/BR) curriculum (included in the CDC *Compendium of Interventions with Evidence of Effectiveness*). Due to budget cuts, as of July 2003, ISAP programming is discontinued with the exception of the therapeutic communities at the women’s correctional facility in Eagle River and Wildwood Correctional Center in Kenai.

All Division of Juvenile Justice (DJJ) facilities (Anchorage, Bethel, Fairbanks, Juneau, Ketchikan, Nome, and Palmer) have youth correctional staff trained in the BP/BR curriculum. Group HE/RR sessions following the BP/BR model are conducted on a regular basis at the larger DJJ facilities and, when feasible, at smaller DJJ facilities.

Voluntary HIV and STD testing is available upon request at all DOC and DJJ facilities.

Service Gaps

Interventions in adult correctional programs conducted by CBOs in Anchorage, Fairbanks, and Juneau and by Public Health Nursing in Bethel are funded only through mid-2004. Structural impediments, such as scheduling and space problems, limit their effectiveness. Geographic coverage is currently limited to the three largest cities and one rural hub.

With the elimination of DOC ISAP programming as of July 2003, only Highland Mountain and Wildwood correctional centers will have substance abuse treatment programs that could incorporate HIV prevention education. DOC education coordinators in the Inmate Education Programs have many competing demands for inmate education.

Transition case management is provided for HIV-positive inmates in DOC facilities in the Anchorage area through the Ryan White CARE Act-funded ASO in Anchorage. Elsewhere there is no formal transition case management or pre-release planning for HIV-positive inmates. The ANTHC “Healthy Transitions” demonstration project is currently planned for a correctional facility in one rural hub community in Nome.

There is no systematic HIV or STD screening for persons remanded to correctional facilities. Except in the context of HIV and STD partner notification activities, HIV and STD testing is dependent on an inmate initiating a request to see a health care provider.

Youth at Increased Risk

Indication of Need

Data on teen pregnancy rates, STD morbidity (see Epidemiologic Profile), and data from the 1999 Alaska Youth Risk Behavior Survey (YRBS) indicate the prevalence of sexual risk activity among adolescents. Specifically, youth aged 15-19 years had the highest incidence of chlamydia in Alaska in 2001 through 2003.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement conducted between 2001-2003

A CBO in Anchorage conducted an outreach program entitled, Peer Outreach Worker Education and Referral (POWER) Program. The POWER Program hired and trained teenagers to provide community referrals, education, information, and mentoring to youth in Anchorage. In 2002, 4,241 targeted outreach contacts occurred on streets, in malls, recreation centers, and other sites catering to youth at increased risk. Individual HE/RR prevention counseling was provided to 35 youth visiting the Teen Clinic at the Downtown Anchorage Transit Center.

The Anchorage School District was funded to provide single session group HE/RR for youth using the “RARE-T” (Reduce AIDS Risk Effectively in Teens) curriculum. This intervention uses peer educators targeting the general secondary school population and youth at increased risk in alternative schools. The curriculum was initially developed for adolescents to participate in their own protection against HIV/AIDS by the National Institute on Drug Abuse. In 2002, there were 5,445 participants in RARE-T presentations.

Grantees provided HIV Testing and Counseling in non-clinic settings for approximately 200 youth at increased risk in Anchorage and Fairbanks during 2002.

Group HE/RR sessions using the *Be Proud! Be Responsible!* (BP/BR) curriculum were offered by CBOs at agencies serving youth at increased risk in Anchorage and Fairbanks, with 281 participants in 2002. In Juneau, over 400 youth at increased risk participated in group HE/RR sessions provided by a CBO at youth serving agencies and the youth detention facility.

A CBO in the Mat-Su Valley conducted the Peer Outreach Program, which prepares students to teach other students about risk and risk reduction related to drug and alcohol use and sexual behavior. The program reached over 1,700 contacts through targeted outreach on the streets, in recreation centers, malls, and other sites that cater to youth at increased risk. This grantee also offered single session group HE/RR interventions at the alternative school and at agencies serving youth at increased risk, reaching over 1,300 youth in 2002. Youth at risk group HE/RR sites included the Graf Healing Center (sponsored by the Fairbanks Native Association) and Life Givers in Fairbanks, as well as the Anchorage centered programs, such as Apollo Shelter, the Challenge Center, the “Alternatives” program at Charter North Hospital, “Our Clinic” at the youth clinic in the Downtown Transit Center, and the “Youth Companionship Program,” which is Alaska Youth and Parents Foundation’s (AYPF) electronic monitoring program for youthful offenders.

State-funded Services

The Alaska Department of Education and Early Development receives CDC Division of

Adolescent and School Health (DASH) funds for school-based health education to prevent the most serious health risk behaviors among children, adolescents and young adults. In Alaska, these funds are used to support purchase of HIV prevention curricula materials and teacher training in the delivery of these curricula as well as training for health education standards and assessment.

The Alaska Department of Health and Social Services receives additional federal funds to promote an abstinence-only program, "Postponing Sexual Involvement" targeting middle school students. This funding is given to Kids Are People, Inc. a non-profit charity offering services for youth who coordinate the abstinence-only program in the Mat-Su Valley, Sitka, Kenai, Kodiak, and Fairbanks school districts.

Alaska Division of Juvenile Justice facilities offer multiple session group HE/RR using the BP/BR curriculum and provide STD testing and treatment. State-funded substance abuse treatment programs for youth are required to provide HIV education and risk reduction counseling.

Service Gaps

Street and community outreach for at-risk youth is only available through grantees in Anchorage and the Mat-Su Borough that are funded by the State under the CDC cooperative agreement through mid-2004.

Group health education/risk reduction sessions are available in substance abuse treatment programs and youth detention facilities conducted mostly by staff who are non-HIV specialists, but augmented in the urban centers by sessions conducted by CBOs funded by the State under the CDC cooperative agreement.

While HIV prevention education in the context of comprehensive health education is recommended for kindergarten through 12th grade by the Alaska Department of Education and Early Development (DEED), it is up to individual school districts to set district requirements for health education. No school district in Alaska currently mandates HIV education. The HIV Prevention Planning Group is concerned that school aged children and adolescents in Alaska are not receiving age-appropriate HIV prevention education because of (a) the lack of universal HIV education and (b) competing demands of other subjects on classroom and teacher time. Planning Group members are especially concerned that rural schools do not have the resources to include HIV prevention education. Given the high rates of STDs in teenagers and other indicators of risk such as substance use and unintended pregnancies, the Planning Group feels strongly that school-based HIV prevention education remains an unmet need.

Current data on adolescent risk behaviors and prevention preferences are needed to guide future HIV prevention efforts. The Youth Risk Behavior Survey is an important source of data. The HPPG urges school districts to participate in the YRBS conducted by the State's DEED and DHSS approximately every other year.

HIV-Positive Persons

Indication of Need

In a June 2002 forum, HIV-positive clients of Alaska's largest AIDS service organization gave

recommendations regarding proposed HIV prevention activities and support services for HIV-positive individuals. Participants expressed opinions about direct client services, prevention and education activities, and social marketing plans. The group consensus was that HIV-positive persons play a key role in HIV prevention efforts as mentors/buddies for other HIV-positive individuals and as educators of HIV-negative people and the wider community. Participants offered specific suggestions for the content and format of a client handbook and the proposed social marketing for the agency's "Prevention With Positives" program. Needs identified included social venues for interacting with other HIV-positive persons and group sessions and workshops. Topics of interest included: disclosing HIV status to partners; dealing with stigma; and relationships with family and friends.

Alaska's Ryan White CARE Act Statewide Coordinated Statement of Need in 2001 identified that gaps in available case management services were primarily geographic in nature. Persons living with HIV and AIDS (PLWHA) with co-existing mental health problems also face special challenges. Title II and Title III providers reported that approximately 50% of the PLWHA they serve were in need of some level of mental health services. Persons with more severe mental health problems had more subsidized service options available to them, but continuity of care was an issue. Persons with mental illness and disruptive behaviors had limited service options. PLWHA released from incarceration in correctional settings in Anchorage received logistic and financial assistance to access medical care and medications, as well as other supportive services. Such planning and assistance was a routine need across the correctional system in all areas of the state, although the numbers of affected persons are small.

Research on interventions for HIV-positive persons by the University of Wisconsin Medical College, Center for AIDS Intervention Research (CAIR) indicates that components of problem solving, decision-making and skill building are important to help participants reduce the stress of disclosure of HIV status and reduce HIV transmission risk behaviors.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement conducted between 2001-2003
The AIDS service organization with the greatest number of HIV-positive clients has been funded to provide prevention case management, group single and multi-session health education/risk reduction (HE/RR), outreach, and targeted social marketing for prevention for HIV-positive persons.

HIV-specific Services Directly Funded by Federal Agencies

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act authorizes federal funding to (1) increase the availability of primary health care and support services, (2) reduce utilization of more costly inpatient care, (3) increase access to care for underserved populations, and (4) improve the quality of life for persons living with HIV disease. Several entities in Alaska receive funding under different parts of the CARE Act. Title II of the CARE Act funds the State of Alaska to purchase medical services, medications, and supportive services such as case management that assist low income PLWHA to participate in medical care.

Ryan White Title III Early Intervention Services (EIS) funding received by the Anchorage Neighborhood Health Center covers comprehensive primary health care for individuals living with HIV disease. Title III services include: risk-reduction counseling, antibody testing, medical evaluation, and clinical care; antiretroviral therapies; protection against opportunistic infections;

and ongoing medical, oral health, nutritional, psychosocial, and other care services for HIV-infected clients; case management to ensure access to services and continuity of care for HIV-infected clients; and attention to other health problems that occur frequently with HIV infection, including tuberculosis and substance abuse.

The Alaska Native Tribal Health Consortium receives Ryan White Title III funding for Early Intervention Services to develop and provide HIV/AIDS case management, and treatment for Alaskan Natives and rural Alaskans. A centralized clinical team is located in Anchorage, and hub site coordinators in Anchorage, Bethel, Fairbanks, Juneau, and Sitka provide case management for clients in their respective regions. The EIS team provides program services, such as consultation, collaborative patient case management, and HIV specialty clinics. Case management for HIV-positive patients includes coordination and referrals for medical and counseling services.

Service Gaps

Only one CBO funded by the State under the CDC cooperative agreement through mid-2004 offers prevention interventions specifically designed for HIV-positive persons. Individual risk reduction counseling in the context of Ryan White CARE services through itinerant case managers on an infrequent basis for HIV-positive persons is available in the three urban centers of Anchorage, Fairbanks and Juneau, and in two rural hubs served by the Alaska Native Tribal Health Consortium Early Intervention Services.

Assessment of the prevention needs and preferences of HIV-positive persons is needed on an ongoing basis to guide future prevention efforts.

Alaska Native and Other Ethnic Minority Women

Indication of Need

The high incidence of STDs in heterosexual women (See Epidemiologic Profile) is an indicator of sexual risk behavior. Data from partner notification activities also indicate that, among women whose sole risk is heterosexual contact and who test HIV-positive or who are named as partners of HIV-positives, most are unaware of their risk. ASOs have reported that women clients expressed ignorance of their partners' risk behavior or HIV status prior to the women's own HIV diagnosis. Such women are therefore unlikely to avail themselves of HIV prevention activities specifically recruiting women who perceive themselves at risk. Rather, HIV prevention efforts must 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 reaching homeless and substance abusing women and sex workers, and provision of or referrals for HIV prevention counseling for women receiving treatment for STDs. Because women often do not perceive themselves or their sexual partners to be at risk for HIV, partner notification services are important for early detection of HIV and for providing risk reduction counseling for HIV-negative women at high risk.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement conducted between 2001-2003

An Anchorage CBO provided outreach to homeless persons, especially ethnic minority women, reaching 753 women in 2002 of which 78% were Alaska Native. In 2003, this CBO initiated an intervention for African American and Hispanic women in Anchorage based on the Real AIDS Prevention Project (RAPP), a multi-strategy community-based intervention model that includes targeted social marketing, peer outreach, small group sessions and community mobilization.

In 2002, outreach was provided to sex workers in Anchorage (87 contacts); to minority women in Fairbanks (952 contacts of which 86% were Alaska Native); and to homeless persons in Juneau (169 contacts of which 50% were Alaska Native and 44% were women).

In 2002, group HE/RR sessions for women at increased risk were provided by CBOs in Anchorage (at Clitheroe Reflections, Dena-A-Coy, Women's Resource Center, Stepping Stones, and Claire Swan) reaching 556 participants; in Fairbanks (at the WIC-CA Domestic Violence Shelter) for 24 women, and in Juneau (at the Juneau Recovery Hospital, AWARE Women's Shelter, and Coming Home Project of Tlingit/Haida Tribal Council) for approximately 50 women.

Service Gaps

Outreach and HIV counseling and testing in community settings are available for women at increased risk only in the three urban centers through grantees receiving State funds under the CDC cooperative agreement through mid-2004.

Group health education/risk reduction sessions by HIV education specialists are available only at the Highland Mountain Correctional facility for women and at women serving agencies in the three urban centers and one rural hub. These interventions are provided by grantees and Public Health Nursing personnel funded by the State under the CDC cooperative agreement only through mid-2004.

HIV-specific interventions and social marketing efforts in rural Alaska are limited to a few communities participating in federally funded special projects.

Culture- and gender-specific programming and materials are needed for ethnic minority women in both urban and rural communities.

Additional data on the prevention needs and preferences of Alaska Native and other minority women, as well as potential venues, are needed to guide future HIV prevention efforts.

All Populations

Indication of Need

HIV Counseling and Testing

All persons with risk factors for HIV should undergo screening to determine their HIV status. The CDC estimates that about 25% of persons who have HIV infection are not aware of their

serostatus. It is important for HIV counseling and testing services to be available and accessible. According to Behavioral Risk Factor Surveillance System data (BRFSS) for 2001, 57% of Alaskan adults have been tested for HIV. The national median in 2001 was 33%. In the BRFSS survey, a higher percentage of Alaskans who self-identified as Black or Hispanic reported having ever been tested for HIV than had Whites and Alaska Natives. Those adults reporting ever having been tested for HIV were: 88% of Blacks, 67% of Hispanics, 57% of Whites, 55% of Alaska Natives/American Indians, 33% of Asians, and 33% of Native Hawaiians or other Pacific Islanders. Data from HIV tests processed by the State Virology Laboratory through 2002 indicate that a higher percentage of the state's population of Alaska Natives and African-Americans have been tested for HIV as compared to Whites. Because HIV testing is required of all military personnel, the relatively high proportion of active duty and reserve military personnel in Alaska, including Alaska National Guard personnel, may help account for the higher proportion of persons in Alaska who have been tested for HIV compared to the contiguous U.S.

Because there are effective treatments available to prevent perinatal HIV transmission, voluntary HIV testing is the standard of care as part of routine prenatal care for all pregnant women. In 2000, 81% of respondents on the Pregnancy Risk Assessment and Monitoring System (PRAMS) survey of women giving birth in Alaska reported that a provider talked with them about HIV testing. Studies have indicated that recalling such a discussion was highly correlated with having received an HIV test.

One national study of persons diagnosed with HIV between 1994 and 1999 found that 41% were diagnosed with AIDS within one year after their positive HIV test. In Alaska, of persons diagnosed with AIDS between 1999 and 2002, 64% had their first diagnosis of HIV within the 12 months prior to their AIDS diagnosis. To promote early diagnosis of HIV, CDC recommends that health care providers include voluntary HIV screening, when indicated, as part of routine medical care.

STD Diagnosis and Treatment

As documented in the Epidemiologic Profile, Alaska has a high incidence of certain sexually transmitted diseases, especially among adolescents and young adults and minority populations. Targeted screening, low cost, accessible services for STD diagnosis and treatment make an important contribution to HIV prevention by (a) reducing STD morbidity which is a risk factor for HIV transmission and (b) reaching persons for whom HIV counseling and testing may be appropriate who might not otherwise seek out HIV testing and risk reduction counseling.

HIV and STD Partner Notification

At highest risk for HIV infection are persons who have been exposed to HIV through sex and/or needle sharing with HIV-positive partners. Persons who have been exposed to HIV may be unaware of their exposure because they are not aware of the HIV status of their partners. Others, aware of a partner's HIV-positive status, may have minimized their risk of infection or have delayed HIV testing for a variety of reasons. Partner notification and the offer of immediate, field-based HIV counseling and testing can effect earlier diagnosis of HIV infection and provide prevention counseling to those most at risk. Similarly, STD partner notification is an important service for persons exposed to an STD, especially for those with asymptomatic STD infection who are not aware of their infection. STD partner notification also facilitates prevention counseling and HIV testing for those for whom it is appropriate.

Community Awareness of HIV

Raising awareness about the risk of HIV infection is a challenge for HIV prevention in low prevalence states like Alaska. This is particularly true for rural Alaska where the perception often persists that HIV is not an issue of concern. In all areas of the State stigma attached to having HIV and fear of disclosure are impediments to getting tested, and if HIV-positive, seeking care. Where protecting personal information may be particularly difficult, it may be even more so in small communities. Public information efforts are needed to keep the issue before the public, to de-stigmatize HIV testing, to direct people to prevention resources, and to foster a compassionate response to persons with HIV.

Prevention Services

State-funded Interventions under CDC Cooperative Agreement conducted between 2001-2003

The HIV/STD Program in the Alaska Department of Health and Social Services, Section of Epidemiology, coordinates HIV and STD partner notification statewide and provides field-based HIV counseling and testing, and STD testing and treatment in the context of partner notification encounters. The State also funds the Municipality of Anchorage and Public Health Nursing personnel in three communities to provide HIV counseling and testing and HIV/STD partner notification services.

HIV-specific Services Directly Funded by Federal Agencies

The Alaska Native Health Board was funded directly by CDC for a five-year project to increase HIV testing in project communities through public information campaigns. Project areas are Yukon-Kuskokwim Delta villages and Sitka area communities, and will include the Maniilaq Region (Kotzebue) in 2003-2004. This project is currently funded through May 2004.

The Yukon-Kuskokwim Health Corporation (YKHC) was funded in 2002 by the Health Resources and Services Administration (HRSA) for a five-year project to increase HIV testing and facilitate linkages to care for HIV-positive persons. Voluntary HIV testing will be offered in two Yukon-Kuskokwim regional villages in 2003 and 2004 as part of this project.

State-funded Services

The State Virology Laboratory provides HIV antibody and confirmatory tests at no cost to public or private providers.

HIV counseling and testing, and STD diagnosis and treatment are provided at most State-funded Public Health Nursing Centers and by public health nurses at tribal health clinics under PL93-638 contracts with the State. Public health nurses also work closely with HIV/STD Program staff, ANTHC, and other Alaska Native Health Corporations to carry out partner notification activities in rural communities.

Service Gaps

Partner notification services, including field-based HIV counseling and testing, carried out by the HIV/STD Program are partially funded through CY2004 under the CDC HIV prevention cooperative agreement. HIV counseling and testing and HIV/STD partner notification services carried out by grantees funded by the State under the CDC cooperative agreement are funded through mid-2004. CDC directly-funded public information efforts (ANHB) are geographically

limited and are funded through May 2004. The HRSA-funded special project to provide HIV testing in rural communities (YKHC) is limited to that geographic region.

Table 49. Fiscal Year 2002 Federal Funding for HIV/AIDS in Alaska

Federal Dept./Agency	Federal Program	Alaska Grantee	Amount
Dept. of Health and Human Services (DHHS)/ Health Resources and Services Administration (HRSA)	Ryan White CARE Act	State of Alaska/ Ryan White Consortia	
	Title II		
	Base		\$500,000
	MHAI		1,610
	ADAP		397,076
	Total Title II		\$898,686
	Title III Early Intervention Services and Capacity Building	Alaska Native Tribal Health Consortium	\$500,000
		Anchorage Neighborhood Health Center	290,272
	Total Title III		\$790,272
	Special Projects of National Significance	Alaska Native Tribal Health Consortium	\$200,000
Yukon-Kuskokwim Health Corporation		\$200,000	
Total HRSA		\$2,088,958	
DHHS/Centers for Disease Control and Prevention (CDC)	HIV Prevention Cooperative Agreement	State of Alaska, DHSS, Division of Public Health, Section of Epidemiology	\$1,482,135
	HIV Surveillance Cooperative Agreement		\$120,750
	STD Prevention		\$477,037
	HIV Prevention Directly- funded CBO	Alaska Native Health Board	\$209,372
	School Health (Div. Of Adolescent and School Health)	Alaska Dept. of Education and Early Development	\$240,345
Total CDC		\$2,529,639	
Housing and Urban Development (HUD)/ Office of HIV/AIDS Housing	Housing Opportunities for People with AIDS (HOPWA)	Alaskan AIDS Assistance Assoc.; Interior AIDS Assoc.	\$2,285,800
TOTAL- All Programs			\$6,904,397

Table 50. Community (Needs and) Services Assessment (CSA)

Population	Data Sources on Need for Prevention Services	Data Sources on Prevention Services Needs and/or Preferences	Prevention Services* Shaded cells are interventions funded by State HIV/STD Program through HIV Prevention Cooperative Agreement from CDC. Funded through June 30, 2004. PN services are funded by both the HIV CDC funds and the STD Coop. Agreement.				
HIV+ Persons	Four A's client consumer input group 2002	Four A's client consumer input group 2002	Anchorage Pop: 260,283 (42%)	Fairbanks Pop: 82,840 (13%)	Juneau Pop. 30,711 (5%)	15 Urban Satellites and Rural Hubs Pop: 159,592(25%)	260 Towns/Villages with ≤2,000 residents Pop: 93,506 (15%)
			PN	PN	PN	PN	PN
			Four A's PCM Group SS OR HC/PI Group MS 2003				
			Four A's RW II AIDS Drug Assist. Program (ADAP)	IAA RW II ADAP	Four A's RWII, ADAP		
			ANHC RW III				
			ANTHC RW III	ANTHC RW III	ANTHC RW III	ANTHC RW III Sitka, Bethel	

*Key to Prevention Interventions: **OR** – Outreach; **IND** – Individual Health Ed./Risk Reduction (HE/RR) Counseling; **Group SS** – Single session Group HE/RR; **Group MS** - Multiple Session Group HE/RR; **PCM** – Prevention Case Management; **HIVCT** – HIV Counseling and Testing; **PN** – Partner Notification and Disease Intervention; **HC/PI** – Health Communication/Public Information.

Key to Agencies: **Four A's** – Alaskan AIDS Assistance Assoc.; **IAA** – Interior AIDS Association; **ANHC** – Anchorage Neighborhood Health Center; **ANHB** – Alaska Native Health Board; **AYPF** – Alaska Youth and Parent Foundation; **ANTHC** – Alaska Native Tribal Health Consortium; **RW** – Ryan White CARE Grant; **HRSA SPNS** – Health Resource Service Admin, Special Projects of Nat'l Significance; **ASD** – Anchorage School District; **BHS** – Burchell Alternative High School; **MOA** – Municipality of Anchorage Health Department

Population	Data Sources on Need for Prevention Services	Data Sources on Prevention Services Needs and/or Preferences	Prevention Services* Shaded cells are interventions funded by State HIV/STD Program through HIV Prevention Cooperative Agreement from CDC, funded through June 30, 2004. PN services are funded by both the HIV CDC funds and the STD Coop. Agreement.				
			Anchorage	Fairbanks	Juneau	Urb Sat, Rur Hub	Villages
MSM	HIV/STD Program MSM Interviews, Anchorage and Fairbanks 2001	Four A's MPower Core Group 2002 (MSM<29y/o) ----- HIV/STD Program MSM Interviews, Anchorage and Fairbanks 2001	PN	PN	PN	PN	PN
• Young Adult			MSM <29 years old Four A's MPower: OR (AA 8.1%; AN 4.3%; A/PI 2.7%; Hispanic (10.4%)	IAA POL OR 76.8% <30yo AA 16%; AN 10.2%; A/PI 6.6%; Hisp. 13.6%			
• Ethnic Min.			Group SS = 47 (AA 12.8%; AN 2.1%; A/PI 6.4%; Hispanic 12.8%)	IAA HIVCT		ANHB AK Native and Rural MSM POL (Anchorage and hubs combined)	May reach men in villages
• NGI			HC/PI ----- MSM NGI Bookstore OR Chat Rm OR ----- MOA Bar HIVCT ----- ANHB AK Native MSM in Anchorage				
<p>*Key to Prevention Interventions: OR – Outreach; IND – Individual Health Ed./Risk Reduction (HE/RR) Counseling; Group SS – Single session Group HE/RR; Group MS - Multiple Session Group HE/RR; PCM – Prevention Case Management; HIVCT – HIV Counseling and Testing; PN – Partner Notification and Disease Intervention; HC/PI – Health Communication/Public Information.</p>							

Population	Data Sources on Need for Prevention Services	Data Sources on Prevention Services Needs and/or Preferences	Prevention Services* Shaded cells are interventions funded by State HIV/STD Program through HIV Prevention Cooperative Agreement from CDC, funded through June 30, 2004. PN services are funded by both the HIV CDC funds and the STD Coop. Agreement.			
Injection Drug User <ul style="list-style-type: none"> • Males • Females 	HIV/STD Program Consumer Input Groups 2002, Anchorage ----- NIDA Study Interviews and Focus Groups with Female IDU Anchorage	HIV/STD Program Consumer Input Groups 2002, Anchorage ----- NIDA Study Interviews and Focus Groups Female IDU Anchorage	PN See also under Heterosexual: Four A's DOC groups and ANHC DOC groups. STOP AIDS – OR and HIV CT	PN IAA OR (70.2% male) Group MS (66.1% male) HIVCT NE I Needle exchange	PN Shanti OR (70.4% male) Group SS (68.2% male) IND (52% male) NE II Needle exchange	Juneau Urb Sat, Rur Hub Villages PN PN PN
State-funded Substance Abuse Treatment Programs: HIV education is required in treatment plan for all clients.			*Key to Prevention Interventions: OR – Outreach; IND – Individual Health Ed./Risk Reduction (HE/RR) Counseling; Group SS – Single session Group HE/RR; Group MS – Multiple Session Group HE/RR; PCM – Prevention Case Management; HIVCT – HIV Counseling and Testing; PN – Partner Notification and Disease Intervention; HC/PI – Health Communication/Public Information.			
Key to Agencies: Four A's – Alaskan AIDS Assistance Assoc.; IAA – Interior AIDS Association; ANHC – Anchorage Neighborhood Health Center; ANHB – Alaska Native Health Board; AYPF – Alaska Youth and Parent Foundation; ANTHC – Alaska Native Tribal Health Consortium; RW – Ryan White CARE Grant; HRSA SPNS – Health Resource Service Admin, Special Projects of Nat'l Significance; ASD – Anchorage School District; BHS – Burchell Alternative High School; MOA – Municipality of Anchorage Health Department						

Population		Data Sources on Need for Prevention Services	Data Sources on Prevention Services Needs and/or Preferences	Prevention Services* Shaded cells are interventions funded by State HIV/STD Program through HIV Prevention Cooperative Agreement from CDC, funded through June 30, 2004. PN services are funded by both the HIV CDC funds and the STD Coop. Agreement.				
				Anchorage	Fairbanks	Juneau	Urb Sat, Rur Hub	Villages
Heterosexual Adults <ul style="list-style-type: none"> Males 	STD Epi Data	2001 BRFSS Data Nationally =33% have had an HIV test; AK =57% In AK, % tested: 88% of Afr. Am. 66.8% of Hispan 57% of Whites 55% of AN/AI	PN Four A's, Men (DOC): Group SS Group MS	PN	PN	PN	PN	PN
				ANHC Minority Women (DOC) Group SS ANHC/ANHB Minority Women Group MS MOA OR Sex workers	IAA Minority Women OR (AK Nat 86.2%) Group MS (AK Nat 41.7%)	Shanti Homeless OR (AK Nat 49.7%; Women 43.8%)	Group SS (AK Nat 43.1%; Women 49.5%)	
<ul style="list-style-type: none"> Females 								
<ul style="list-style-type: none"> Pregnant Women 		PRAMS 2000 81% offered HIV testing						

Population	Data Sources on Need for Prevention Services	Data Sources on Prevention Services Needs and/or Preferences	Prevention Services* Shaded cells are interventions funded by State HIV/STD Program through HIV Prevention Cooperative Agreement from CDC, funded through June 30, 2004. PN services are funded by both the HIV CDC funds and the STD Coop. Agreement.				
			Anchorage	Fairbanks	Juneau	Urb Sat, Rur Hub	Villages
Incarcerated	DOC: 4,661 average daily population; 10% = controlled substance related charge; Male (9.7%) Female (16%) ----- ADAM Study 2000 Data 52% males and 56% of females tested positive for drugs. 5.7% of males self reported IDU		PN	PN	PN	PN	PN
<ul style="list-style-type: none"> Males Average daily pop = 4,240 38% AK Native Females Average daily pop = 421 36% AK Native 		Four A's, Men (DOC) Group SS Group MS					
		ANHC Minority Women (DOC) Group SS					ANTHC HRSA SPNS grant; \$200,000/yr for 5 years. Nome.
		Group SS or MS – DOC Education Coordinators institutions (Anchorage, Bethel, Eagle River, Fairbanks, Juneau, Kenai, Ketchikan, Nome, Palmer, and Seward) Voluntary HIVCT and STD treatment – All DOC facilities					

Population	Data Sources on Need for Prevention Services	Data Sources on Prevention Services Needs and/or Preferences	Prevention Services* Shaded cells are interventions funded by State HIV/STD Program through HIV Prevention Cooperative Agreement from CDC, funded through June 30, 2004. PN services are funded by both the HIV CDC funds and the STD Coop. Agreement.				
			Anchorage	Fairbanks	Juneau	Urb Sat, Rur Hub	Villages
Youth at Increased Risk	STD Epi Data (No YRBS 2000-2002)		AYPF OR Group SS Group MS IND ASD Group SS w/o skills ----- MOA HIVCT	IAA Group MS	Shanti Group SS Group MS	BHS (Wasilla) OR Group SS Group SS w/o skills	
			AK Dept. of Education and Early Development – CDC DASH funds for school-based health education. \$240,345. AK DHSS – Abstinence-only education funds (Mat-Su Valley, Sitka, Kenai, Kodiak, and Fairbanks school districts).				
			Group MS; STD treatment – State-funded Div. of Juvenile Justice Facilities (Anchorage, Bethel, Fairbanks, Juneau, Ketchikan, Palmer) Group SS and MS - State-funded Substance Abuse Treatment Programs.				

Population	Data Sources on Need for Prevention Services	Data Sources on Prevention Services Needs and/or Preferences	Prevention Services* Shaded cells are interventions funded by State HIV/STD Program through HIV Prevention Cooperative Agreement from CDC, funded through June 30, 2004. PN services are funded by both the HIV CDC funds and the STD Coop. Agreement.				
			Anchorage	Fairbanks	Juneau	Urb Sat, Rur Hub	Villages
All Populations			HIVCT – MOA Reproductive Health Clinics			HC/PI – AK Native focused ANHB CDC Directly Funded ----- HC/PI and HIVCT - YKHC HRSA SPNS 5 yr. Grant 3 villages -----	
			State-funded Substance Abuse Treatment Programs HIV education is required in treatment plan for all clients.				
			HIVCT - State-funded and PL93-638 contracted Public Health Nursing Centers				
			HIVCT and PN- Public Health Nurses in Juneau, Fairbanks, Bethel				
			HIVCT and STD treatment – AK Native tribal health facilities, itinerating providers, and, for STDs, village health aides.				



Chapter 4

Prioritized Populations

Chapter 4: Prioritized Populations

According to the CDC HIV Prevention Community Planning Guidance, “Target populations should include populations in which the most HIV infections are occurring or populations with the highest HIV incidence” and should consider “the risk behaviors and prevention needs of People Living With HIV/AIDS (PLWHA)”. The HPPG carried out an evidence-based process to determine the highest priority populations with prevention needs in Alaska. The HPPG based their decisions on data from the epidemiologic profile and the community services assessment (see *Chapters 2 and 3*) and their knowledge of Alaskan communities.

The six priority populations for the *2004-2006 Alaska HIV Prevention Plan* in order are:

1. HIV-positive persons;
2. Men who have Sex with Men (MSM);
3. Incarcerated individuals;
4. Alaska Native and other ethnic minority women,
5. Youth at increased risk; and
6. Injection Drug Users (IDU).

“Priority setting for target populations must address populations for which HIV prevention will have the greatest impact.”
-- CDC 2003c

The following section presents the prioritized populations and summarizes the key reasons for prioritization.

#1 HIV-Positive Persons

HIV-positive individuals are an important population for both preventing further transmission of HIV infection and for preventing co-infection with other STDs. Fortunately, the availability of increasingly effective therapies for HIV disease has contributed significantly to longer, healthier lives for persons with HIV. It is critical 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. Primary prevention refers to helping persons avoid contracting HIV infections and secondary prevention refers to reducing or alleviating adverse consequences among persons who are living with HIV disease. A high proportion of persons who learn that they are HIV-infected adopt behaviors that are known to reduce the risk for transmitting HIV (CDC, 2000). However, data from national studies and HIV partner notification services conducted by the State HIV/STD Program indicate risk behavior among some HIV-positive persons. Also, clients of the largest Alaskan ASO expressed need for prevention services that would provide the opportunity for PLWHA to confer with their peers and to have support in dealing with issues of disclosure and risk reduction.

#2 Men who have Sex with Men (MSM)

Men who have sex with men make up 30% of all recent (1998 through 2002) cases of HIV (non-AIDS) in Alaska. When MSM/IDU cases are included, MSM comprise 50% of recent cases in males. MSM is the most prevalent risk factor in each race/ethnicity category of men and the proportion of recent cases in Alaska Native and African-American men is increasing. Qualitative data from the 2001 MSM interviews in Anchorage and Fairbanks indicate high-risk behaviors, especially among young adult MSM, and an absence of community norms (attitudes and policies) supportive of HIV testing, disclosure of HIV status, and safer sex.

#3 Incarcerated Persons

Correctional settings provide an opportunity to deliver HIV prevention interventions to populations with risk behaviors. Interventions can provide information and prevention skills applicable to life in the community after release from incarceration. Although there is a potential transmission risk from situational sex between men, injection drug use, and piercing and tattooing while incarcerated, transmission inside correctional settings has not been shown to be a big factor in the epidemic. Nationally, high rates of HIV and STD have been documented among persons as they enter the correctional system. In 2000, approximately 3% of the incarcerated population in the U.S. was known to be HIV-positive and the prevalence rate of AIDS in the prison population was four times higher than in the general US population (World Health CME, New World Health, 2003). A high proportion of incarcerated persons have a history of drug use. Data from the ADAM study in Alaska indicate that in 2000, 52% of male arrestees and 56% of female arrestees tested positive for drugs (cocaine, marijuana, methamphetamine, opiates, and PCP). In 2002, 10% of the incarcerated population in Alaska was convicted on a charge involving a controlled substance.

#4 Alaska Native and Other Ethnic Minority Women

Alaska Native and other ethnic minority women with heterosexual contact transmission risk makeup the second highest percentage (18%) of all recent (1998-2002) HIV only cases. There are indications of an increasing proportion of women compared to men of HIV only (non-AIDS) cases in women. This can be attributed to more cases being diagnosed in women in the last 5-8 years and less cases being diagnosed in men. Thirty-eight percent of recent HIV only (non-AIDS) cases were in females compared to 18% of earlier cases (HIV only cases prior to 1998 and all AIDS cases combined). As well, recent HIV infection rates in Alaska Native women are disproportionate to their representation in the adult population: 39% of all recent female HIV (non-AIDS) cases are Alaska Native women whereas Alaska Native women make up approximately 16% of the state population. African-American and Hispanic females are also slightly over-represented in recent HIV (non-AIDS) cases compared to the state population. An increasing number of cases in women are related to IDU. Focus group and interview data from Alaska Native women with a history of recent drug use indicate sexual risk behaviors.

#5 Youth at Increased Risk

The population of youth at increased risk was prioritized on the basis of morbidity data that indicated a high prevalence of sexual risk behaviors. Youth aged 15-19 years had the highest incidence of chlamydia. Teen pregnancy rates also indicate unprotected sex.

#6 Injection Drug Users

Injection drug use is an important exposure risk for HIV for people who live in all areas of Alaska. Injection drug use is the second highest prevalent risk factor of cumulative cases – 12% (an addition 7% of all cumulative cases if including MSM/IDU). Transmission through injection

drug use made up 16% of recent (1998-2002) HIV (non-AIDS) cases. An increasing number of cases in women were attributed to injection drug use. Focus groups with IDU in Anchorage in 2002 indicated a need for syringe access. There is an active syringe exchange program in Fairbanks, an inactive one in Juneau, and none in Anchorage or other areas of Alaska. Focus group and interview data from Alaska Native women with a history of recent drug use indicate sexual risk behaviors

Chapter 5: Interventions, presents the science-based prevention interventions that were considered for each of these populations.



Chapter 5

Interventions

Chapter 5: Interventions

Research on the effectiveness of prevention interventions is available from published studies on HIV prevention projects that have been scientifically evaluated and shown to be effective in reducing risk behaviors associated with HIV transmission. In developing recommendations in the *2004-2006 Alaska HIV Prevention Plan*, the Alaska HPPG considered only those interventions that have a sound basis in social and behavioral science theory and have demonstrated effectiveness in influencing behavior change, or are recommended by CDC as an essential component of a comprehensive HIV prevention program.

Sources of Information on Effective Interventions

1. Core theories of behavior change from behavioral science research.

Behavioral science research has shown that 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

The Compendium is based on research from the 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 31). 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 at:

<http://www.cdc.gov/hiv/pubs/HIVcompendium/hivcompendium.htm>.

The CDC is in the process of updating the Compendium.

Figure 31. *Compendium of HIV Prevention Interventions with Evidence of Effectiveness*

Drug Users	ACDP 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)

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

These fact sheets summarize research on various issues related to HIV prevention including research on risks, barriers, prevention needs and effective interventions of specific target populations. A compilation of these fact sheets is available from the CAPS web site at www.caps.ucsf.edu. Information pertinent to Alaska’s prioritized populations is located in the following “Fact Sheets”: “What Are Men Who Have Sex With Men (MSM)’s HIV Prevention Needs?”; “What Are the HIV Prevention Needs of Young Men Who Have Sex With Men?”; “What Is the Role of Prisons in HIV, Hepatitis, STD and TB Prevention?”; “What Are Substance Abusers’ HIV Prevention Needs?”; and “What Are HIV+ Persons’ HIV Prevention Needs?”

4. Characteristics of Effective Interventions

The HPPG has determined that it is important to build into all interventions the characteristics of effective HIV prevention interventions that have emerged from the years of

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

prevention research and program experience. These “Characteristics of Effective Interventions” are listed in Figure 32.

Figure 32. Characteristics of Effective Interventions

Interventions should:

- › have a clearly defined target population;
- › have clearly defined objectives and implementation plan;
- › be accessible and affordable to the target 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 target 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 target 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 target population(s);
- › have sufficient resources to accomplish their objectives;
- › have flexibility to make mid-course modifications as necessary;
- › be operated by an agency with 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 target populations to promote referrals; and
- › evaluate interventions to assure that they are implemented as proposed and meeting objectives.

5. CDC’s Diffusion of Effective Behavioral Interventions (DEBI) Project

The following effective behavioral interventions are listed in the *Compendium*, and more extensive descriptions are available through the DEBI Project. Materials and training for adopting selected evidence based interventions are available through the CDC on the following:

Voices/Voces is a group-level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Participants, grouped by gender and ethnicity, view an English or Spanish video on HIV risk behaviors and condom use and participate in a facilitated discussion (O'Donnell et al, 1998).

MPowerment is a community-level intervention for young men who have sex with men that uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, positive social opportunities, and social marketing to reach a broad range of young gay and bisexual men with HIV prevention, safer sex and risk reduction messages (Kegeles et al, 1996).

Promise is a community-level intervention based on several behavior change theories. A community identification process is conducted, role model stories are written from target population interviews, and these stories are distributed along with other risk reduction materials to target audiences to help people move toward safer sex or risk reduction practices. The intervention has been adapted for various population groups (IDUs, MSM, sex workers, Native Americans, and youth at high risk) (CDC AIDS Community Demonstration Projects Research Group, 1999).

Real AIDS Prevention Project (RAPP) is a community mobilization program, based on the transtheoretical model of behavior change, designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. This intervention relies on peer-led activities, including: outreach/one-on-one brief conversations with brochures, referrals, and condom distribution; small group safer sex discussions and presentations; and community business participation in media campaigns, including distribution of role model stories and prevention/health information newsletters and brochures (Lauby et al, 2000).

SISTA is a group-level, gender- and culturally-relevant intervention designed to increase condom use among African American women. The intervention is based on Social Learning theory and the theory of Gender and Power. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making (DiClemente et al, 1995).

Street Smart is a multi-session, skills-building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use. Sessions address improving youths' social skills, assertiveness and coping through exercises on problem solving, identifying triggers and reducing harmful behaviors. Agency staff also provide individual counseling and trips to community health providers (Rotheram-Borus et al, 1997).

6. **Prevention Interventions with HIV-Positive Persons**

Most of the research on interventions designed specifically for HIV-positive persons is still in the formative stages. Prevention Case Management is a model of intensive, individualized counseling promoted by CDC (CDC, 1997). The Center for AIDS Intervention Research has developed and evaluated a group HE/RR intervention for HIV-positive men and women based on Social Cognitive Theory and conducted in five 90-minute sessions. Using excerpts from popular movies as triggers to discussion, the groups

focus on skill building and problem solving about disclosing HIV status to intimate partners and negotiating safer sex. This model has demonstrated effectiveness in reducing transmission risk behaviors (Kalichman et al, 2001). Other models of interventions for HIV-positives will be considered by the HPPG as the results of evaluation research become available.

7. **Interventions for Incarcerated Populations**

Three HIV prevention program models that could be implemented by community-based organizations for incarcerated populations (Ehrmann, 2002) include:

Peer education as an HIV prevention intervention successfully crosses culturally, geographically, and linguistically diverse people because peer educators have the advantage of sharing the same unique environment as their target audiences. This intervention was evaluated as being cost effective, as effective as professional-led education, and favored by inmates. A successful example of this intervention is Centerforce within the San Quentin State Prison.

Pre-release Planning programs link incarcerated populations to resources and services before release and try to provide a smooth transition into the community. People living with HIV/AIDS in correctional facilities address needs prior to and immediately following their release from an institution, including medical insurance, financial and social supports, and stable housing. One successful example of this intervention is the Empowerment Through HIV/AIDS Information, Community, and Services (ETHICS) program sponsored by the Fortune Society in New York City.

Transitional Case Management assigns a case manager who is responsible for making referrals to address the psychosocial and medical needs of the ex-offender being released from correctional facilities. Ideally, case management picks up where pre-release planning ends. A successful example of this intervention is the Transitional Services Unit at the Women's Prison Association in New York City.

Appropriate Intervention Types

Nine intervention types were considered by the HPPG for selecting interventions to recommend for the *2004-2006 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 target 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 that has CDC support to replicate and make available materials for adopting the program for use elsewhere.
- ⌘ There are trained facilitators for this curriculum in Alaska. Training of trainers is available.

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

Group Health Education/Risk Reduction

Applicable Target Populations:

High-risk youth; heterosexual adults; IDU; sexual partners of IDU, MSM, HIV-positive persons

Prevention Goals:

- Reduce unsafe sexual behaviors; increase condom use
- Reduce unsafe injection practices
- In youth, decrease number of sexual partners and delay initiation of sexual activity
- For HIV-positive persons, increase disclosure of HIV status to partners and increase condom use

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)
- Culturally appropriate materials
- Interactive discussion or role-play
- 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)

- Social science theories on ethnic pride and gender and power issues

Evidence of Effectiveness (model or study):

Youth in Community

- ^{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.
- ^{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

- ^{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

- ^{REP} “Get Real About AIDS.” Main 1994. 15 session skills-based curriculum taught by high school teachers. Outcome: fewer sex partners, increased condom use.
- ^{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.
- Reducing AIDS Risk Effectively in Teens (RARE-T)[Ⓢ]

Youth in Shelters

- ^{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

- ^{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 Adults

- ^{REP} “Voices/Voces” O’Donnell 1994. 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.
- ^{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.

Heterosexual Women

- ^{COM} DiClemente 1995. Five 2 hour sessions for African-American women residents of a housing project. Outcome: increased condom use, decreased unprotected sex.
- ^{COM} Hobfoll 1994. Four 2-hour sessions for low-income, single, pregnant women. Outcome: increased condom use. Financial incentive to attend.
- ^{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

- ^{COM} Kelly et al. 1989. Twelve weekly group sessions for gay men. Outcome: reduced unprotected anal intercourse and increased condom use.
- ^{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

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

HIV-Positive Persons

- Kalichman et al. 2001. Health Relationship Groups: Coping and Safer Sex Maintenance Intervention for Men and Women Living with HIV/AIDS. Five sessions focusing on communication and problem solving skills applied to disclosure of HIV status and protecting safer sex. Outcome: decreased unprotected sex; increased condom use.

HIV Counseling and Testing

Applicable Target Populations: All. Early recognition of infection allows persons to consider treatment options and also allows them to take steps to prevent transmitting the virus to others. The availability of effective drug therapies makes it more important than ever for HIV-infected persons to know their serostatus. Client-centered HIV risk reduction counseling in the context of HIV testing can help non-infected persons reduce their risk of acquiring HIV. To increase the acceptability of testing in some settings, such as medical care and correctional facilities, it may be appropriate to omit prevention counseling.

Prevention Goals:

- Reduce sharing of injection equipment
- Reduce unsafe sexual behaviors; increase condom use
- Practice harm reduction behaviors related to HIV prevention
- Increase the number of people who know their serostatus
- Offer social service referrals
- Link HIV-positive person to medical care, PCRS, and prevention services

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.
- Persons tested receive results of and follow-up risk reduction counseling and referrals.
- 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):

- ^{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.
- ^{COM} Wenger et al 1991. Enhanced counseling component with HIV testing. Outcome: reduced unprotected sex.
- 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.
- Adoption of Protective Behaviors Among Persons with Recent HIV Infection and Diagnosis – Alabama, New Jersey, and Tennessee, 1997-1998. *MMWR* 2000; 49:512-515.

Partner Notification

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

Prevention Goals:

- Reduce sharing of injection equipment
- Reduce unsafe sexual behaviors; increase condom use
- Practice harm reduction behaviors related to HIV prevention
- Increase the number of people who know their serostatus
- Offer social service referrals
- Link HIV-positive persons to medical care and prevention services

Essential Components:

- A voluntary, confidential service by trained public health personnel to notify named sex or needle sharing partners to HIV-positive individuals that they have been exposed to HIV.
- Confidential, assisted partner notification 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:

- Varghese B, Peterman TA, Holtgrave DR. 1999. Cost-effectiveness of counseling and testing and partner notification: a decision analysis. *AIDS*, 13(13): 1745-51.
- West GR, Stark KA. 1997. Partner notification for HIV prevention: A critical re-examination. *AIDS Education and Prevention*, 9, Supplement B: 68-78.
- Wycoff 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.

Prevention Case Management

Applicable Target Populations: HIV-positive persons and HIV-negative persons at high risk.

Prevention Goals:

- Reduce sharing of injection equipment
- Reduce unsafe sexual behaviors; increase condom use
- Increase linkages to medical care

Essential Components:

- Multiple, one-on-one sessions of 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.

Individual Health Education/Risk Reduction

Applicable Target Populations:

Heterosexual Adults; high-risk youth.

Prevention Goals:

- 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):

- ^{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.
- ^{COM} Wenger et al 1991. Enhanced counseling component with HIV testing. Outcome: reduced unprotected sex.

Multi-strategy Intervention (Community Level Intervention)

Applicable Target Populations:

MSM; youth at high risk; heterosexual minority women; IDU

Prevention Goals:

- Reduce unsafe sexual behaviors; increase condom use
- Reduce sharing of injection equipment
- Influence community norms about safer sex and HIV testing

Essential Components:

- Formal and informal outreach, peer led small groups, targeted, small scale social marketing campaign
- Safer sex promotion is embedded in a series of fun social and community-building events
- Small groups build skills for safer sex and motivate participants to promote safer sex
- Informal outreach consists of peer-initiated communications about the need for safer sex

Behavioral/Social Science Theoretical Basis:

- Theory of Reasoned Action; Social Cognitive Theory; and Diffusion of Innovation

Evidence of Effectiveness (model or study):

- ^{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.
- ^{REP} Real AIDS Prevention Project (RAPP). Lauby et al. 1998. Outcome: increased condom use with non-main partners by women in inner city communities.
- ^{COM} Promise. CDC AIDS Community Demonstration Projects Research Group. 1999. Outcome: increased and maintained consistent condom use with non-main partners.

Street and Community Outreach

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

Prevention Goals:

- Reduce unsafe sexual behaviors; increase condom use; delay sexual activity
- Reduce sharing of injection equipment; increase clean 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 target population.
- Sustained and regular presence in the community.
- Focus efforts on specific areas of a community frequented by persons 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.

- Identification and training of volunteer peer educators recruited from among popular opinion leaders (POLs) of a 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:

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 or readiness according to the stages of change process and provide peer role models of successful risk reduction and community support for change (ORW as role model and role model stories from community members). For POL, theories of social influence and diffusion of innovation.

Evidence of Effectiveness (model or study):

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

Targeted Health Communication/Public Information

Applicable Target Populations: Any specified target population.

Prevention Goals:

- Encourage persons at risk to seek HIV counseling and testing
- Raise awareness and dispel myths about HIV/AIDS
- Influence community norms in support of safer behavior
- Support individual efforts for personal risk reduction

Essential Components:

- Use of broadcast (TV, radio), electronic (websites, email, list serves), and print media, and hotlines, advertised to and accessed by a specific target population
- Culturally, linguistically, and community appropriate messages to raise awareness, educate about risk reduction, and to influence community norms

Syringe Exchange

Applicable Target Populations: Injection Drug Users

Prevention Goals:

- Reduce sharing of injection equipment
- Reduce unsafe sexual behaviors
- Increase HIV Counseling and Testing

Essential Components:

- Paid or volunteer peer outreach workers, culturally and linguistically representative of the target population
- Sustained and regular presence in the community
- Provide clean new syringes, needles and other sterile injection 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, 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):

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

Selecting Interventions

For recommendation in the *2004-2006 Comprehensive Plan*, the Alaska HPPG selected interventions from among the nine intervention types previously described that have a theoretical basis and evidence of effectiveness or are strongly recommended by CDC.

“The set of prevention interventions/activities for prioritized target populations should have the potential to prevent the greatest number of new infections.”
--CDC 2003

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

- acceptability of the intervention for the intended 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 are preferable where feasible;
- percentage of the target population that could be reached by the intervention; and
- the relative number of persons in the target population reached per time/effort expended.

In addition to selecting appropriate interventions specific to each priority population, the HPPG considered consistency with the national strategy to identify previously undiagnosed HIV infection and the feasibility of implementing strategies across Alaska. The HPPG reached consensus on a set of interventions to recommend for each priority population.

Considerations for HIV Counseling, Testing, Referral and Partner Notification Services

Nationally, HIV prevention funds are increasingly tied to the proportion of persons newly tested that are found to be infected (yield). In low HIV prevalence areas like Alaska, targeting HIV testing services in ways that produce a “defensible” or cost effective yield is a challenging task. Special HIV testing activities should be targeted first to persons and populations with risk behavior and increased likelihood of exposure, and then extended to other populations as resources permit.

Sexual and/or injecting partners of HIV-positive persons are the persons at highest risk of acquiring HIV infection and all such individuals should be offered readily available, voluntary HIV testing and prevention counseling in clinical or field settings. To make this possible, all persons in whom HIV infection is detected should be offered partner notification services. These services optimally should include interviewing by trained public health personnel with confidential, individualized follow-up activities to advise potentially exposed partners of their exposure. (Medical providers generally refer HIV-positive patients to public health providers for these services.) Partner notification is necessary because partners may be unaware they have been exposed to HIV or may minimize their likelihood of infection. Partner notification supports earlier identification of previously undiagnosed HIV infection, reducing the likelihood of further transmission and creating an entrée to medical care. Coupling HIV prevention counseling with HIV testing increases the likelihood of reducing risk behavior in persons who are not infected. CDC’s “Revised Guidelines for HIV Counseling, Testing, and Referral” (2001) offer evidence- and experience-based guidelines for such services.

HIV testing technology options are increasing and excellent tests are available for blood specimens (standard blood draws or finger pricks) and oral transudate (current urine tests have some drawbacks). Conventional and rapid tests are available and/or under development. Different technologies may influence individuals’ willingness to undergo testing, and their uses may be tailored to the situation and resources available.

Considerations for Sexually Transmitted Disease (STD) Treatment and Partner Notification Services

Infection with STD indicates unprotected sexual intercourse, which is also a risk behavior for HIV infection. Studies have shown that persons infected with STD are more likely to transmit HIV, if infected, and more susceptible to HIV infection, if exposed and uninfected. HIV infection has been most closely associated in the U.S. with syphilis and gonorrhea infections in heterosexual populations in the Southeast and with syphilis and gonorrhea among men who have sex with men in a number of urban settings. An association between HIV and chlamydia infection is biologically plausible but has not been well explored. Treating an STD is considered an effective approach to reducing the likelihood of HIV transmission, if an exposure were to

occur (Fleming and Wasserheit, 1999). Consistent efforts to locate, counsel, test, and treat exposed sexual partners are critical to reducing STD transmission, especially since STD symptoms may be absent or ignored.

Compared to other U.S. states, Alaska has a relatively low prevalence of HIV infection, a gonorrhea rate slightly below the average rate for the U.S. as a whole, and a comparatively high rate of chlamydia infection (this may be due in part to increased public health efforts to detect infections). Infectious syphilis is rare in Alaska. Additionally, concurrent (co-) infection with two STDs or with HIV and another reportable STD are uncommon in Alaska. This indicates that individuals' sexual networks differ and that certain infections are more common in some networks than others. Since having an STD indicates risk behavior (unprotected sex, multiple partners), persons with STD and their partners are candidates for prevention counseling and potentially for HIV testing. Because some STD are so common, because STD infection facilitates HIV transmission, and because the number of persons living with HIV increases each year (since infection is lifelong), activities to reduce STD infection rates (especially gonorrhea and syphilis) have a role in overall efforts to reduce HIV transmission.

Considerations for Urban Centers

The recommended interventions in *Chapter 6: Recommendations* focus on specific populations and involve the types of activities shown most likely to reduce HIV transmission and effect behavior change. These activities take place within the broader social context. Some of the interventions proposed are logistically more feasible in settings where there are larger populations, including larger populations of persons with the targeted risk behaviors. Some interventions require considerable infrastructure and resources. Organizations and communities can marshal many human and other resources to carry out activities, even though HIV-specific resources are limited. Resource-intensive interventions can generally only be funded with HIV-specific resources in settings where they influence enough persons in the targeted populations to be considered cost effective in the context of total HIV prevention needs. Since such considerations tend to focus HIV-specific resources in more populated, urban areas, the Planning Group has specifically identified certain interventions for rural areas in order to help offset this disparity.

HIV infection has historically been more prevalent in the more populous areas of Alaska, although all geographic areas of the state are affected to some degree. Risk behaviors among people in the urban centers, either by individuals who reside in these areas or who travel to the cities from outlying areas, are therefore more likely to involve exposure to HIV than in areas with lower prevalence of HIV infection. The size of the priority populations of persons with demographic and behavioral risk factors in common – injection drug users, men who have sex with men, women at increased risk, and youth at increased risk – and their concentration in identifiable locations, make targeted outreach and group interventions feasible in the urban setting. Urban centers may also have concentrations of target populations whose members interact with sufficient frequency to make it possible to influence community norms about HIV risk reduction through prevention interventions that employ multiple strategies, also referred to as community level interventions. Substance abuse treatment facilities, social service organizations, and correctional facilities in urban centers provide additional venues for interventions to reach individuals with behavioral risks for HIV infection. Three cities in Alaska – Anchorage,

Fairbanks, and Juneau – currently offer a continuum of HIV prevention services that includes an AIDS service organization (ASO), community organizations with ties to at-risk populations, and organizations with staff that specializes in HIV prevention.

Considerations for Rural Areas

In less populous areas of the state, the smaller numbers of people, particularly those in the target populations, as well as lower HIV prevalence, often preclude establishment of AIDS specific organizations or prevention programs focused exclusively or predominantly on HIV and staffed by HIV prevention specialists. In these areas, the intensive interventions of partner notification and prevention case management for HIV-positive persons can be provided for the small number of persons for whom they are appropriate. However, other HIV prevention activities generally must rely heavily on agencies and organizations with broader missions to integrate HIV prevention into counseling or health education services for their clients and communities. Lower population density, lower HIV prevalence and the social dynamics and cultural factors of rural communities may make infeasible HIV prevention activities that target persons with acknowledged, specified behavioral risk factors such as injection drug use or sex between men. Risk behavior-specific interventions are generally the kinds of activities for which HIV-specific funds are available. In rural areas, most HIV prevention efforts must reach out to a broader audience of persons potentially at risk to raise awareness of risk and provide referrals to individualized services for the fewer individuals at higher risk.

Please see the following section, *Chapter 6: Recommendations*, for the Alaska HPPG’s overall goals, recommendations for statewide prevention activities, and recommended interventions for each priority population.



Chapter 6

Recommendations

Chapter 6: Recommendations

HIV Prevention Goals

1. Increase the number of HIV-infected persons who know their HIV status. Strategies for doing so include: offering HIV testing in conjunction with partner notification services to persons potentially exposed to HIV; providing HIV testing services in sites reaching persons at increased risk; encouraging HIV testing, when indicated, as part of routine medical care; and supporting use of testing technologies acceptable to patients and appropriate to settings.
2. Reduce HIV transmission to prevent new infections. Strategies for doing so include early case identification through providing notification, testing, and prevention counseling for sex and needle-sharing partners of infected persons; providing targeted behavior change interventions for persons with HIV infection and their partners; facilitating infected persons' participation in medical care and supportive services; and encouraging routine incorporation of prevention into medical care for HIV-positive persons.
3. Reduce HIV risk behavior by providing targeted behavior change interventions for HIV-negative persons and persons of unknown HIV status who have behavioral risk factors for HIV infection.
4. Reduce the annual incidence of AIDS by linking persons with newly diagnosed HIV infection to medical care and support services.

HIV Prevention Recommendations

The Alaska HIV Prevention Planning Group recommends that the full range of comprehensive HIV prevention program activities set forth in CDC guidelines be conducted in Alaska. Recommended prevention interventions are, to the greatest extent possible, science-based with evidence of effectiveness for the specified priority populations.

Recommendations for interventions and supporting activities are organized in the following order: statewide prevention services for all affected persons; interventions for specific priority populations; and interventions designated for rural Alaska. These are followed by overall recommendations for capacity building, needs assessment, evaluation, and other health department activities necessary for a comprehensive HIV prevention program.

Prevention Services for All Affected Persons Statewide

HIV Counseling, Testing and Referral

- ⇒ Free or low cost, voluntary HIV counseling and testing should be available in all urban centers, at public health clinics in rural hubs, at federally funded rural primary care clinics and at tribal health facilities. All persons testing HIV-positive should receive or be referred for partner notification, medical evaluation and care, and supportive services. When resources are limited, testing services should be tailored to reach those at greatest risk and

monitored for yield. Use of rapid and other test technologies should be considered, where applicable and feasible. HIV prevention counseling consistent with CDC’s most current CTR guidelines is recommended.

- ⇒ Voluntary HIV testing, where indicated, should be provided within the context of routine medical care.
- ⇒ HIV testing should be provided as a voluntary part of routine prenatal care for all pregnant women. This national recommendation is based on the fact that medical treatment and other interventions can reduce the likelihood that an infected mother will transmit HIV to her infant, rather than on the assumption that all pregnant women are at risk for HIV infection.

Partner Notification

- ⇒ All HIV-infected persons should be offered partner notification services. These services should optimally include interviewing by trained public health personnel, prevention counseling, and confidential, individualized follow-up activities to advise potentially exposed partners of their exposure.
- ⇒ All locatable partners potentially exposed to HIV should be offered HIV testing and prevention counseling in clinical or field settings.
- ⇒ Persons exposed to other STD, minimally those exposed to gonorrhea or syphilis, should be notified of their exposure and provided appropriate treatment, prevention counseling, and offered or referred to HIV counseling and testing.

Interventions Specific to Priority Populations

Table 51 lists the recommended intervention types by intended priority population. These interventions are in addition to those interventions recommended for all populations.

PRIORITY POPULATION	Outreach	Multi-strategy Intervention	Syringe Exchange Program	Group Health Education/Risk Reduction	Individual Health Education/Risk Reduction Counseling	Prevention Case Management	HIV Counseling & Testing in Non-clinic Settings	Health Communication /Public Information
1. HIV-Positives				✓	✓	✓		✓
2. MSM	✓	✓		✓	✓		✓	
3. Incarcerated				✓	✓		✓	
4. Alaska Native/Other Ethnic Minority Women	✓	✓		✓			✓	✓
5. Youth at Increased Risk	✓	✓		✓				✓
6. IDU	✓	✓	✓	✓			✓	

Specific intervention types recommended for each priority population are listed below. Populations are listed in order of priority. Interventions are not listed in any order of preference. In some instances, additional qualifiers are provided for interventions. The “Characteristics of Effective Interventions” apply to all interventions listed.

1. HIV-POSITIVE INDIVIDUALS

Recommended interventions include:

Prevention Case Management

⇒ Prevention Case Management (PCM) for HIV-positive individuals who can benefit from reducing risk of further transmission. CDC's publication, "HIV Prevention Case Management" (1997) provides guidelines for this type of intervention. Counseling activities may employ telecommunication technology to extend access to and acceptability of the services.

Group Health Education/Risk Reduction

⇒ Culturally appropriate group HE/RR sessions for HIV-positive persons. Group HE/RR may employ telecommunication and internet technology to extend the reach and acceptability to the intended population. When feasible, include peers as group facilitators.

Individual Health Education/Risk Reduction

⇒ Individual HE/RR interventions (HIV prevention counseling) in conjunction with medical care.

Health Communication/Public Information

⇒ Broadcast, print, and/or electronic media disseminating targeted messages about available resources, practicing risk reduction, and benefits of treatment for persons with HIV.

2. MEN WHO HAVE SEX WITH MEN

Recommended interventions include:

HIV Counseling and Testing

⇒ HIV counseling and testing in non-clinic settings convenient to men who have sex with men (for example, bars, gay community events, and at AIDS Support Organizations) and in conjunction with group HE/RR presentations.

Group Health Education/Risk Reduction

⇒ Culturally appropriate group HE/RR sessions. Group HE/RR may include telecommunication and internet technology to extend the reach and acceptability to the intended population.

Outreach

⇒ Outreach to promote HIV risk reduction and encourage HIV counseling and testing. Outreach may include use of internet chat rooms to extend the reach and acceptability.

Multi-strategy Interventions

⇒ Interventions that employ a combination of strategies, including peer outreach, group HE/RR, and targeted social marketing to influence community norms regarding risk reduction and support individual behavior change.

Individual Health Education/Risk Reduction

⇒ Individual counseling and support for safer behaviors. These services may be provided by phone or in computer chat rooms to increase access.

3. INCARCERATED PERSONS

Recommended interventions include:

HIV Counseling and Testing

- ⇒ Voluntary HIV counseling and testing at community release centers, especially in conjunction with Group HE/RR sessions.
- ⇒ Voluntary HIV testing available to inmates of correctional institutions.

Group Health Education/Risk Reduction

- ⇒ Group HE/RR sessions should be available in community release centers and in correctional facilities with therapeutic communities.

Individual Health Education /Risk Reduction

- ⇒ Individual counseling such as transition case management for HIV-positive inmates on release and/or pre-release planning for HIV-positive inmates.

4. ALASKA NATIVE AND OTHER ETHNIC MINORITY WOMEN

Recommended interventions include:

HIV Counseling and Testing

- ⇒ HIV counseling and testing in non-clinic settings convenient to women at increased risk (for example, commercial sex environments, shelters, bars, and at AIDS Support Organization offices) and in conjunction with group HE/RR presentations at substance abuse treatment programs or shelters serving women.

Group Health Education/Risk Reduction

- ⇒ Group HE/RR sessions in substance abuse treatment programs, shelters, and community release centers serving at-risk Alaska Native and other ethnic minority women.
- ⇒ Group HE/RR sessions for women in correctional institutions.

Health Communication/Public Information

- ⇒ Female-specific risk reduction messages distributed through print media (pamphlets and posters) at agencies and places frequented by at-risk Alaska Native and other ethnic minority women (for example, shelters, health clinics, bars, and substance abuse treatment facilities).

Multi-strategy Interventions

- ⇒ Interventions that employ a combination of strategies, including peer outreach, group HE/RR, and targeted social marketing to influence community norms regarding risk reduction and to support individual behavior change.

Outreach

- ⇒ Targeted outreach in settings frequented by women at increased risk (for example, bars, street areas, and commercial sex environments) and in conjunction with existing Syringe Exchange programs.
- ⇒ Free condoms and risk reduction literature available at public health clinics, community mental health centers, community residential centers, substance abuse treatment programs, soup kitchens, shelters, bars, and adult bookstores.

5. YOUTH AT INCREASED RISK

Recommended interventions include:

Group Health Education/Risk Reduction

- ⇒ Group HE/RR sessions in each of the juvenile detention facilities.
- ⇒ Group HE/RR sessions at agencies or drop-in sites serving youth at increased risk.
- ⇒ Age-appropriate, school-based HIV prevention education in the context of comprehensive health and life skills education in schools statewide. These activities should employ evaluated and validated curricula.

Outreach

- ⇒ Targeted outreach at places frequented by youth at increased risk.
- ⇒ Free condoms and age-appropriate risk reduction literature available to sexually active youth at public health clinics and other sites, as appropriate.

Health Communication/Public Information

- ⇒ Posters displayed and informational materials distributed in places frequented by at-risk youth.
- ⇒ Local broadcast, print and/or electronic media to raise awareness about risks, risk reduction, and referrals for local sexual health services for youth.

Multi-strategy Interventions

- ⇒ Interventions that employ a combination of strategies including peer outreach, group HE/RR, and targeted social marketing to influence community norms regarding risk reduction and to support individual behavior change.

6. INJECTION DRUG USERS

Recommended interventions include:

HIV Counseling and Testing

⇒ HIV counseling and testing in non-clinic settings at places accessed by IDU (for example, at or near syringe exchange programs and commercial sex environments), and in conjunction with group HE/RR sessions at substance abuse treatment programs and community release centers.

Group Health Education/Risk Reduction

⇒ Group HE/RR sessions in programs serving active or former drug users.

Outreach

⇒ Active street outreach to IDU and, in communities with operating Syringe Exchange Programs (SEPs), collaboration with SEPs to outreach to IDU with harm reduction materials, sexual risk reduction messages, referrals to HIV counseling and testing, and other service referrals, as well as targeted messages displayed in venues likely to be seen by IDU. (Note: federal funds cannot be used to purchase or distribute needles and syringes.)

Multi-strategy Interventions

⇒ Interventions that involve a combination of strategies including peer outreach, group HE/RR, and targeted social marketing to influence community norms regarding risk reduction and to support individual behavior change.

Syringe Exchange Programs

⇒ Syringe exchange to provide sterile needles and syringes for active drug users in conjunction with distribution of condoms, referrals to HIV counseling and testing, assistance in accessing drug treatment, and other service referrals. (Note: syringe exchange programs cannot be supported with federal funds.)

Rural-Specific Interventions

As discussed above, infrastructure and resource requirements, small populations, as well as considerations inherent in small communities about identifying individuals with certain risk behaviors, limit interventions that may be feasible in more rural areas. To address this, lower cost, non-targeted interventions may be appropriate.

Recommended interventions include offering:

Health Communication/Public Information

- ⇒ Media-based social marketing campaigns focused on rural areas to raise awareness of HIV risk, risk reduction strategies, the importance of community support, and resources for HIV information, counseling, testing, and care.
- ⇒ Informational forums conducted by organizations serving rural communities to raise awareness and mobilize involvement in HIV prevention. Forums should be conducted in conjunction with a local gathering attracting residents including community leaders and gatekeepers.

Recommendations for Capacity Building

Capacity building refers to a planned process by which individuals, organizations, and communities are assisted to develop skills and abilities to enhance and sustain HIV prevention efforts. Capacity building activities may include, but are not limited to, training, technical assistance, quality assurance guidance, recommendations for materials and intervention models and curricula, assistance in grant writing, and support for organizational and infrastructure development. Capacity building may be provided by the health department, national HIV prevention capacity building providers, or by public or private local, state or national organizations with expertise in the areas of interest.

The HIV Prevention Planning Group recommends:

- ⇒ For community-based organizations funded for HIV prevention and other HIV prevention providers, and for organizations with ties to priority populations, capacity building activities in the areas of design, implementation, and evaluation of HIV prevention interventions, grant writing, and organizational development.
- ⇒ For agencies and institutions serving priority populations (such as correctional facilities, substance abuse treatment programs, social service agencies, mental health services, women's shelters, local government agencies, Alaska Native tribal organizations, and programs serving youth), capacity building activities to foster and support the incorporation of HIV prevention into their programs and services.
- ⇒ For public health and private sector health care providers, training in HIV counseling for use of rapid HIV testing technologies, and promotion of offering HIV testing, when indicated, in the context of clinical care.

- ⇒ For the Alaska HIV Prevention Planning Group, capacity building activities to support the prevention planning process and the members' interface with their respective communities. To support the HPPG in making recommendations for appropriate interventions, the HPPG requires information on emerging research on effective interventions and on adapting proven interventions to be culturally appropriate for the diverse populations of Alaska.
- ⇒ For the HIV/STD Program staff, training opportunities to assure that the health department has the capacity to manage and support all components of a comprehensive HIV prevention program.

Recommendations for Needs Assessment

To support the ongoing work of assessing HIV prevention needs and preferences of populations at risk of acquiring or transmitting HIV, the HIV Prevention Planning Group requires the input of the following populations during the period of 2004 to 2006:

- HIV-positive persons;
- Alaska Native and other minority women at increased risk;
- Youth at increased risk;
- Incarcerated; and
- African American, Hispanic, and other ethnic minority men.

Additional needs for input from affected communities and populations may emerge within the time period covered by the Plan.

Recommendations for Evaluation

The HPPG supports the use of HIV Prevention funds to evaluate the community planning process and the HIV prevention activities carried out by the HIV/STD Program and its grantees and contractors. Continuation is recommended for the activities below.

The HPPG participates in an annual self-evaluation to assess its achievement of the core objectives of community planning. The HPPG annually examines the state health department's application to CDC to assess its correspondence with the Comprehensive Plan. Annually the health department presents to the HPPG data on the allocation of HIV prevention resources so that the HPPG can assess the correspondence between this resource allocation and the Comprehensive Plan.

The HIV/STD Program requires process evaluation data on all funded interventions that are carried out by grantees, contractors, or Program staff. Process data provide information on the reach and retention of the intervention and the demographic characteristics of participants. The HIV/STD Program uses these data to monitor the implementation of funded activities and presents summary data to the HPPG in support of the planning process. Grantee organizations use these data to monitor their programs' progress toward their objectives and to inform their program planning.

The HIV/STD Program requires outcome monitoring data on selected interventions. Outcome monitoring data provide a measure of the effectiveness of an intervention to influence risk reduction intentions or behavior.

For performance evaluation, the HIV/STD Program routinely collects and reports data to CDC on core indicators for community planning, HIV prevention activities, evaluation activities and capacity building.

Other Health Department Activities Carried Out Under the CDC Cooperative Agreement

The HPPG endorses the use of HIV prevention funds under the CDC cooperative agreement to assure that the Alaska HIV/STD Programs retains the staff and infrastructure to implement all components of a comprehensive HIV prevention program. In addition to the health department's responsibilities noted in previous sections of the Plan with respect to community planning, HIV prevention activities, capacity building and evaluation, the HIV/STD Program must have the ability to: prepare grant applications and reports; manage grants to CBOs and other agencies; implement quality assurance systems; respond to the surveillance data needs of the HPPG, prevention programs, and providers; convene program review panels; collaborate and coordinate with other state and community agencies, health department programs, and Alaska Native tribal organizations that serve priority populations as defined in the Plan; and provide guidance on policy issues related to HIV/AIDS for the State of Alaska.



Chapter 7

Overview of the Community Planning Process

Chapter 7: Overview of the Community Planning Process

Goals of HIV Prevention Community Planning

The CDC has defined three major goals to provide an overall direction. The goals provide an overall direction for HIV prevention community planning.

Goal One — Community planning supports broad-based community participation in HIV prevention planning.

Goal Two — Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

Goal Three — Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.

Guiding Principles for HIV Prevention Community Planning

To ensure that the HIV prevention community planning process is carried out in a participatory manner, the CDC has specified the following Guiding Principles of HIV Prevention Community Planning:

1. The health department and community planning group must work collaboratively to develop a comprehensive HIV prevention plan for the jurisdiction.
2. The community planning process must reflect an open, candid, and participatory process, in which differences in cultural and ethnic background, perspective, and experience are essential and valued.
3. The community planning process must involve representatives of populations at greatest risk for HIV infection and people living with HIV/AIDS (PLWHA).
4. The fundamental tenets of community planning are parity, inclusion, and representation.

Parity is the condition whereby all members participate equally in the planning process and have equal voice in voting and other decision-making activities.

Inclusion is the assurance that the views, perspectives, and needs of all affected communities are included and involved in a meaningful manner in the community planning process.

Representation means that members reflect the perspective of a specific community and that they understand that community's values, norms, and behaviors. Representatives must also be able to participate as group members in objectively weighing the overall priority prevention needs of the State.

5. An inclusive community planning process includes representatives of varying races and ethnicities, genders, sexual orientations, ages, and other characteristics such as varying educational backgrounds, professions, and expertise.
6. The community planning process must actively encourage and seek out community participation.
7. Nominations for membership should be solicited through an open process and candidates' selection should be based on criteria established by the health department and the community planning group.
8. An evidence-based process for setting priorities among target populations should be based on the epidemiologic profile and the community services assessment.
9. Priority setting for target populations must address populations for which HIV prevention will have the greatest impact.
10. The set of prevention interventions/activities for prioritized target populations should have the potential to prevent the greatest number of new infections.

Current Alaska HIV Prevention Group Members

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. 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 and HPPG member nominations are solicited from consumers and HIV prevention providers throughout the state representing both governmental and non-governmental agencies. The State Epidemiologist in the Division of Public Health, Department of Health and Social Services, appoints members.

A charter that describes the purpose, duties, liaisons, membership, records, and governance of meetings, subcommittees, and working teams guides the HPPG. The HPPG has adopted a consensus model and the principles upon which consensus is built. Meetings are generally held quarterly and additional meetings and/or teleconferences for the full HPPG may be scheduled if deemed necessary by the co-chairs. Three HPPG members, two of whom are community members and one of whom represents the Alaska Department of Health and Social Services, share the Chair of the Alaska HPPG. Facilitation of meetings is rotated among the three co-chairs. From 2001 through 2003, during the development of the *2004-2006 Alaska HIV Prevention Plan*, the HPPG was composed of the following members:

Hugh Brown, III, Anchorage
Victor Carlson, Anchorage
Wendy Craytor, Health Department Co-chair, Anchorage
Diana Cunnea-Schilling, Anchorage

Ella Jones, Kotzebue
Michael Jones, Nome and Anchorage
Sigvold Juliussen, Anchorage
Elizabeth Lee, Aniak and Bethel
Mary Lee, Community Co-chair, Anchorage
Brenda Reichenberg, Fairbanks
Eddie Singleton,* Juneau
Clarence Smelcer, Community Co-chair, Anchorage
Rebecca Tonsgard-Gibson, Anchorage
Joe Torres,* Anchorage
Barbara Wilson, Barrow and Fairbanks
Margaret Wilson, Fairbanks
*Members resigning from the HPPG in 2003

Efforts are made to organize a diverse planning group that is guided by the fundamental tenets of HIV prevention community planning: parity, inclusion and representation.

Community Input Process

In addition to the HPPG's 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. Meetings are advertised in local newspapers and posted on the State's website. 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 from 2001 to 2003 were:

Viki Wells, Division of Alcoholism and Drug Abuse
Beth Shober (2001-2002), Tammy Green (2002-2003), Department of Education and Early Development
Sara Williams, Department of Corrections

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. Periodically, meetings are held outside of Anchorage to encourage participation from other communities in Alaska.

The Alaska HPPG and the Alaska Ryan White CARE Consortia and lead agencies share information and mutual participation in their respective activities through several mechanisms. Since the Alaska HIV/STD Program supports both groups, communication about prevention and care activities is easily facilitated by HIV/STD Program staff. Generally there is some overlapping membership between the HPPG and one or more HIV CARE Consortia. Data from Ryan White CARE Act activities are shared with the HPPG and included in the needs assessment process. Reciprocally, the comprehensive Plan is sent to each CARE Consortium for participant 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*. Since 2001, there has been an increase in the interaction between the HPPG and the Ryan White CARE services with the implementation of more prevention activities for HIV-positive persons.

Beginning in 2000, HPPG information is made available on the Internet through the Section of Epidemiology web site at www.akepi.org. Approved meeting minutes, upcoming meeting dates and agendas, a list of current HPPG members and their areas of residence, and applications for HPPG membership are posted on the website. The current *Alaska HIV Prevention Plan* is posted on the website and public comment is welcome. Comments and questions can be e-mailed directly to the HPPG through this website.



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