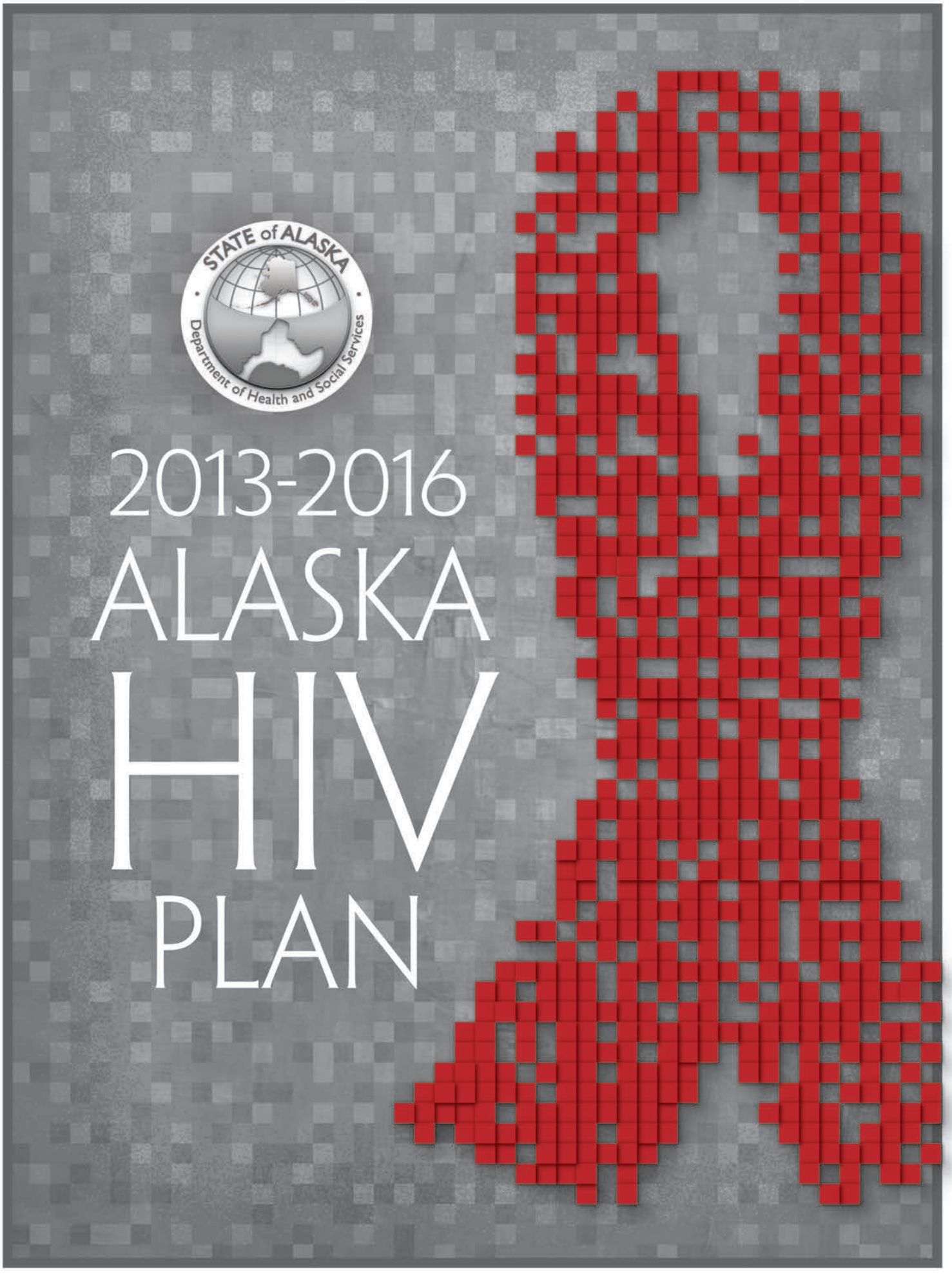
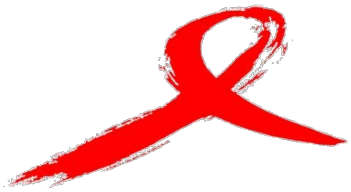


2013-2016 ALASKA HIV PLAN

The *2013-2016 Alaska HIV Prevention Plan* has been developed by the Alaska HIV 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://epi.alaska.gov/hivstd/hppg.

Dear Alaskan,



The Alaska HIV Planning Group is pleased to present the *2013-2016 Alaska HIV Plan.* This Plan is designed to serve as a guide and a resource for community partners working in the field of HIV prevention, as well as in HIV treatment and care.

This is a time of both great challenge and unprecedented potential for organizations serving individuals at risk of acquiring HIV disease and those living with HIV/AIDS. The National HIV/AIDS Strategy released by the White House in July 2010 called for a renewal of efforts to reduce HIV incidence and to align available resources to areas and populations with the highest rates of HIV infection. In turn, the Centers for Disease Control (CDC) reallocated its HIV Prevention awards to high incidence jurisdictions. As a result, Alaska lost a significant amount of prevention funding. However, CDC prevention funds awarded through state grants are just one part of the overall effort to fight HIV in Alaska. Indeed, Alaska's HIV prevention providers have risen to the challenge of continuing to provide quality services in this resource challenged environment.

Alongside these fiscal challenges, we have witnessed great developments and look forward to a time of renewed promise for combating HIV disease. In recent years, enormous strides have been made in the field of HIV prevention, and scientific processes have led to the development of promising interventions, such as linkage to care programs, and a renewed focus on testing. In addition, the implementation of the Affordable Care Act presents great opportunity for both HIV prevention and for HIV care.

The Planning Group looks forward to the facing the challenges and opportunities of the future. The Group would like to thank the many stakeholders who contributed to the development of this Plan, including those living with HIV and those who work every day to provide essential HIV prevention and care services to Alaskans throughout our state. We encourage all Alaskans to take part in local HIV prevention activities, to increase awareness and understanding of HIV/ADIS, and to show compassion for and solidarity with those infected with and affected by HIV and AIDS.

Alex Barros

Samuel Senft

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HIV Planning Group
State of Alaska HIV/STD Program
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2013-2016
ALASKA HIV PLAN

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Preface

The State of Alaska established a statewide HIV Prevention Planning Group (HPPG) in Spring 1994 under guidelines and funding from the Centers for Disease Control and Prevention, the federal agency with primary responsibility for national HIV prevention activities. The HPPG, in collaboration with the Alaska HIV/STD Program, published the first HIV Prevention Plan in 1996. Beginning in 2012, based on new evidence which demonstrates the close relationship between HIV prevention and treatment, the CDC mandated the integration of HIV prevention, and care treatment planning. For the remainder of this Plan and in the future the HPPG will be known as the HIV Planning Group (HPG) and address statewide strategic planning for all aspects of HIV prevention, care and treatment.

The *2013-2016 Alaska HIV Plan,* HIV prevention, and the HIV planning process have been significantly impacted by two events:

1) Release of the National HIV/AIDS Strategy (NHAS) – July 2010
2) Release of the CDC's Funding Opportunity Announcement (FOA) PS12-1201 – Comprehensive HIV Prevention Programs for Health Departments (PS12-1201) – July 2011

"On July 13, 2010 the White House released the National HIV/AIDS Strategy (NHAS). This ambitious plan is the nation's first ever comprehensive coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015."[1]
The vision of the NHAS is that, "*The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.*"[2] To meet this vision the NHAS established the following goals:

1. Reduce New HIV Infections

- Reduce the annual number of new infections by 25%
- Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30%
- Increase the percentage of people living with HIV who know their serostatus from 79% to 90%

[1] AIDS.gov, *National HIV/AIDS Strategy Overview.* http://aids.gov/federal-resources/national-hiv-aids-strategy/overview/
[2] The White House. *National HIV/AIDS Strategy for the United States*. Available at http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf. Published July 13, 2010.

2. **Increase access to care and improve health outcomes for people living with HIV**

   - Increase the proportion of newly diagnosed patients linked to clinical care from 65% to 85%
   - Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care from 73% to 80%
   - Increase the number of Ryan White clients with permanent housing from 82% to 86%

3. **Reduce HIV-related health disparities**
   - Improve access to prevention and care services for all Americans
   - Increase the proportion of HIV-diagnosed gay and bisexual men with undetectable viral load by 20%
   - Increase the proportion of HIV-diagnosed Blacks with undiagnosed viral load by 20%
   - Increase the proportion of HIV-diagnosed Hispanics with undiagnosed viral load by 20%

The recommended action that most significantly impacts HIV prevention efforts in Alaska is to "*Promote equitable resource allocation – The Federal Government should review the methods used to distribute Federal funds and take steps to ensure that resources go to the States and localities with the greatest need*."[3]

In response to the NHAS, CDC was tasked to "*develop policy recommendations for revising funding formulas and policy guidance in order to ensure that federal HIV prevention funding allocations go to jurisdictions with the greatest need…*"[4] For PS 12-1201, CDC created a new method of distributing funds for providing HIV prevention resources to areas of the country with the highest disease burden. As a result of this re-distribution of funds, some jurisdictions with low HIV incidence received a decrease in funding, while areas with high HIV incidence received an increase. PS12-1201 also requires that health departments ensure that the majority of funding goes to the area(s) in the State with at least 30% of the HIV

PS12-1201

Required Core Components:

1) HIV Testing
2) Comprehensive Prevention with Positives
3) Condom Distribution
4) Policy Initiatives

Required Program Activities:

1) HIV Planning
2) Capacity Building and Technical Assistance
3) Program Planning, Monitoring and Evaluation, and Quality Assurance

Recommended Program Components:

1) Evidence-based HIV Prevention Interventions for HIV-Risk Negative Persons
2) Social Marketing, Media, and Mobilization
3) Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post-Exposure Prophylaxis (nPEP) Services

[3] Ibid

[4] CDC, *Funding Opportunity Announcement PS12-1201: Comprehensive HIV Prevention Programs for Health Departments.* Available online at: http://www.cdc.gov/hiv/topics/funding/PS12-1201/pdf/PS12-1201.pdf.

epidemic in the jurisdiction.[5] The only area in the State that meets this requirement is Anchorage.

As a low-incidence state, Alaska was impacted significantly by the Federal resource re-allocation. As a result of this re-allocation of funds, the HIV/STD Program's funding was reduced by almost $330,000 for calendar year 2012 and will be reduced further (potentially to almost half of its 2011 funding level) by the end of the five-year grant cycle (2016).

In addition to identifying priority geographic areas, PS-1201 identifies required core components, required program activities, and recommended program components.[6] The HIV/STD Program has taken the following steps toward meeting the goals of the NHAS and the requirements of PS12-1201:

A. Issued a request for proposals (RFP) for a three-year funding cycle in which the following HIV prevention interventions were funded:

   - HIV Testing – Increased testing in non-healthcare settings targeting individuals at highest risk (i.e. MSM, IDU, high risk heterosexuals)

   - Condom Distribution – At sites targeting HIV positive and high-risk negative individuals; also, all programs are required to distribute condoms at funded interventions such as HIV testing

   - Prevention with Positives – Incorporating HIV prevention in the medical care of HIV positive persons

B. Continues to provide HIV partner services to newly and previously diagnosed clients.

C. Conducts HIV testing in the field to individuals at increased risk identified through HIV and STD partner services.

D. Applied for and received funding to conduct Enhanced Linkage to Care (L2C) to identify and contact HIV-positive individuals who are newly diagnosed or out of care, and provide them with short-term, intensive support in engaging with an HIV care provider and with long-term medical case management.

E. Continues to provide staff to:

   - Facilitate HIV planning
   - Provide capacity building and technical assistance

[5] The Centers for Disease Control and Prevention, *Funding Opportunity Announcement PS12-1201—Comprehensive HIV Prevention Program for Health Departments, Available at: http://www.cdc.gov/hiv/topics/funding/PS12-1201/pdf/PS12-1201.pdf. Published July 2011.*

[6] Ibid

- Conduct program planning, monitoring and evaluation, and quality assurance

Unfortunately, due to the aforementioned funding reductions, the Alaska HIV/STD Program is not able to meet all of the goals of NHAS or fund or conduct the recommended program components in PS12-1201. **Evidence-based interventions targeting MSM, IDU and high risk heterosexuals (HRH) will no longer be funded by the HIV/STD Program after June 30, 2013.** These losses include long-standing and popular interventions such as Mpowerment (targeting young MSM), Options (targeting IDU), street and community outreach (targeting MSM, IDU, and HRH), and social marketing/public information (targeting the general population including rural Alaska). To best meet the goals of the NHAS and the requirements of PS12-1201, the HIV/STD Program will focus on HIV testing, comprehensive prevention with positives (including PS and L2C), and condom distribution. It is the hope of the HIV/STD Program and the HIV Planning Group (HPG) that the interventions lost due to decreased federal resources will continue with other funding. Other funding sources could include private foundations and fund raising. The HIV/STD Program will continue to explore other funding opportunities and share them through the Alaska HIV Prevention Listserv and personal conversations when appropriate.

Chapter 1

Introduction

OVERVIEW: 1982-2012

The Centers for Disease Control and Prevention (CDC) estimates that 1.2 million people are living with HIV in the United States, with approximately 50,000 new infections occurring on an annual basis. One in five (20%) of those infected are unaware of his/her infection.[7] While antiretroviral therapy (ART) has allowed individuals with HIV to live longer, the absolute number of new infections has remained steady in Alaska. With HIV infected individuals surviving longer and the number of new infections per year remaining steady, there are more people living with HIV in the state, indicating a strong need for HIV prevention, care, and treatment services.

From January 1, 1982 through December 31, 2011, 1,458 cases of HIV infection were reported to the State of Alaska, Section of Epidemiology (SOE), 504 (35%) of which were in persons known to have died as of December 31, 2011. During 2011, 61 cases of HIV were reported to the SOE, two of which were in persons known to have died as December 31, 2011. Of those 61 cases, 24 (39%) were initially diagnosed in Alaska. Twelve of the 24 cases diagnosed in Alaska were men who have sex with men (MSM), which continues to be the population at greatest risk for HIV in Alaska.[8]

HIV Impacts women, men, and children from all regions of the state and all socioeconomic backarounds

To address the challenges of the national epidemic, the CDC requires health departments to work with the community and key stakeholders in developing an HIV Prevention Plan. According to the CDC's 2012 *HIV Planning Guidance, "…to achieve the goals of the NHAS, the HIV planning process remains essential. The process involves the identification of the appropriate stakeholders to engage in a process that is results-oriented, in order to ensure that the goals of the NHAS are achieved and that an HIV Plan is developed, implemented, and monitored*."[9]

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[7] Centers for Disease Control and Prevention. *HIV in the United States: At A Glance.* Available at http://www.cdc.gov/hiv/resources/factsheets/PDF/HIV_at_a_glance.pdf. Published March 2012. Accessed August 22, 2012.

[8] Alaska Epidemiology Bulletin. *Summary of HIV Infection- Alaska, 1982-2011.* Available at http://www.epi.hss.state.ak.us/bulletins/docs/b2012_07.pdf. Published March 27, 2012.

[9] [9] Centers for Disease Control and Prevention. *HIV Planning Guidance*. Available at http://www.cdc.gov/hiv/topics/funding/PS12-1201/pdf/HIV_Planning_Guidance.pdf. Published July 2012.

This *2013-2016 Alaska HIV Plan (*the *Plan*) is a collaboration between the health department (HD), HIV planning group (HPG) members, and key stakeholders. The Plan includes a brief description of epidemiological data; identification of priority populations and interventions; a description of existing resources including HIV prevention, care, and treatment resources; gaps in services; and prevention activities being implemented within the State of Alaska.[10]

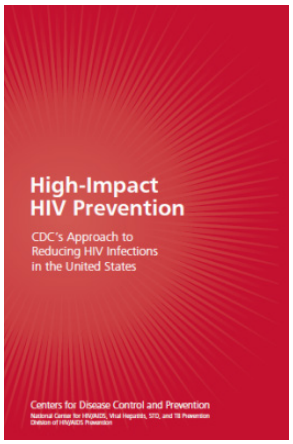
National HIV/AIDS Strategy for the United States and CDC Response

On July 13, 2010, the White House released the National HIV/AIDS Strategy for the United States (NHAS), a document designed to guide the provision of HIV services for the foreseeable future, and that set ambitious goals for the reduction of the domestic impact of HIV. The NHAS established three primary goals:

1) Reduction in the number of people who become infected with HIV
2) Increased access to care and improved health outcomes for people living with HIV
3) Reduction of HIV-related health disparities[11]

To advance the prevention goals of the NHAS and maximize the effectiveness of current HIV prevention methods, CDC pursues a High-Impact Prevention (HIP) approach. By using combinations of scientifically proven, cost-effective Interventions that reach a significant portion of those in need, this approach promises to greatly increase the impact of HIV prevention efforts.[12]

Components of High-Impact Prevention (HIP)



In the HIP approach, HIV prevention efforts are guided by five considerations:

- ***Effectiveness and cost.*** *While all proven interventions may have a place in HIV prevention programs, High-Impact Prevention prioritizes those that are most cost-effective at reducing overall HIV infections. Available cost-effectiveness data strongly supports interventions such as HIV testing and condom distribution. Programs to help people living with HIV avoid transmitting HIV to others are also cost-effective, since it's more effective to target people already infected than to target the general population for prevention efforts.*

[10] Ibid
[11] The White House. *National HIV/AIDS Strategy for the United States*. Available at http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf. Published July 13, 2010.
[12] Centers for Disease Control and Prevention. High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. Available at http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf. Published August 2011.

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

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

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

- ***Prioritization:*** *To put the above considerations into practice, prevention planners need to rigorously assess the potential impact on HIV infections of combining different interventions for specific populations. This will allow for prioritizing the interventions that will have the greatest overall potential to reduce infections.*[13]

To comply with the NHAS and HIP, the CDC, through PS12-1201, re-distributed funding to accommodate jurisdictions with the greatest need. For Alaska, this has meant a significant reduction in funding, approaching a 50% cut by 2016, as compared to 2011 funding levels. In response to this reduction the HIV/STD Program has realigned its funding priorities to direct services to HIV positive and high-risk negative individuals using the CDC-required core components: 1) HIV Testing, 2) Comprehensive Prevention with Positives, and 3) Condom Distribution. Unfortunately, this re-distribution of funding also means defunding of behavioral, outreach, and social marketing/public information interventions.

Priority target populations are identified through the use of epidemiologic data. Based on this data, the State of Alaska is focusing its prevention efforts on five target populations identified as the populations that have been impacted the most by HIV, and therefore at higher risk of transmitting or acquiring HIV. Any HIV prevention programs funded by the State with CDC pass-through funds must incorporate the required core components of HIV prevention for health departments – HIV testing, condom distribution, and prevention with positives – and be

[13] Centers for Disease Control and Prevention. High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. Available at http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf. Published August 2011.

targeted to the priority populations identified through the epidemiologic data. The priority populations for the 2013-2016 planning period, in order of priority, are:

1) HIV Positive Persons
2) Men Who Have Sex with Men (MSM)
3) Injection Drug Users (IDU)
4) High Risk Heterosexual (HRH) Women
5) High Risk Heterosexual (HRH) Men

Detailed information concerning the epidemiology of these priority populations is available in Chapter 3: Epidemiologic Profile. Detailed information concerning risk factors, resources, needs, and gaps in services concerning the priority populations is available in Chapter 4.

In addition to the Category A funding for Prevention Programs for Health Departments described above, PS12-1201 offered Category C funding for Demonstration Projects. Proposed Category C projects could fall into any of five categories: (1) structural, behavioral, and/or biomedical interventions that will have a high impact on reducing HIV incidence; (2) innovative testing activities that increase identification of undiagnosed HIV infections and/or improve the cost effectiveness of HIV testing activities; (3) enhanced linkage to and retention in care for persons with new and prior diagnosis of HIV infection; (4) advanced use of technology or; (5) programmatic and epidemiologic use of CD4, viral load and other surveillance data to assess and reduce HIV transmission risk.

Alaska applied for and received Category C funding for a demonstration project to create a system for enhanced linkage to and retention in care for persons with new and prior diagnosis of HIV infection through use of surveillance data. The Linkage to Care (L2C) demonstration project was implemented in late 2012 and will continue through the three-year Category C funding period.

Organization of the *2013-2016 Alaska HIV Plan*

The *Plan* is organized to incorporate the key components of an HIV prevention plan, as outlined in CDC's 2012 *HIV Planning Guidance*.

Preface: Provides an overview of the impact of the National HIV/AIDS Strategy and Funding Opportunity Announcement PS12-1201 – Comprehensive HIV Prevention Programs for Health Departments on HIV Prevention in Alaska.

Chapter 1 – Introduction: Provides an overview of HIV in Alaska, describes the National HIV/AIDS Strategy and High-Impact Prevention, and identifies priority target populations and interventions.

Chapter 2 – Overview of the Planning Process: Provides an overview of the history and process of HIV community planning.

Chapter 3 – Epidemiologic Profile: Describes the demographics of Alaska, the impact and the epidemiology of the HIV epidemic, and the geographic distribution of infection across the state.

Chapter 4 – Resources, Indication of Need, and Gaps in Service: Provides an overview of prevention, care, and treatment resources, needs and gaps in services.

Chapter 5 – Priority Populations, Interventions, and Recommendations: Focuses on a set of populations identified for prevention efforts through epidemiologic data, CDC-required interventions for each priority population, and recommendations for other prevention and care interventions not to be funded with State HIV Prevention funds.

Chapter 6 – Goals, Objective, Activities, and Recommendations: Describes goals, objectives, and activities for a statewide strategic HIV plan developed by the HIV Planning Group (HPG), HIV/STD Program, and key community stakeholders. In addition, recommendations for capacity building, technical assistance, and needs assessments are described.

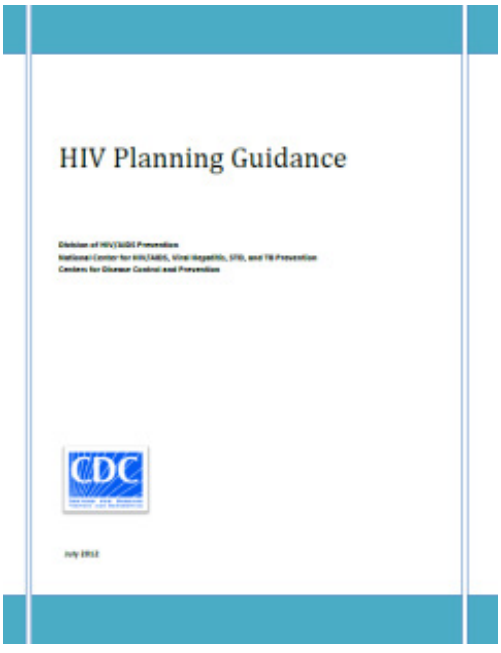
Chapter 2
Overview of the Planning Process

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 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. 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 HIV plan that best represents the needs of populations at risk for, or infected with, HIV/AIDS. In 2012 the planning process was expanded to include HIV prevention, care and treatment and the planning group was renamed the HIV Planning Group (HPG) to reflect the expanded focus of planning activities.

HIV Planning Process

According to CDC's new *HIV Planning Guidance* released in July 2012, "In order to achieve the goals of NHAS, the HIV planning process remains essential.[14]



[14] Centers for Disease Control and Prevention. *HIV Planning Guidance*. Available at http://www.cdc.gov/hiv/topics/funding/PS12-1201/pdf/HIV_Planning_Guidance.pdf. Published July 2012.

HIV Planning Process[15]

Step 1: Stakeholder Identification

Objective 1:
By the end of each project year, the HD and HPG will identify and implement various strategies to recruit and retain HPG members, targeting participants in the HIV planning process that represent the diversity of HIV-infected populations, other key stakeholders in HIV prevention and care and related services.

Activity:
Identify community members, key stakeholders, and other HIV service providers involved in HIV prevention, care, and treatment services to participate in a comprehensive engagement process.

Principles:
- Planning processes should align with, and support, the NHAS and HIP.
- The HIV planning group should reflect the local epidemic by involving representatives of populations with high prevalence of HIV infection and should include HIV service providers.
- HPGs and HDs will assess representation and participation of HPG members, HIV service providers, and key stakeholders involved in the planning process to ensure optimal participation.

Step 2: Results-oriented Engagement Process

Objective 2:
By the end of the project year, the HPG will develop strategies for increasing coordination across HIV programs. The HD will implement this mutual strategy that results in a seamless approach to accessing HIV prevention, care, and treatment services for the highest-risk populations.

Activity:
Develop a mutual strategy that results in greater access to HIV prevention, care, and treatment services for the most disproportionately affected populations and moves the jurisdiction towards a greater reduction in HIV incidence and HIV-related health disparities.

Principles:
- HDs and HPGs must work collaboratively to develop strategies that will increase access to HIV prevention, care, and treatment services.
- HPGs should identify, encourage, and facilitate the participation of key stakeholders and HIV service providers, particularly those not represented on the HPG, who can best inform and support the goals of the HIV planning process.

Step 3: Jurisdictional Plan Development, Implementation and Monitoring

Objective 3:
By the end of the project year, HPGs and HDs will elicit input on the development (or update) and implementation of the HIV Plan from HPG members, other stakeholders, and providers.

Activity:
Inform and monitor the development (or update) and implementation of the HIV Plan to ensure that the plan is progressing towards reducing HIV incidence and HIV-related health disparities.

Principles:
- HDs and HPG members must engage other key stakeholders and providers (non-members of the HPG) who can best inform the development and implementation of the plan.
- HDs and HPGs should make every effort to engage all key stakeholders and providers since their participation in the planning and implementation processes is vital to reducing HIV incidence.
- HPG members should promote and support, as appropriate and feasible, the implementation of the HIV Plan in conjunction with the HD.

[15] Ibid

Responsibilities of the Health Department and HIV Planning Group[16]

Health Department

- Create and maintain at least one HIV planning group (HPG) that meets the objectives and principles of the *HIV Planning Guidance.* Appoint the Health Department co-chair.
- Develop the Alaska HIV Plan with input from the HPG and other key stakeholders.
- Ensure that the HPG has access to current HIV prevention information and analyses of data which may have implications for HIV information, to include surveillance data, program information and research, and the best available science.
- Develop the application for HIV prevention cooperative agreement funds (PS12-1201).
- Provide the HPG with information on the application, including how it meets the goals and objectives of the NHAS and Division of HIV/AIDS Prevention (DHAP).
- Regularly inform the HPG on the successes and barriers in implementing the HIV services identified in the *Plan.*

HIV Planning Group

- Elect a community co-chair.
- Recruit and approve new members that represent the community and key stakeholders.
- Inform the development or update of the Alaska HIV Plan.
- Submit a letter of concurrence, concurrence with reservations, or non-concurrence.

Due to re-aligned priorities and reduced funding levels, the HIV/STD Program has lessened the role of the HPG, reduced meeting frequency, and increased the use of teleconferencing as opposed to in-person meetings. With the NHAS recommending re-distribution of funds and PS12-1201 focusing on required elements (such as HIV testing, comprehensive prevention with positives, and condom distribution) the HPG has a reduced role in planning HIV prevention activities because the HIV/STD Program does not have sufficient funding for recommended activities identified in PS12-1201.

However, the HPG still plays a significant role in the HIV planning process. The HPG continues to meet at least once per quarter (one in-person meeting per year, the remainder through teleconference or webinar). As each chapter of the *Plan* was developed it was sent to each

[16] Ibid

member of the HPG for review and input. Even though the structure and responsibilities of the HPG has changed, HPG members can continue to play a vital role in developing the Plan, especially in identifying HIV resources and gaps in services. And, most importantly, HPG members along with key stakeholders in the community assisted in developing goals, activities, and recommendations for HIV prevention activities that do not utilize CDC pass-through funding. For example, the last several Plans have recommended syringe exchange programs (SEP) as an HIV prevention intervention, even though federal funds cannot be used to implement or conduct SEPs. The defunding of prevention interventions targeting of MSM, IDU, and HRH emphasizes the importance of strong and clear recommendations for HIV prevention activities funded by other than CDC pass-through funds. The HPG's feedback was instrumental in developing the *Plan.*

In 2011, the HPG, in collaboration with the HIV/STD Program, revised the by-laws reflecting their new roles and responsibilities. In addition, the HPG was instrumental in recruiting and approving three new members in 2012. These new members represent vast experience in dealing with risk populations, HIV prevention, and hepatitis C programming.

At the time the *Plan* was drafted, the HPG was composed of the following members:

* Alex Barros, Anchorage
* Victor Carlson, Anchorage
* Gloria Eldridge, Anchorage
* Tim (Sigvold) Juliussen, Community Co-Chair, Anchorage
* Tiffany McClain, Anchorage
* Ginger Provo, Anchorage
* Brenda Reichenberg, Fairbanks
* Inna Rivkin, Fairbanks, Assistant Professor of Psychology, University of Alaska Fairbanks
* Samuel Senft, Health Department Co-Chair, Anchorage
* Simon Tony-Abraham, Toksook Bay

The HIV/STD Program strives to organize a diverse planning group, guided by the fundamental tenets of HIV planning described in the *HIV Planning Guidance*: parity, inclusion and representation.

The HPG seeks input from populations at increased risk, service providers, experts in related fields, and interested others. HPG meetings are open to the public and each full meeting includes a public comment period. Meeting dates are advertised on the HPG website at http://www.epi.hss.state.ak.us/hivstd/hppg and advertised through HIV Prevention Listserv announcements. Other individuals and agency representatives are invited to participate in HPG meetings where their expertise is particularly relevant.

We hope that the *2013-2016 Alaska HIV Plan* proves useful to community-based organizations, other prevention providers, and members of the public. We welcome your comments and suggestions regarding the *Plan's* content, and HIV prevention, care, and treatment in Alaska in general.

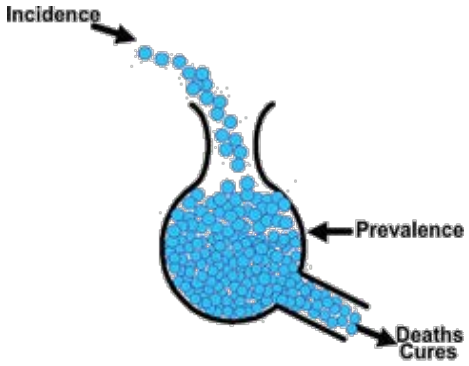
Chapter 3
Epidemiologic Profile

This chapter describes the general population of Alaska, HIV-infected persons living in Alaska, and persons at risk for HIV infection. The data presented herein serves to guide prevention, care and treatment efforts, to justify and assist in obtaining funding for the implementation of prevention and service programs, and to evaluate programs and policies throughout Alaska.

Notes on Epidemiology

Definitions

As illustrated in the figure at right: Incidence is the number of new cases of a disease in a specified population over a specified period in time. Prevalence is the number of affected persons in the population at a given point in time.



Accessed at: http://quizlet.com/2621588/tjd_epi-flash-cards/

Rate is the number cases of HIV in a given population at a given point of time. Rate is calculated as the number of cases per 100,000 population. Rates are useful in comparing disease in different populations or areas. An example would be to compare the number of HIV cases in two different cities. City A has a population of 1,000 with 10 cases of persons living with HIV (PLWH); city B has a population of 10,000 with 10 cases of PLWH. City A would have a rate of 1,000 cases of PLWH per 100,000 population; City B would have a rate of 100 cases of PLWH per 100,000 population.

Percentage is the number of cases in a specified time period divided by the size of the population. In the example given above 10% of the population in City A is PLWH; City B, 1%.

Interpreting Trends in Alaska

Important note on interpreting percentages and rates in this document:

Alaska is a low incidence state and many subgroups have a small number of events each year. Both small numerators and denominators can make interpretation of results difficult. To help control for these random variations which occur from year to year, most data are shown in either 5-year or 10-year aggregates. Even using aggregate data, many of the subgroups discussed in this document, particularly females, youth aged 14 years and younger, and most

races, contain fewer than 20 events. Therefore, many changes in percentages and rates presented in this document should be interpreted with caution.

For example, an analysis of new cases of HIV among females in Alaska might initially suggest that HIV is increasing in this population. Since 1982, the proportion of diagnosed cases of HIV in Alaska in females has more than doubled, from 12% to 27%. At first glance this appears significant. However, in reality, from 1992 to 2011, the average number of diagnosed cases in females per decade has actually decreased, from 11 to 9. The increase in the proportion of cases in this instance is in actuality due to a decrease in the number of cases in the male population over time.

Newly Diagnosed vs. Newly Infected

Newly diagnosed with HIV does not mean newly infected with HIV. It is important to emphasize that while a person may be newly diagnosed with HIV it is usually not possible to determine at what point infection occurred.

Sociodemographic Characteristics of the Population

Population Demographics

Alaska is comprised of eighteen boroughs and eleven U.S. Census-defined census areas[17], with populations ranging from 646 persons in Yakutat City and Borough to 295,570 persons in the Anchorage Municipality (Table 1; Figure 1). The latter represents 38% of Alaska's population. Alaska's major cities in order of descending populations are Anchorage (pop. 295,170), Juneau (pop. 32,164), and Fairbanks (pop. 32,036).

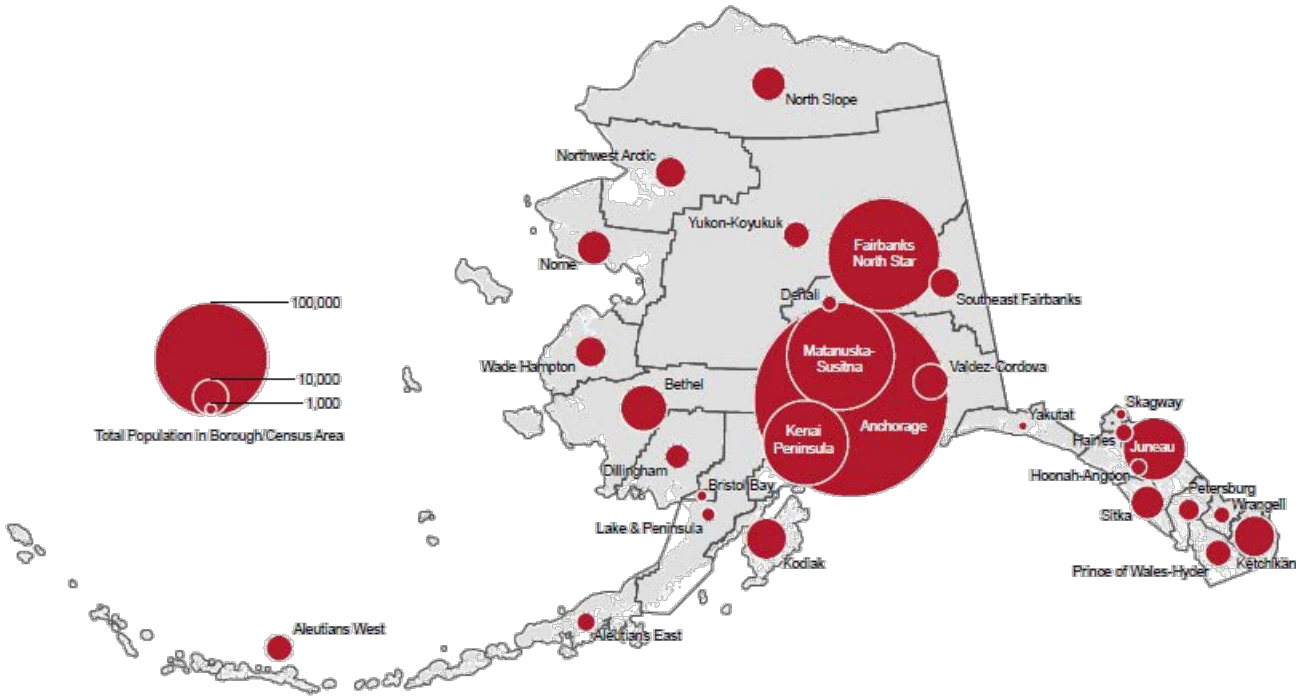
Alaska's population varies considerably by geographic region. One borough (Northwest Arctic) and three census areas (Bethel, Nome, and Wade-Hampton) are more than 75% Alaska Native. Conversely, ten boroughs (Denali, Fairbanks North Star, Haines, Juneau, Kenai Peninsula, Ketchikan Gateway, Kodiak Island, Matanuska-Susitna, Sitka, and the Anchorage Municipality) and four census areas (Aleutians West, Southeast Fairbanks, Valdez-Cordova, and Wrangell-Petersburg) are more than 75% non-Native. The Municipality of Anchorage has the highest absolute number of American Indians or Alaska Natives (AI/AN) with 24,237, or 22.5% of the AI/AN population. The overall racial and ethnic breakdown of the Alaska population is: 67.9% White, 3.6% Black, 14.9% American Indian/Alaska Native, 5.5% Asian; 1.1% Native Hawaiian/Pacific Islander, and 7% Multi-Race. Of the total Alaska population by race, 5.8% are of Hispanic ethnicity.[18]

[17] Alaska Department of Health and Social Services, *Alaska BRFSS Health Profiles: Boroughs/Census Areas.* Available online at: http://www.hss.state.ak.us/dph/infocenter/ia/brfss/census.htm. Accessed September 30, 2012 .
[18] US Census Bureau. State & Country QuickFacts: Alaska. Available online at http://quickfacts.census.gov. Accessed August 23, 2012.

Table 1: Estimated Population by Race, Ethnicity, and Borough/Census Area[19]								
Borough/Census Area	**Total Population**	**%White**	**%Black**	**%AI/AN**	**%Asian**	**%NH/PI**	**%More than 1**	**%Hispanic**
Aleutians East	3,172	25.1%	7.4%	25.2%	37.8%	0.6%	3.9%	12.8%
Aleutians West	5,504	41.3%	6.8%	15.4%	30.0%	2.0%	4.6%	14.0%
Anchorage Municipality	295,570	67.6%	5.9%	8.2%	8.4%	2.1%	7.7%	7.9%
Bethel	17,416	12.0%	0.6%	81.7%	1.0%	0.2%	4.5%	1.4%
Bristol Bay	1,030	48.9%	0.2%	32.6%	0.9%	0.3%	17.1%	2.8%
Denali	1,855	90.0%	0.9%	3.7%	1.1%	0.1%	4.3%	2.6%
Dillingham	4,975	19.2%	0.4%	70.7%	0.7%	0.1%	8.9%	2.3%
Fairbanks North Star	99,192	78.2%	5.0%	7.2%	2.8%	0.4%	6.4%	6.3%
Haines	2,554	83.2%	0.6%	9.4%	0.8%	0.0%	5.9%	2.3%
Hoonah-Angoon	2,112	48.1%	0.5%	40.3%	0.7%	0.0%	10.4%	3.8%
Juneau City and Borough	32,164	70.7%	1.2%	12.0%	6.1%	0.7%	9.3%	5.4%
Kenai Peninsula	56,293	85.0%	0.6%	7.5%	1.2%	0.3%	5.4%	3.2%
Ketchikan Gateway	13,593	68.7%	0.7%	14.3%	7.1%	0.2%	8.9%	4.3%
Kodiak Island	13,872	57.6%	1.1%	13.4%	19.9%	0.8%	7.2%	7.9%
Lake and Peninsula	1,668	25.1%	1.1%	62.5%	0.3%	0.3%	10.7%	3.3%
Matanuska-Susitna	91,946	85.1%	1.2%	5.8%	1.4%	0.3%	6.3%	3.9%
Nome	9,856	17.4%	0.5%	74.6%	1.1%	0.1%	6.2%	1.6%
North Slope	9,503	34.1%	1.2%	53.4%	4.8%	1.2%	5.3%	3.0%
Northwest Arctic	7,733	12.3%	0.6%	80.1%	0.6%	0.2%	6.2%	1.1%
Petersburg	3,838	71.1%	0.9%	16.3%	2.8%	0.2%	8.8%	3.9%
Prince of Wales-Hyder	5,737	50.5%	0.5%	39.6%	0.5%	0.4%	8.6%	2.8%
Sitka City and Borough	8,952	66.7%	0.8%	17.1%	6.0%	0.4%	9.0%	5.0%
Skagway Municipality	935	91.2%	0.2%	3.7%	0.5%	0.1%	4.2%	2.8%
Southeast Fairbanks	7,132	80.9%	1.4%	11.5%	1.0%	0.4%	4.7%	3.7%
Valdez-Cordova	9,770	74.1%	0.8%	13.4%	4.1%	0.6%	6.9%	3.9%
Wade Hampton	7,662	3.9%	0.2%	93.3%	0.3%	0.0%	3.3%	0.2%
Wrangell City and Borough	2,382	72.4%	0.2%	16.0%	1.4%	0.0%	9.9%	1.7%
Yakutat City and Borough	646	41.5%	0.3%	35.6%	5.0%	2.0%	15.6%	2.8%
Yukon-Koyukuk	5,656	22.7%	0.4%	70.2%	0.3%	0.1%	6.3%	1.4%
Alaska TOTAL	**722,718**	**67.9%**	**3.6%**	**14.9%**	**5.5%**	**1.1%**	**7.0%**	**5.8%**

[19] Ibid

Figure 1: Total Population by Borough/Census Area



Produced by: Alaska Department of Labor and Workforce Development, Research and Analysis Section
Source: 2010 US Census

As of July 1, 2011 the Alaska Department of Labor and Workforce Development (AKDOL) estimated the population of Alaska to be 722,190. Of those, 375,331 (52%) were male and 346,859 (48%) were female (Table 2). Alaska's population is younger on average compared to the U.S as a whole. The U.S. Census Bureau reports that the median age for Alaska residents is 34.1 years of age,[20] compared to 37.2[21] for U.S. residents. Over 50% of the Alaska population is under 35 years of age and 26.1% of the population in Alaska is under 18 years of age, well below the U.S. averages. The overall youth of Alaska's population plays an important role in sexually transmitted disease trends in the State, as younger persons tend to have more sexual partners and acitivity. This not only impacts the number of new cases of disease reported each year, but as the population ages, can significantly impact the long term need for comprehensive HIV prevention, care, and treatment services.

Table 2: Estimated Distribution of Alaska Population by Gender and Age [22]

Age Group	# Male	% Male	# Female	% Female	Total	Percent
<15	81,095	21.6%	76,716	22.1%	157,901	21.9%
15-24	56,399	15.0%	49,276	14.2%	105,675	14.6%
25-34	56,526	15.1%	51,189	14.8%	107,715	14.9%
35-44	47,838	12.7%	44,119	12.7%	91,957	12.7%
45-54	56,501	15.1%	52,364	15.1%	108,865	15.1%
55-64	48,111	12.8%	43,149	12.4%	91,260	12.6%
65+	28,861	7.7%	29,956	8.6%	58,817	8.1%
TOTAL	**375,331**	**100%**	**346,859**	**100%**	**722,190**	**100%**

[20] U.S. Census Bureau, *Population Estimates (April 1, 2010 to July 1, 2011).* Available online at http://www.census.gov/popest/data/state/asrh/2011/SC-EST2011-02.html. Accessed August 28, 2012,
[21] U.S. Census Bureau, *Age and Sex Composition: 2010.* Available online at http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf. Accessed August 28, 2012.
[22] Alaska Department of Labor and Workforce Development, *2011 Population Estimates,* Available online at: http://labor.alaska.gov/research/pop/popest.htm.

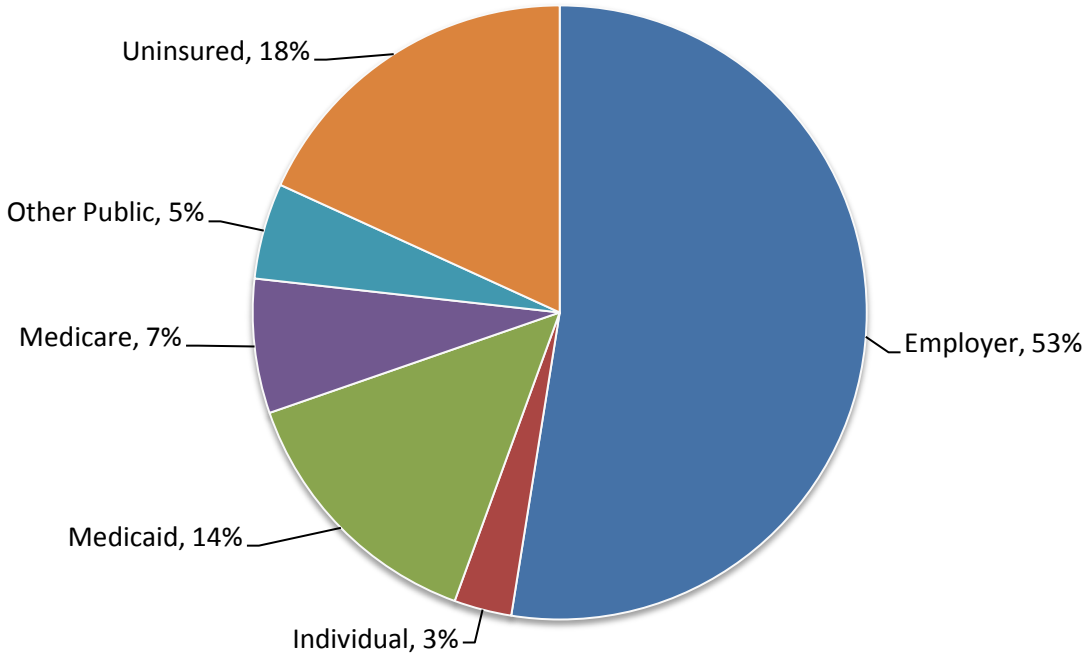
Social Determinants of Health

Health Insurance

In 2010-2011, 18% of Alaskans were reported to not have any form of health insurance (see Figure 2). Of those Alaskans who did have health insurance, the majority (52%) received coverage through their employer.[23]

Lack of insurance and the inability to pay for medical services and medications is one of the most commonly cited barriers to accessing health care by HIV-positive individuals.[24] Some HIV-positive individuals who need assistance in paying for medical visits, health care and medications associated with their HIV infection are eligible to receive health insurance assistance through Ryan White Part B funded agencies . However, of the 308 clients currently enrolled in Ryan White CARE Programs in Alaska, 89 (28.9%) do not have health insurance.

Figure 2. Health Insurance Coverage of the Total Population – Alaska, 2010-2011



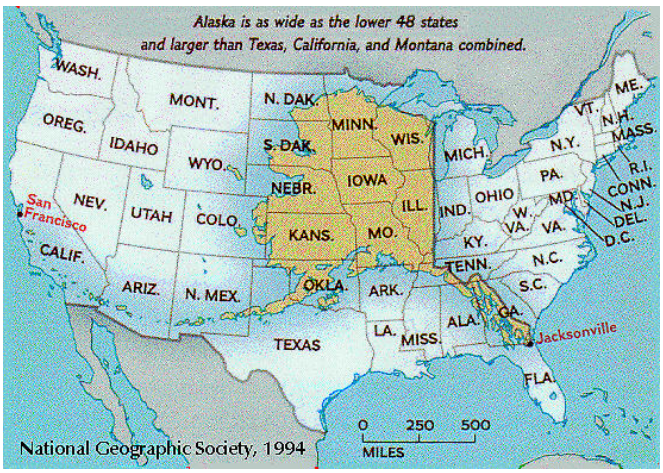
[23] Kaiser Family Foundation, *State Health Facts, Alaska Health Insurance Coverage of the Total Population (2010-2011).* Available online at: http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=3&ind=125&sub=39. Accessed on November 21, 2012.

[24] 2011 Alaska Statewide Coordinated Statement of Need

Geography

In Alaska, geography remains a key barrier to health care service delivery. With a total area of 663,268 square miles and larger than Texas, California and Montana combined, Alaska is as wide as the entire United States, stretching a length equivalent to the distance from San Francisco, California to Jacksonville, Florida (Figure 3). Further complicating service delivery in Alaska is the fact that *82% of Alaska's communities are NOT connected to a highway or road system.*[25]

Figure 3: Alaska's size versus the contiguous U.S.

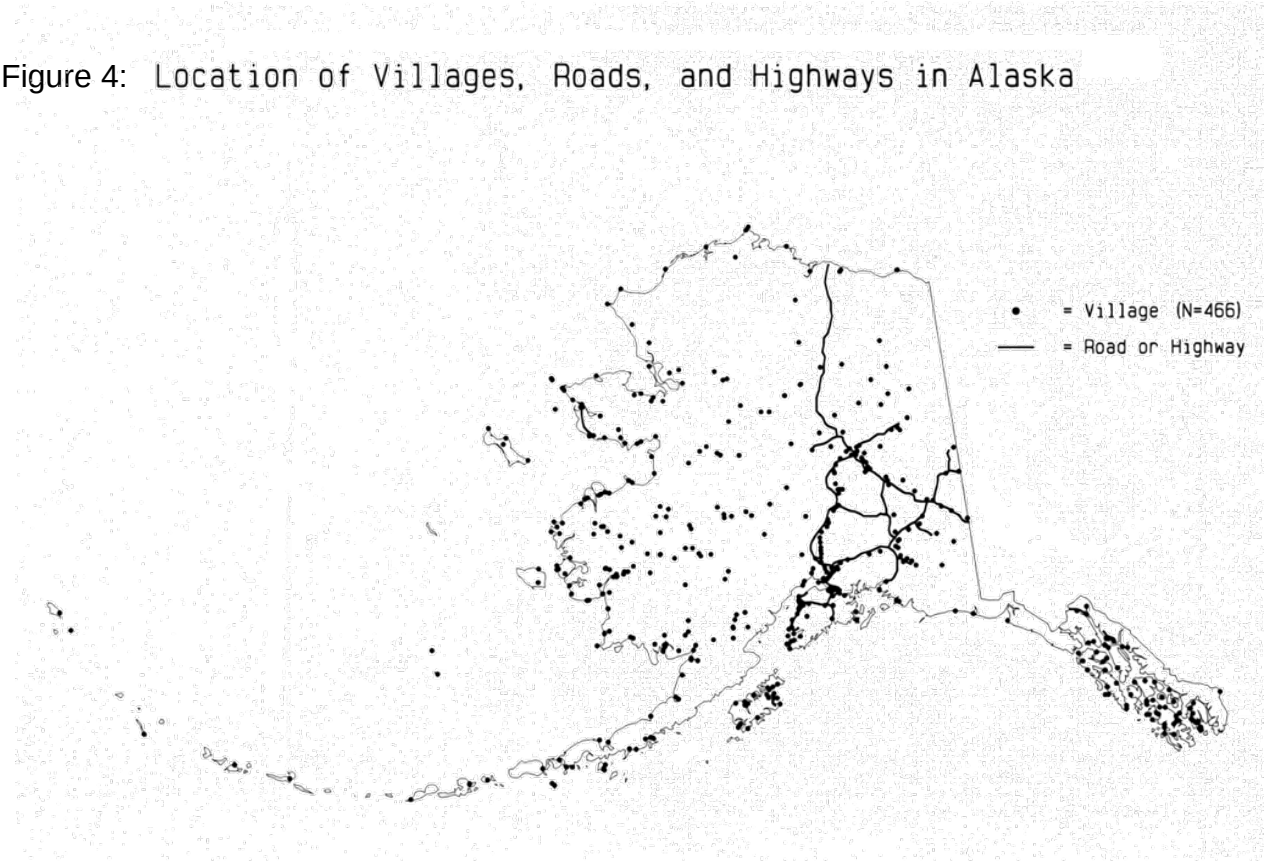


The difficulty in providing HIV services in Alaska is demonstrated by the hypothetical example of a newly diagnosed case of HIV in Barrow, the northernmost point in the State.

In order to receive services, the newly diagnosed person must often travel to Anchorage, 725 miles south, the equivalent of traveling from Atlanta, Georgia to Detroit, Michigan. Road access in northern Alaska is extremely limited, and no road connects Barrow to the state highway system (Figure 4). Due to lack of commercial carriers and the small population served, flights are often expensive, ranging in cost from several hundred to one thousand dollars. Flight delays and interuptions due to seasonal weather are also common, making a single doctor's appointment a potentially time consuming and expensive venture.

[25] Alaska Department of Transportation and Public Facilities, *Did You Know…?*, Available online at: http://dot.alaska.gov/comm/legislative/v1_i3.html.

Figure 4: Location of Villages, Roads, and Highways in Alaska



HIV Testing in Alaska

From April 1, 2011 to March 31, 2012, the State Virology Laboratory (SVL) conducted 10,246 HIV tests. The SVL provides conventional HIV antibody and confirmatory tests at no cost to public and private providers. An additional 1,697 HIV rapid tests were provided by the Alaska HIV/STD Program and its contracted providers (Alaskan AIDS Assistance Association, Municipality of Anchorage, and Interior AIDS Association) using CDC HIV Prevention funds. The non-clinical rapid testing conducted and funded by the HIV/STD Program was targeted to high-risk populations such as sexual and needle-sharing partners of HIV positive individuals, MSM, IDU, and high-risk heterosexuals (HRH) in venues such as correctional facilities, substance abuse treatment centers, homeless shelters, and gay bars. Of the total 11,943 tests conducted, 18 (.15%) were positive; 13 from SVL, 3 from HIV partner services, and 2 from non-clinical testing conducted by HIV/STD Program contractors. The testing explained above does not describe all the testing conducted in Alaska, as the state does not have access to testing data from private laboratories when the test result is negative. The state also lacks access to rapid testing data that is not conducted or funded by the HIV/STD Program when the result is negative.

According the Alaska Behavioral Risk Factor Survey (BRFSS), in 2011, 46.7% of Alaskan adults aged 18-64 reported ever having had an HIV test. Since 1993, Alaska has had a consistently higher prevalence of having an HIV test than the national median. In 2009, 50% of Alaska adults age 18 to 64 years reported ever having an HIV test, compared to 39% of U.S. adults.[26]

Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) indicate that in 2007, 2008, 2009, and 2010, respectively, 71.8%, 74.7%, 72.7%, and 68.3% of women delivering live births in Alaska reported that their prenatal care providers discussed HIV testing with them (Table 3).[27]

Table 3. Percentage of Females Delivering Births in Alaska Reporting that Their Prenatal Care Providers Discussed HIV Testing with Them

Response	2007	2008	2009	2010
Yes	71.84	74.74	72.70	68.27
No	24.68	22.84	24.68	29.26
Skip	0.93	0.67	1.02	0.40
Blank	2.55	1.74	1.60	2.07

[26] State of Alaska. Division of Public Health. *2009 Annual Report. Alaska Behavioral Risk Factor Survey*. Available at: http://dhss.alaska.gov/dph/Chronic/Documents/brfss/pubs/BRFSS09_FullReport.pdf. Published December 2011.
[27] Memorandum from Section of Women's, Children's, and Family Health, Alaska Department of Health and Social Services, October 2012.

In 2007, 2008, 2009, and 2010, respectively, 58.1%, 58%, 55.2%, and 51.9% of women delivering live births in Alaska reported knowledge of having an HIV test during their pregnancy or delivery (Table 4)[28]

Table 4. Percentage of Females Delivering Live Births in Alaska Reporting an HIV Test During Pregnancy

Response	2007	2008	2009	2010
Yes	58.08	58.00	55.19	51.89
No	26.84	24.00	27.70	29.42
Don't know	13.73	16.62	15.60	16.76
Blank	1.36	1.39	1.51	1.93

Early Detection of HIV

From 2006-2011, 36% of individuals with an Alaska residence at the time of initial diagnosis are known to have developed AIDS within 12 months of initial HIV diagnosis. This indicates diagnosis late in the course of HIV disease. According to the CDC, comparable data for the U.S. show that of all HIV infection diagnosed in 2008, 32% of individuals received an AIDS diagnosis within 12 months of initial HIV diagnosis.[29] Early disease detection is critical, as an individual diagnosed at 25 years of age can be expected to survive on average 39 more years, compared to 10 years without treatment. Also, individuals diagnosed late in the course of HIV disease may have infected others before they knew they were infected.[30]

Scope of the HIV/AIDS Epidemic in Alaska

Cumulative Cases

From January 1, 1982 through December 31, 2011, 1,458 cases of HIV were reported to the Alaska Section of Epidemiology (AKSOE), 1,130 of which were initially diagnosed in Alaska and 504 (35%) in individuals who are known to have subsequently died.[31] Alaska cases are defined as individuals who claim residency within the state of Alaska at the time of diagnosis. Data summarizing characteristics of these Alaska cases follow, and should be interpreted in the context of cumulative knowledge about HIV/AIDS. For the purposes of this *Plan*, the following data are based on the cases initially diagnosed in Alaska (1,130); and, unless noted, come from HIV/AIDS surveillance data provided by the AKSOE.

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[28] Memorandum from Section of Women's, Children's, and Family Health, Alaska Department of Health and Social Services, October 2012.

[29] CDC. *HIV in the United States: An Overview*. Available at: http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/us_overview.pdf. Published March 2012.

[30] CDC. *Vital Signs: HIV Testing in the U.S.* Available at: http://www.cdc.gov/nchhstp/newsroom/docs/Vital-Signs-Fact-Sheet.pdf. Published December 2010.

[31] State of Alaska. Alaska Epidemiology Bulletin. *Summary of HIV Infection- Alaska, 1982-2011*. Available at http://www.epi.hss.state.ak.us/bulletins/docs/b2012_07.pdf. Published March 27, 2012.

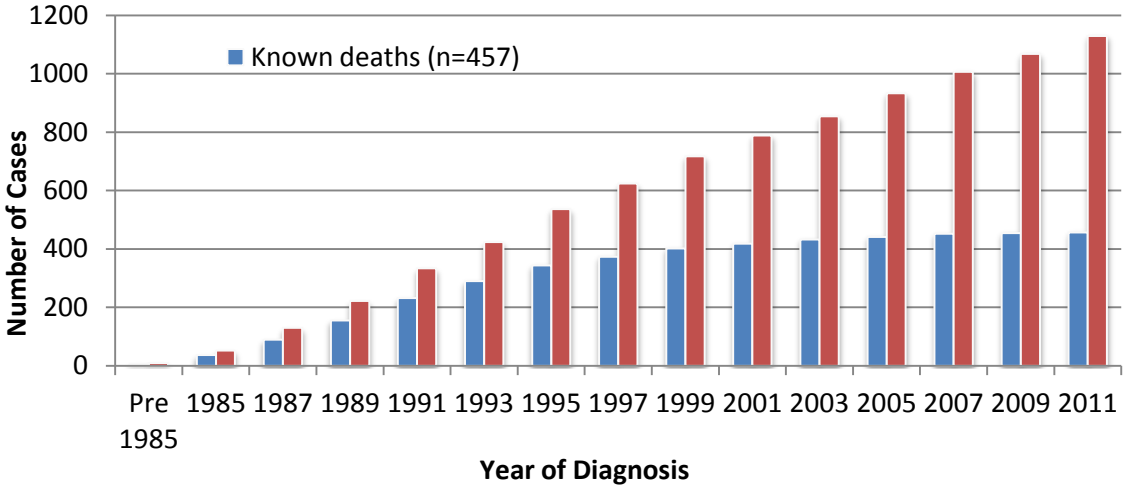
From 1982 through 2011, a total number of 1,130 cases of HIV and AIDS were reported to the AKSOE (Table 5). Of those cases, an estimated 673 HIV/AIDS cases are not known to have died. HIV cases with AIDS and HIV cases without AIDS have been reported separately to better illustrate disease status at diagnosis. It should be noted that not all reported deaths have necessarily been caused by HIV infection; persons living with HIV/AIDS may die due to other causes.

Table 5. Cumulative Alaska HIV/AIDS Cases Reported to the Alaska Section of Epidemiology, 1982-2011, (N=1,130)

	HIV & AIDS Cases Reported in Alaska	HIV/AIDS Cases Not Known to Have Died	HIV & AIDS Cases Known to Have Died
HIV Cases with AIDS	785	374 (48%)	411 (52%)
HIV Cases without AIDS	345	299 (87%)	46 (13%)
Total	**1,130**	**673**	**457**

Of the original 1,130 cumulative cases of HIV and AIDS, 457 are known to have died (Figure 5). To better illustrate case mortality, a death in a person with HIV is shown in the year the case was first diagnosed. On average, 34 HIV/AIDS cases were newly diagnosed between 2002 and 2011, a decline from 45 new cases per year between 1992 and 2001. In addition, advances in medical technology and medications used in the treatment of HIV/AIDS have progressed, resulting in better treatment outcomes for HIV-positive individuals. This decline in deaths among HIV-positive individuals, combined with the ongoing occurrence of new infections, has resulted in a steady increase in the number of persons living with HIV in Alaska. The need for medical care, supportive services, and ongoing prevention will continue to grow as persons with HIV live longer, healthier lives.

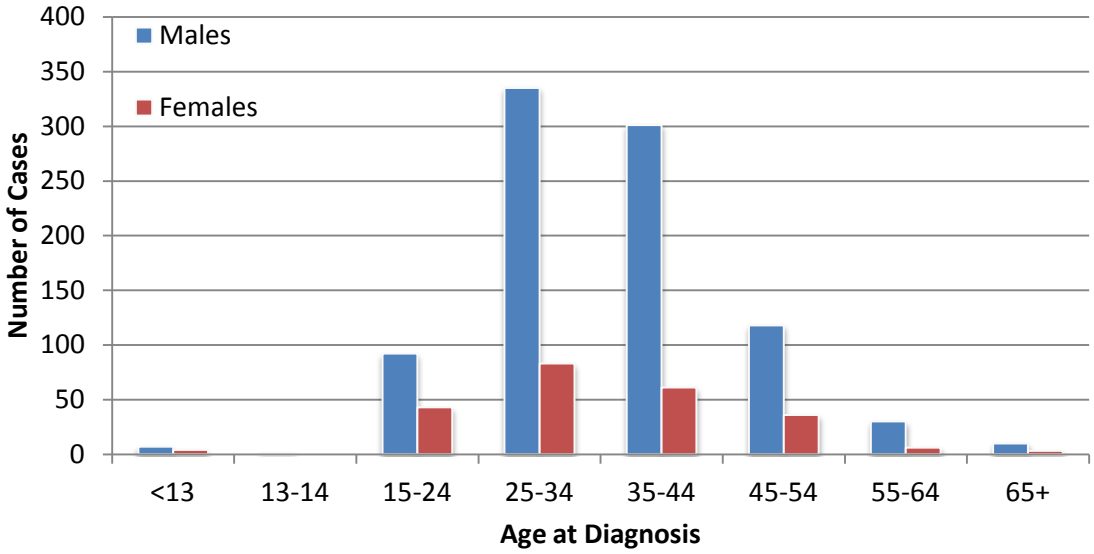
Figure 5. Cumulative HIV Cases and Known Deaths by Year of First Known HIV Diagnosis – Alaska, 1982-2011 (N=1,130)



Age

Of the total cumulative HIV/AIDS cases reported to the State of Alaska Section of Epidemiology, the greatest number were in persons aged 25-44 years at initial diagnosis (n=780; 69%). This varies from national trends where in 2009 young persons aged 13-29 accounted for 39% of all new HIV infections in the U.S.[32] Relatively few cases are reported among young persons in Alaska: 12 (1%) cases were aged 0-14 and 135 (12%) were aged 14-24 at the time of initial HIV diagnosis (Figure 6).

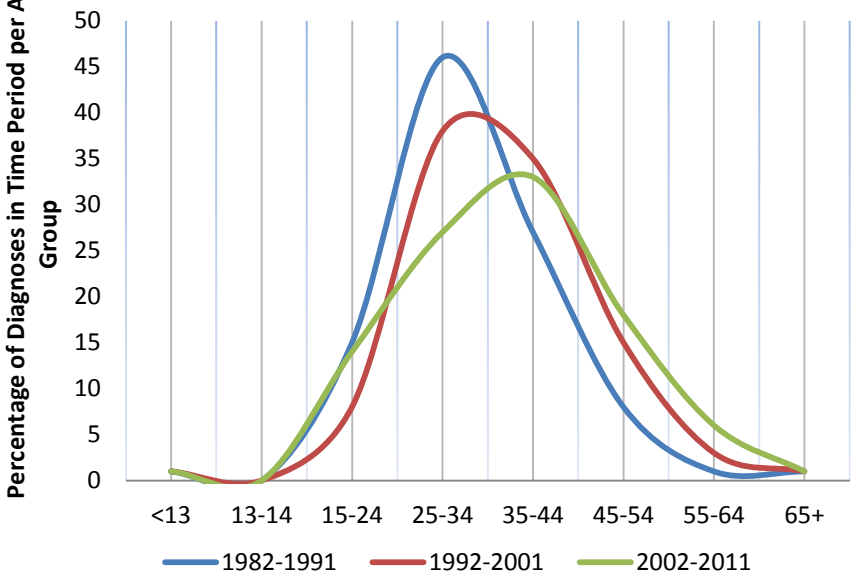
Figure 6. Cumulative HIV Cases (with and without AIDS) by Age at First Known HIV Diagnosis – Alaska, 1982-2011 (N=1,130)



[32] CDC. *HIV among Youth*. Available at: http://www.cdc.gov/hiv/youth/pdf/youth.pdf. Published December 2011. Accessed on August 29, 2012.

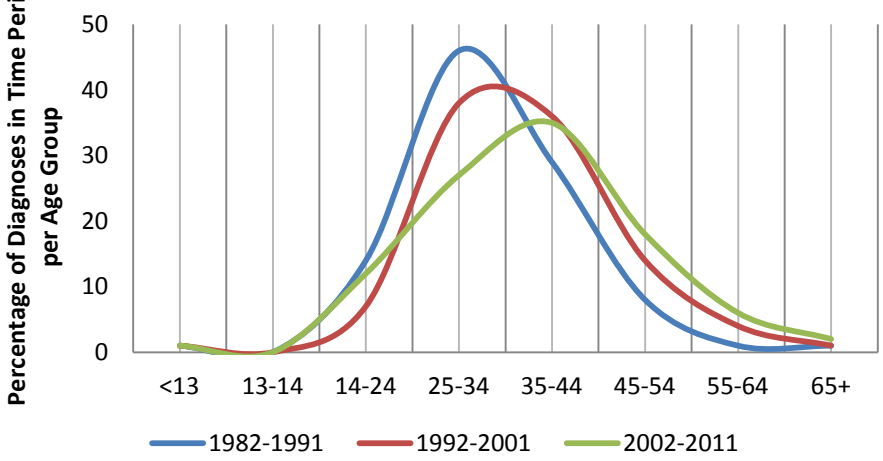
In Alaska, age at initial HIV diagnosis has been gradually increasing since data collection began. From 1982-1991 the majority of newly diagnosed cases in the state were in individuals ages 25-34 years. By 2002-2011 the average age of diagnosis had increased to 35-44 (Figure 7). This shift in demographic trends may be attributed to the gradual aging of Alaska's population, as well as the positive effect improved medical treatment and medications have on life expectancy of people living with HIV/AIDS.

Figure 7. Percentage of HIV/AIDS Diagnoses by Age Group, Both Genders -- Alaska, 1982-2011 (N=1,130)



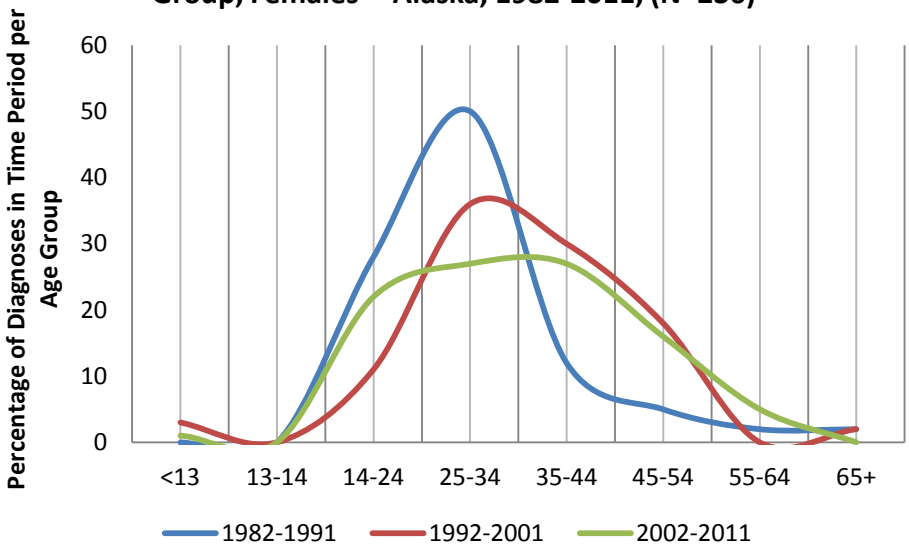
Trends in HIV diagnosis in males have remained relatively steady over time and are similar to the trends for both genders combined, in that the average age of new diagnoses has gradually moved upward from the 25-34 age group to the 35-44 age group (Figure 8).

Figure 8. Percentage of HIV/AIDS Diagnoses by Age Group, Males -- Alaska, 1982- 2011, (N=894)



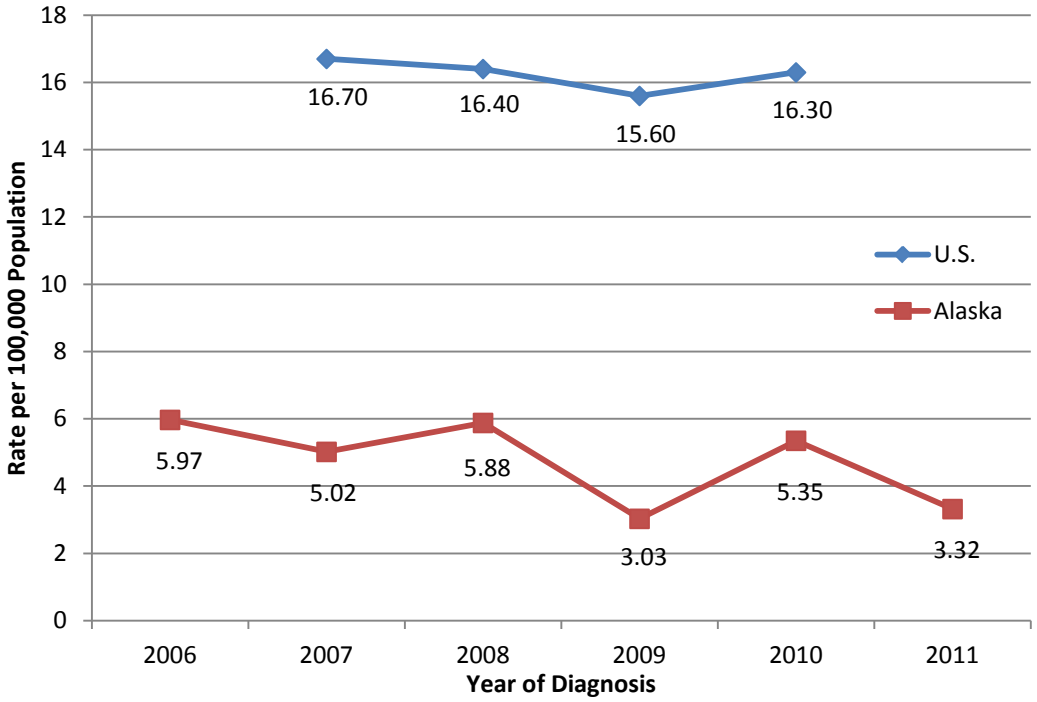
While in 1982-1991 and 1992-2001 trends in HIV diagnosis in females were similar to their male counterparts, in 2002-2011 the trend shifted to be fairly evenly distributed in the 14-24, 25-34, and 35-44 age groups (Figure 9). This change may be attributed to random variation and the small number of cases diagnosed.

Figure 9. Percentage of HIV/AIDS Diagnosis by Age Group, Females -- Alaska, 1982-2011, (N=236)



HIV incidence in Alaska remains well below the 2010 national average of 16 per 100,000 population (Figure 10)[33]. Alaska incidence rates have varied in the past five years from 3.03 to 5.97 cases per 100,000. However, year-to-year trends in HIV incidence in Alaska are not very instructive due to the small number of cases, though the difference between the Alaska and U.S. trends is significant. It is important to note that in Alaska HIV incidence rates are based on cases reported in individuals who were Alaska residents at their first known date of diagnosis.

Figure 10. HIV Incidence Rates (with and without AIDS), 2006-2011, Alaska and the U.S.



[33] Estimated U.S. rates were calculated from CDC data on HIV/AIDS incidence for the 46 states and 5 U.S. dependent areas with confidential HIV reporting as published in the *HIV/AIDS Surveillance Report,* 2010, Volume 22, Table 1b. Available online at http://www.cdc.gov/hiv/surveillance/resources/reports/2010report/index.htm.

Gender

Due to the small number of new HIV cases diagnosed in Alaska each year, the average number and proportion of new HIV cases in the state are presented in 10-year aggregate time periods (Table 6)

Females – Of the 1,130 cumulative HIV cases initially diagnosed in Alaska and reported through 2011, 236 cases (21%) were in females. The percentage of total cases reported in females has increased steadily through each 10-year period, from 12% in 1982-1991 to 27% in 2002-2011. Despite the increase in percentage, the actual average number of females diagnosed has decreased from the last 10-year period, from 11 in 1992-2001 to 9 in 2002-2011. This percentage increase can be attributed to a decrease in the number and percentage of cases in males.

Males – Of the 1,130 cumulative cases initially diagnosed in Alaska and reported through 2011, 894 (79%) were in males. The percentage of total cases occurring in males has decreased steadily through each 10-year period, from 88% to 73%. The average number of cases has also decreased, from 29 in the time period 1982-1991 to 25 in the time period 2002-2011.

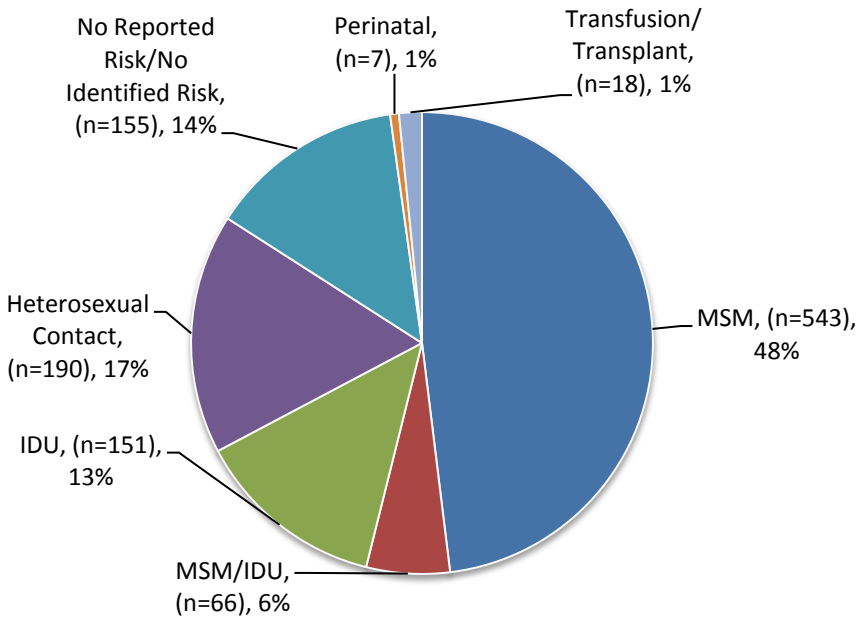
Table 6. Average Number and Proportion of HIV/AIDS Cases Newly Reported per Year by Gender, by 10-Year Time Periods – Alaska, 1982-2011

	Males		Females		Average Total Number of New HIV/AIDS Cases, Males & Females
	Average No.	Proportion in Total HIV/AIDS Cases	Average No.	Proportion in Total HIV/AIDS Cases	
1982-1991	29	88%	4	12%	33
1992-2001	35	77%	11	23%	45
2002-2011	25	73%	9	27%	34

Transmission Category

Male-to-male (MSM) sexual contact is the most commonly reported transmission category of the 1,130 cases of HIV/AIDS initially diagnosed in Alaska and reported to the Alaska Division of Public Health Section of Epidemiology since Alaska's first HIV case was diagnosed in 1982 (Figure 11). MSM comprised 48% (n=543) of all cases diagnosed since 1982; injection drug use, 13% (n=151); MSM/IDU, 6% (n=66); heterosexual contact, 17% (n=190); and perinatal transmission, transfusion and transplant, 2% (n=25).

Figure 11. Cumulative HIV/AIDS Diagnosis through December 31, 2011, by Category of Exposure, Both Sexes – Alaska (N=1,130)



The number and percentage of newly diagnosed HIV positive individuals reporting MSM as an exposure category has decreased over time, concurrent with a comparable increase in number and percentage of individuals reporting high-risk heterosexual contact (Table 7).

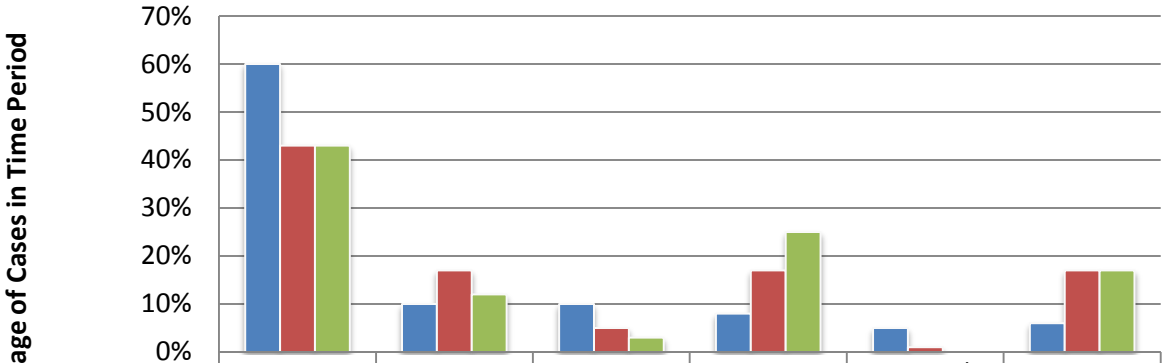
Table 7. HIV/AIDS Diagnoses and Percentages for MSM and Heterosexual Contact through December 31, 2011, both Sexes -- Alaska

	Total Number of Diagnoses	Number of Diagnoses/Percentage -- Male-to-Male Contact	Number of Diagnoses/Percentage -- Heterosexual Contact
1982-1991	334	202/60%	28/8%
1992-2001	455	195/43%	77/17%
2002-2011	341	146/43%	85/25%
1982-2011	**1,130**	**543/48%**	**190/17%**

From 1982-1991 60% (n=202) of new HIV diagnosis reported MSM as an exposure category. From 1992-2001 that number dropped to 43% (n=195) of new diagnoses, and that decrease stayed steady through the 2002-2011 time period, when 43% (n=341) of new diagnoses reported MSM. Conversely, the number and proportion of new diagnoses for heterosexual contact increased from 8% (n=28) of new diagnoses in the time period 1982-1991, to 17% (n=77) of new diagnoses in 1992-2001, to 25% (n=85) of new diagnoses in 2002-2011 (Figure 12).

Numbers and proportions of new diagnoses in the other transmission categories have either decreased or remained stable since 1982-1991.

Figure 12. HIV/AIDS Diagnoses by Category of Exposure, Both Sexes -- Alaska, 1982-2011 (N=1,130)



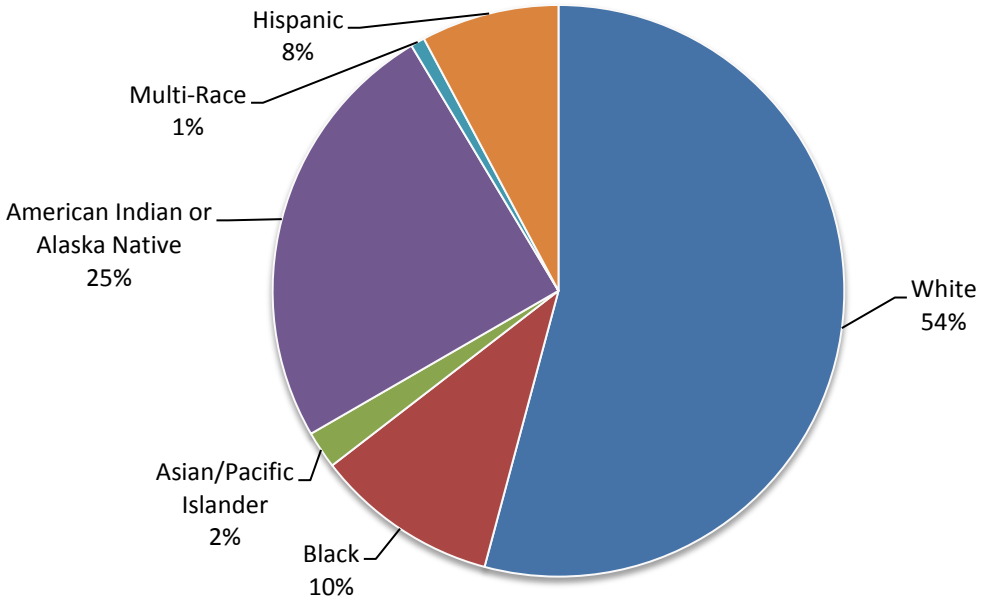
	MSM (n=543)	IDU (n=151)	MSM/IDU (n=66)	Heterosexual Contact (n=190)	Perinatal. Transfusion, or Transplant (n=25)	NIR/NRR (n=155)
1982-1991 (n=334)	60%	10%	10%	8%	5%	6%
1992-2001 (n=455)	43%	17%	5%	17%	1%	17%
2002-2011 (n=341)	43%	12%	3%	25%	0%	17%

Even though MSM contact contributes to a smaller number and proportion of new diagnoses than it did earlier in the epidemic, it is still the most commonly identified exposure category for new diagnoses. This emphasizes the importance of continuing prevention efforts with MSM, while also recognizing that program focus and effort must expand to include other priority groups, including injection drug users and those engaging in high-risk heterosexual sex.

Race and Ethnicity

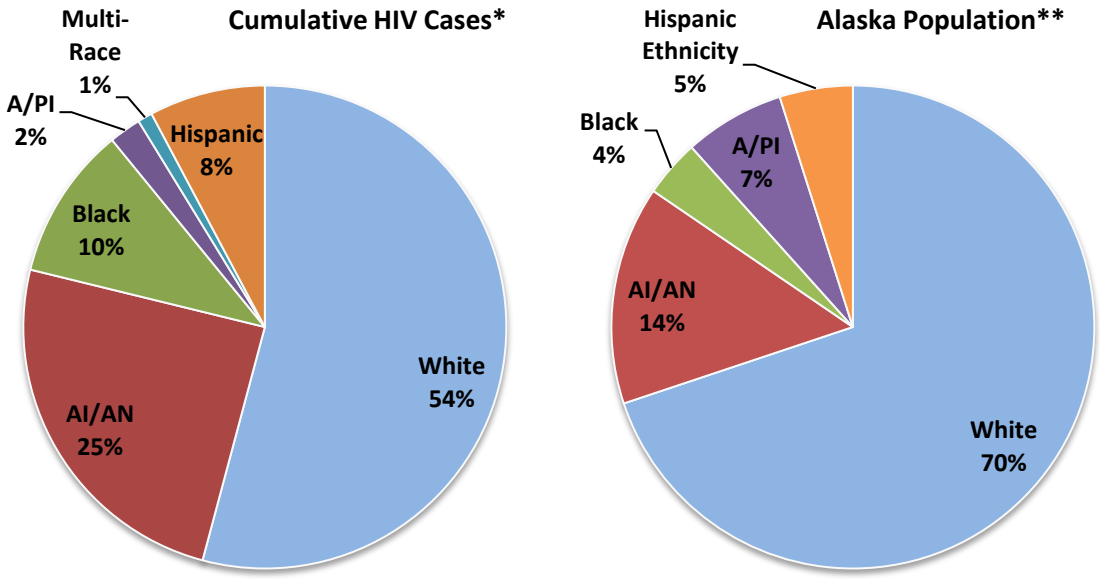
HIV affects individuals of all racial and ethnic groups in Alaska. Although individuals are not at risk of HIV infection due to their race/ethnicity, race and ethnicity can be indicators of economic and social factors that may influence risk of exposure to HIV. Of the 1,130 cases initially diagnosed in Alaska reported through December 31, 2011, 611 (54%) were in Whites, 279 (25%) in American Indians/Alaska Natives (AN/AI), 117 (10%) in Blacks, 24 (2%) in Asian/Pacific Islanders (A/PI), 11 (1%) in those reporting more than one race (multi-race), and 88 (8%) in Hispanics (Figure 13).

Figure 13. Cumulative HIV Cases (with and without AIDS) by Race and Ethnicity -- Alaska, 1982-2011 (N=1,130)



AI/AN, Black and Hispanic populations are over-represented in the HIV positive population in Alaska, which means they make up a greater proportion of the population of persons diagnosed with HIV in Alaska as compared to the general population. American Indians/Alaska Natives make up 14% of the general population compared to 25% of the diagnosed HIV cases; Blacks, 4% of the general population compared to 10% of the diagnosed HIV cases; and Hispanics, 5% of the general population compared to 8% of the diagnosed HIV cases. Conversely, Whites are under-represented in the data; they make up 70% of the general population compared to 54% of the diagnosed HIV cases (Figure 14).

Figure 14. Cumulative HIV Cases (with and without AIDS) Diagnosed through December 31, 2011, by Race/Ethnicity, Both Sexes Aged 15 Years and Older at First Diagnosis vs. Alaska Population Aged 15 Years and Older



*Population data are from the Alaska Department of Labor and Workforce Development's *Alaska State Race Bridged Smooth Series* estimates for July 2011.

** Hispanic/Latino ethnicity is included within the four race categories in the Alaska population data, as well as shown as a separate group.

Data on HIV and AIDS by gender and race/ethnicity are presented for males and females 15 years of age or older, as this age range better demonstrates trends across racial/ethnic groups. Few HIV cases occur in individuals younger than 15 years, but the number of individuals in the population that are younger than 15 years is large and unevenly distributed across the different racial/ethnic groups.

Both genders for AI/AN, Black and Hispanic populations are over-represented in the HIV positive population in Alaska. American Indian/Alaska Native males make up 15% of the general male population in Alaska, compared to 21% of the diagnosed HIV cases In men; females, 16% of the general female population in Alaska and 40% of diagnosed HIV cases in women. Black males make up 4% of the general male population in Alaska, compared to 10% of the diagnosed HIV cases in men; females, 4% of the general female population in Alaska and 13% of diagnosed HIV cases in women. Hispanic males make up 5% of the general male population in Alaska, compared to 8% of the diagnosed HIV cases in men; females, 5% of the general female population in Alaska and 7% of diagnosed HIV cases in women. Conversely White men and women are under-represented in the HIV positive population – 75% of total Alaska population compared to 59% of the HIV positive population in men and 72% of total Alaska population compared to 36% of the HIV positive population in women. Asian/Pacific Islander men and women are also under-represented in the HIV positive population – 6% of total Alaska population compared to 2% of the HIV positive population in men and 8% of total Alaska population compared to 3% of the HIV positive population in women (Table 8).

Table 8. Cumulative HIV Cases (with and without AIDS) Diagnosed through December 31, 2011, by Race/Ethnicity, Both Sexes Aged 15 Years and Older at First Diagnosis vs. Alaska Population Aged 15 Years and Older

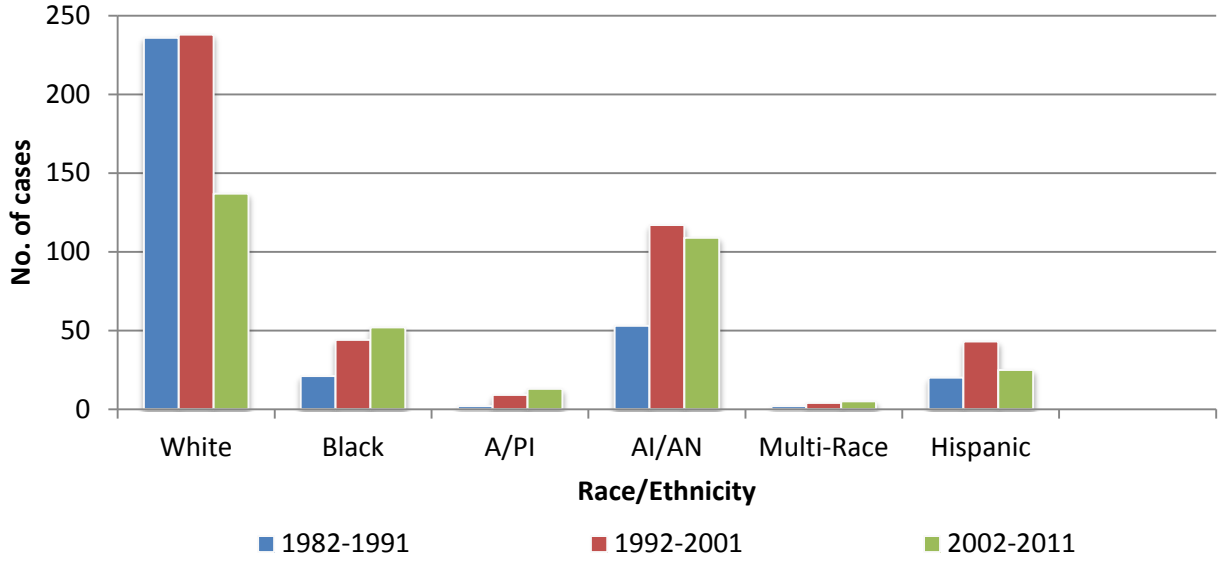
Race/Ethnicity	HIV Cases First Diagnosed in Males ≥15 years of age		Males ≥15 years of age – Alaska Population*		HIV Cases First Diagnosed in Females ≥15 years of age		Females ≥15 years of age – Alaska Population*	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
White	522	59%	219,319	75%	84	36%	195,271	72%
Alaska Native/American Indian	184	21%	43,599	15%	92	40%	43,336	16%
Black	86	10%	12,551	4%	29	13%	10,205	4%
Asian/Pacific Islander	16	2%	18,767	6%	8	3%	21,241	8%
Multi-Race	8	1%	--	--	3	1%	--	--
Hispanic Ethnicity**	71	8%	[15,164]	[5%]	16	7%	[13,885]	[5%]
Total	**887**	**100%**	**294,236**	**100%**	**232**	**100%**	**270,053**	**100%**

*Population data are from the Alaska Department of Labor and Workforce Development's *Alaska State Race Bridged Smooth Series* estimates for July 2011.

**Males and females of Hispanic/Latino ethnicity are included within the four race categories in the Alaska population data, as well as shown as a separate group.

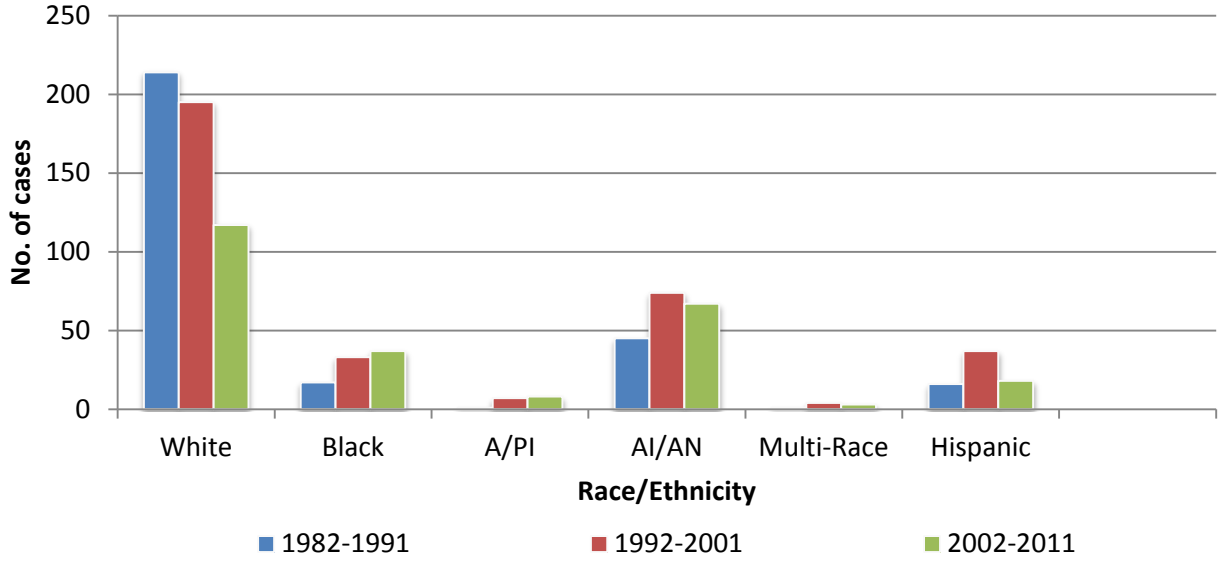
Irrespective of gender, from 1982 through 2001 there was an increase in the number of new HIV diagnoses across all races and ethnicities; from 334 new cases in the time period 1982-1991 to 455 new cases in the time period 1992-2001. However, the greatest increases between those time periods were seen in Black and Alaska Native/American Indian populations (Figure 15). From 2002 the epidemic began to stabilize, and there was a sharp downward trend in the number of newly diagnosed cases of HIV in Whites; from 238 cases in 1992-2001 down to 197 in 2002-2011. However, a similar decrease was not observed in Black, A/PI, AI/AN, and Multi-Race populations although incidence remained relatively stable, with the number of new cases of HIV diagnosis in each ten year period too small to draw any statistically significant conclusions about changes in trends.

Figure 15. HIV/AIDS Diagnoses by Race and Ethnicity, Both Sexes -- Alaska, 1982-2011, (N=1,130)



In 1982-1991 the largest population group impacted by HIV/AIDS was White males. Of the 294 new male cases of HIV in the time period 1982-1991, 73% (n=214) were White. In the time period 1992-2001 the racial makeup of the HIV epidemic in Alaska began to change. While there was a sharp decrease in the number of White males diagnosed with HIV in the time period 1992-2001, the numbers of Black, Asian/Pacific Islander, American Indian/Alaska Native and ethnic Hispanics newly diagnosed with HIV during that time period all increased (Figure 16). By 2002-2011, there had been a 45% decrease in the number of White males newly diagnosed with HIV; from 214 in the time period 1982-1991 to 117 in the time period 2002-2011. Corresponding decreases were not observed in other racial and ethnic groups, which either saw slight increases or remained steady in the number of new HIV diagnoses.

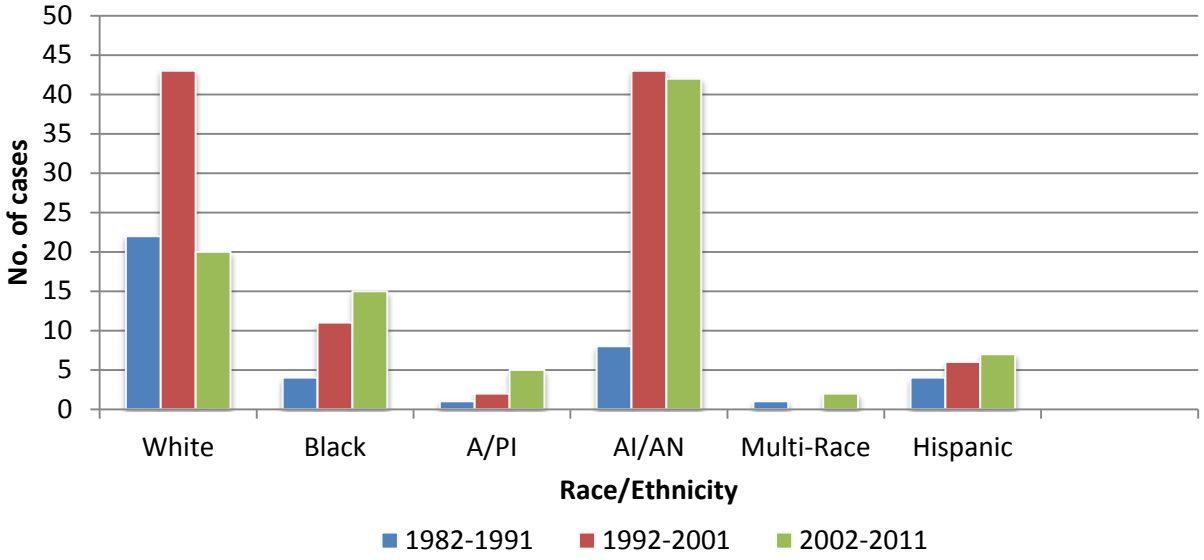
Figure 16. HIV/AIDS Diagnoses by Race and Ethnicity, Males -- Alaska, 1982-2011, (N=894)



Changes in trends by race and ethnicity in the HIV positive female population of Alaska vary significantly from their male counterparts. In 1982-1991 females made up a small proportion of the total number of new HIV cases, approximately 12% (n=40). Of those, over half (55%) were White and 20% were American Indian/Alaska Native (Figure 17). In 1992-2001 the racial makeup of HIV-positive females in Alaska changed dramatically. Not only did the number and percentage of females newly diagnosed with HIV sharply increase, up to 23% (n=105) of all new cases in the time period, but the number of American Indian/Alaska Native females increased to 41% (n=43), on par with White females. This trend continued through the 2002-2011 time period, when American Indian/Alaska Native women made up nearly half of new HIV cases in females—46% (n=42). In the past decade, it appears that while there has been a decrease in newly diagnosed cases in White women, there has not been a commensurate decrease in women of color. Reasons for this disparity are not clear.

It is important to note that even though the percentage of females newly diagnosed increased sharply, the average number of new cases per year decreased from 11 in the time period 1992-2001 to 9 in the time period 2002-2011 (Table 6).

Figure 17. HIV/AIDS Diagnoses by Race and Ethnicity, Females -- Alaska, 1982-2011, (N=236)



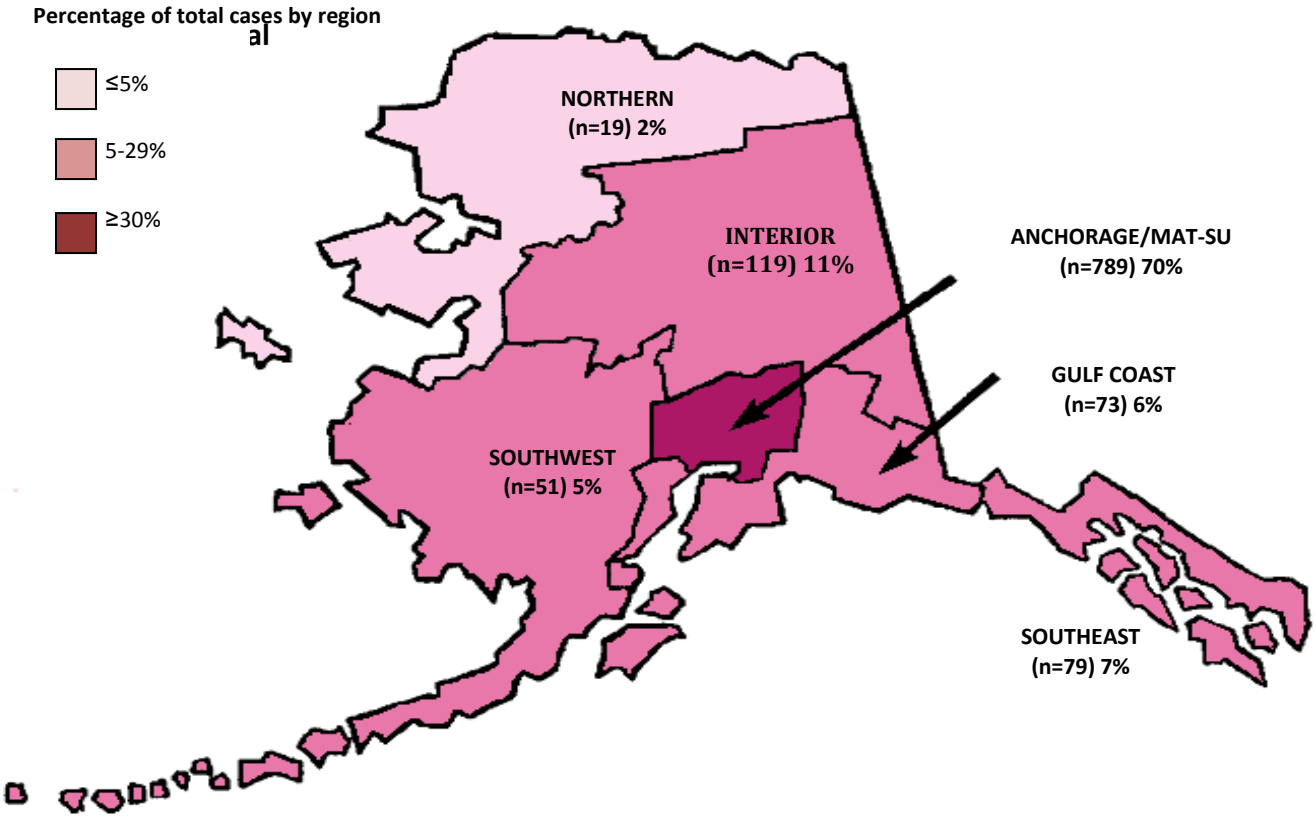
Since 1982, the race and ethnicity makeup of those newly diagnosed with HIV infection in Alaska has changed significantly. Over time, the number and percentage of White males has decreased, while the number of percentage of American Indian/Alaska Native females has increased. Other racial groups, including Black males and females and Asian/Pacific Islander males and females, have remained relatively steady in their incidence. HIV/AIDS prevention and treatment programming has had to adapt to effectively serve these emerging populations.

Geographic Region of Residence at First HIV Diagnosis in Alaska

HIV cases have been reported from all regions of Alaska. At the time of their first HIV diagnoses in Alaska, 789 cases (70%) reported a residence of Anchorage/Mat-Su, the most populous region of the state (54% of the state population was estimated to reside in the Anchorage/Mat-Su region in 2011).[34] (Figure 18) It is important to note that an individual's residence at the time of first diagnosis with HIV is not necessarily the area where infection initially occurred or the area where the infected individual resides or seeks care, if still living. For example, an individual residing in a rural village may have been infected during a visit to Anchorage, and may seek care at a provider located in a hub city. People with HIV infection may not be diagnosed for years after initial infection. Additionally, Alaskans tend to be highly mobile. Therefore, the following data must be interpreted with caution.

Data on newly diagnosed cases of HIV are reported in economic regions of Alaska as opposed to boroughs and census areas as described in Table 1 to protect the confidentiality of HIV positive persons in areas of low population.

Figure 18. Region of Residence at Time of First HIV/AIDS Diagnosis in Alaska, Cumulative Cases Reported – Alaska, 1982-2011 (N=1,130)



[34] Alaska Department of Labor and Workforce Development, *2011 Population Estimates,* Available online at: http://labor.alaska.gov/research/pop/popest.htm

HIV Cases Presumed to be Living

The previous sections of this profile have focused on sub-populations of HIV positive people in Alaska. The following table summarizes all HIV positive people presumed to be living. Of the 1,130 HIV/AIDS cases reported through December 31, 2011, 673 cases were not known to have died. Table 9 assumes that all of these cases are still living in Alaska, although that is unlikely since some undoubtedly have moved and/or died while residents of another state. Table 9 describes the demographics of persons presumed to be living with HIV in Alaska.

Table 9. Characteristics of People Living with HIV/AIDS, 1982-2011 – Alaska (N=673)

	Persons living with HIV/AIDS in Alaska	
	Number	**Percentage**
Total	673	100
Sex		
Male	518	77
Female	155	23
Race/ethnicity		
White	345	51
Alaska Native/American Indian	160	24
African American	76	11
Hispanic	64	10
Asian	13	2
Multi-Race	10	1
Native Hawaiian/Pacific Islander	5	1
Age group (yrs.)		
<14	6	1
14-24	98	15
25-34	244	36
35-44	212	32
45-54	86	13
55-64	21	3
≥ 65	6	1
Region		
Anchorage/Mat-Su	463	69
Gulf Coast	37	5
Interior	77	11
Northern	8	1
Southeast	47	7
Southwest	41	6

Reportable Sexually Transmitted Diseases in Alaska

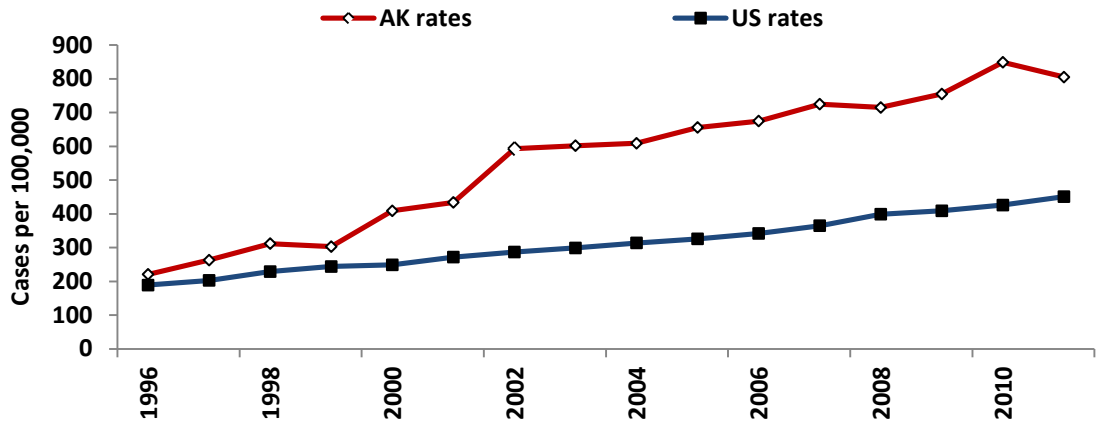
Sexually transmitted diseases (STD) indicate risk behavior (unprotected sex) and potential risk for HIV transmission or acquisition. Individuals with STDs are 2-5 times more likely to acquire HIV, if exposed through unprotected sex, or of transmitting HIV sexually if they have HIV infection. STDs that do not cause a break in the skin, like chlamydia and gonorrhea, increase risk of acquisition of HIV through an increased concentration of cells in genital secretions that can serve as targets for HIV. STDs that cause a break in the skin, like syphilis, facilitate the acquisition of HIV by creating a portal of entry for HIV.[35]

Chlamydia

Alaska had the highest *Chlamydia trachomatis* (CT) infection rates in the U.S. in 2010 and 2011, and has consistently had the first or second highest rate in the nation since 2000. In 2011, the AKSOE received reports of 5,813 cases of CT infection; Alaska's CT case rate was 805 cases per 100,000 persons. The 2011 rate decreased 5% compared to 2010; however, the rate was still almost twice the 2011 U.S. rate of 451 per 100,000 persons.

Of the 5,813 cases of CT infection reported in 2011, 4,895 (84%) were in individuals aged <30 years; 3,852 (66%) were among females; 2,795 (48%) were among American Indian/Alaska Native (AI/AN) persons; 2,051 (35%) were among Whites; and 314 (5.4%) were among persons co infected with gonorrhea. Infection rates were highest among AI/AN females and males (3,444 and 1,222 cases per 100,000 persons, respectively), and Black females and males (1,661 and 1,420 cases per 100,000 persons, respectively). [36] (Figure 19)

Figure 19. Chlamydia Infection Case Rates per 100,000 Persons - Alaska and the U.S., 1996-2011*



**The 2011 US case rate is preliminary*

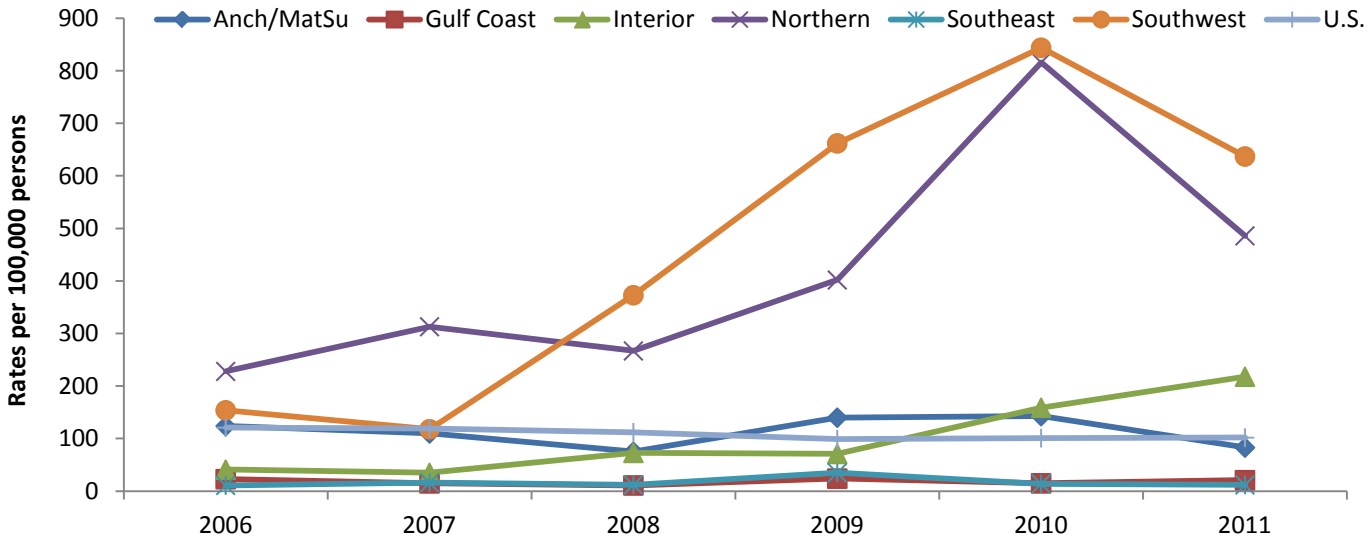
[35] CDC, *The Role of STD Detection and Treatment in HIV Prevention – CDC Fact Sheet.* Available online at: http://www.cdc.gov/std/hiv/STDFact-STD-HIV.htm. Updated September 2010.
[36] State of Alaska. Alaska Epidemiology Bulletin. *Chlamydial Infection – Alaska, 2011.* Available at http://www.epi.hss.state.ak.us/bulletins/docs/b2012_10.pdf. Published June 21, 2012.

Gonorrhea

In recent years, Alaska has experienced relatively high rates of *Neisseria gonorrhoeae*(GC) infection. A GC outbreak began in 2008, particularly in the Northern and Southwest Regions; peaked in 2010, and began declining in 2011. In 2010, Alaska's GC infection rates were the third highest in the nation.

In 2011, a total of 993 GC cases were reported to the AKSOE; Alaska's GC case rate was 138 cases per 100,000 persons. This represents a 22% decrease in case numbers and a 25% decrease in case rates compared to 2010 reports (Figure 20). [37]

Figure 20. Gonococcal Case Rates by Region - Alaska and the U.S., 2006-2011*



**The U.S. 2011 rate is preliminary*

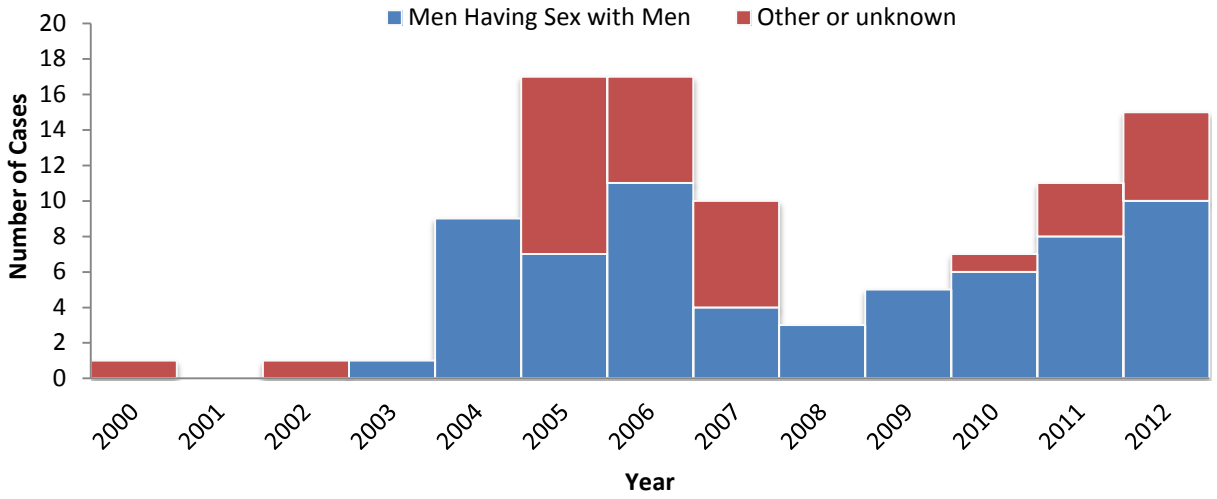
Of the 993 case reports, 662 (67%) were aged <30 years; 519 (52%) were among females; 714 (72%) were among American Indian/Alaska Native (AI/AN) persons; 314 (32%) were co-infected with CT. [38]

[37] State of Alaska. Alaska Epidemiology Bulletin. *Gonococcal Infection – Alaska, 2011*. Available at: http://www.epi.hss.state.ak.us/bulletins/docs/b2012_11.pdf. Published June 21, 2012.
[38] Ibid

Syphilis

Alaska experienced few primary, secondary, and early latent syphilis cases until late 2004, when an outbreak began that was not controlled until the fall of 2007. An unrelated outbreak was also identified in 2010. Both of these outbreaks primarily involved men who have sex with men (MSM) who were engaging in high-risk sexual behaviors. Many of the MSM reported having anonymous sexual partners whom they met through internet sex-seeking websites. A rise in syphilis cases was also identified beginning in 2011.[39] From January 1, 2011 through October 15, 2012, 26 syphilis cases were reported to Alaska Section of Epidemiology; 22 of these cases were reported since October 2011. Eighteen of the 26 cases were among MSM (Figure 21).[40]

Figure 21. Primary, Secondary, and Early Latent Syphilis, by Year and Risk Factor – Alaska, 2000-2012



[39] State of Alaska. Alaska Epidemiology Bulletin. *Syphilis Outbreak – Alaska, 2011-2012.* Available at: http://www.epi.hss.state.ak.us/bulletins/docs/b2012_04.pdf. Published February 21, 2012. Accessed August 29, 2012.

[40] Alaska Section of Epidemiology Reportable Conditions Database, Alaska Department of Health and Social Services.

Hepatitis

Hepatitis A[41,42]

Hepatitis A virus (HAV) infection was once a common, cyclically-occurring disease in Alaska. Large outbreaks comprising thousands of cases regularly occurred up until the early 1990s, with the highest rates of infection among children aged ≤14 years. Since the licensing of hepatitis A vaccines in 1995, the number of HAV infections in Alaska has decreased greatly (Table 10); only 24 cases have been reported since 2005.

Hepatitis B

Hepatitis B virus (HBV) is transmitted through the same routes as HIV, blood and body fluids. Alaska has reported 78 acute cases of hepatitis B since 2002.Alaska follows the national pattern with the highest rate of acute hepatitis B in the 30-50 year old range. The Gulf Coast region had approximately the same number of cases of acute hepatitis B as Anchorage/Mat-Su region with only 20% of the population (31 cases / pop 80,002 vs. 35 cases / pop 387894). Injection drug use is a risk factor for hepatitis B infection in this region as well as in the Interior and Southeast. The three-dose series of hepatitis B vaccine or the combination hepatitis A /B vaccine is recommended for those infected with HIV.

Hepatitis C

In 1996, hepatitis C virus (HCV) became a condition reportable to the Alaska SOE by healthcare providers and laboratories. Since then SOE has received 14,034 reports of hepatitis C. This represents incidence and prevalence data for each time period. The majority (51.7%) of HCV cases were 40-54 years of age at the time of first report. Males comprised the majority (57%) of all HCV cases reported. The highest numbers of reports come from the Anchorage / Mat-Su region; however the highest rate was from the Gulf Coast region. Note that residence may actually reflect location where cases sought healthcare. Because cases are often diagnosed and reported long after initial HCV exposure, residence may not reflect where HCV was acquired. Table 10 displays the number of annual reported cases of hepatitis in Alaska from 1993-2011. Counts are provisional and subject to change.

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[41] State of Alaska. Alaska Epidemiology Bulletin. *Hepatitis A Infections Associated with International Travel, Anchorage, 2010.* Available at: http://www.epi.hss.state.ak.us/bulletins/docs/b2011_14.pdf. Published May 17, 2011. Accessed August 29, 2012.

[42] Data was accessed from the State of Alaska, Alaska Epidemiology Bulletin *Annual (January-December) Infectious Disease Reports*, published from 1993-2011. To see individual reports, see http://www.epi.hss.state.ak.us/bulletins/catlist.jsp?cattype=Infectious+Disease+Reports.

Table 10. Number of Annual Reported Cases of Hepatitis in Alaska, 1993-2011[43]			
Year	**Hepatitis A**	**Hepatitis B**	**Hepatitis C***
2011	2	5	964
2010	4	5	672
2009	2	5	855
2008	5	10	1040
2007	5	9	1032
2006	2	8	1073
2005	4	8	1008
2004	4	11	957
2003	10	8	845
2002	12	12	754
2001	16	10	760
2000	13	13	732
1999	15	18	805
1998	17	13	756
1997	34	15	617
1996	53	16	366
1995	50	13	0
1994	209	13	0
1993	775	15	0

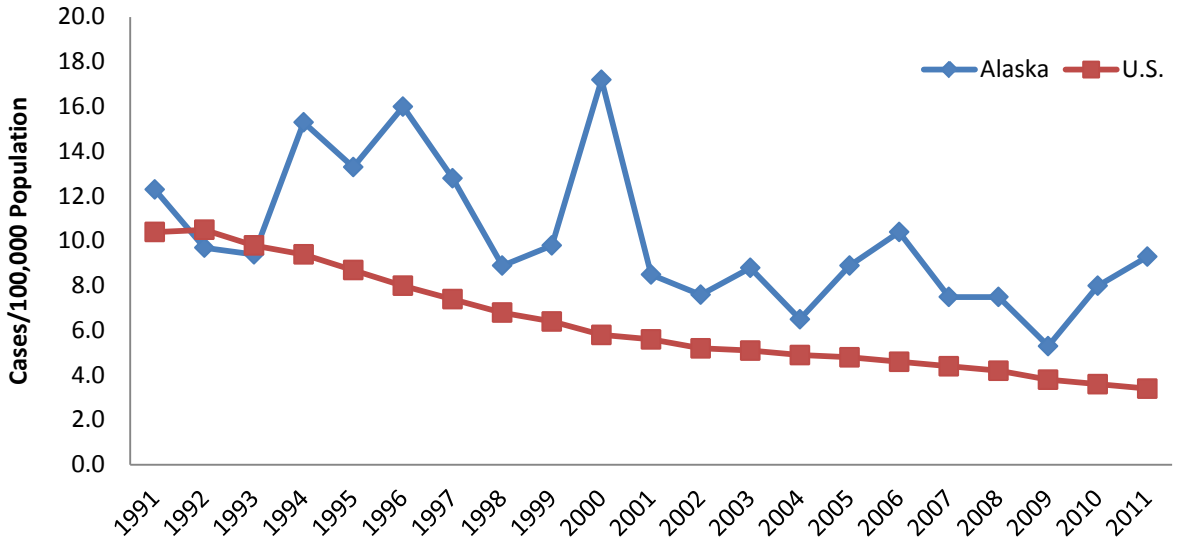
**Numbers for Hepatitis C represent prevalent cases for each time period, not incidence of new disease. Case counts are provisional and subject to change.*

[43] State of Alaska, Section of Epidemiology, AKSTARS database.

Tuberculosis

In 2011, 67 cases of tuberculosis (TB) were reported in Alaska for an incidence rate of 9.3 cases per 100,000 population. This was an 18% increase in the number of cases and a 21% increase in the incidence of TB when compared to 2010. The U.S. TB incidence was 3.4 cases per 100,000 in 2011, a 6.4% decline from 2010 (Figure 22).[44]

Figure 22. TB Incidence Rates -- Alaska and the U.S., 1991-2011



Also In 2011, the State of Alaska Tuberculosis Program reported that 98% of patients with TB, 15-54 years of age, were offered an HIV test.[45]

[44] State of Alaska Department of Health and Social Services, Division of Public Health, Section of Epidemiology,, *Tuberculosis in Alaska – 2011 Annual Report,*

[45] Ibid

Chapter 4

Resources, Indication of Need, and Gaps in Service

HIV Prevention Resources

State of Alaska – HIV/STD Program

The main source of HIV Prevention funding in Alaska is federal CDC HIV Prevention funds administered through the State of Alaska HIV/STD Program. The calendar year 2012 CDC Funding Opportunity Announcement (FOA) PS12-1201– Comprehensive HIV Prevention Programs for Health Departments consists of several categories of funds. Alaska received funding in two of these categories: Category A base funding and Category C demonstration project funding.

In calendar year 2012, the HIV/STD Program was awarded $1,077,036 in Category A funds to conduct the required core components and required activities for health departments. There are four required core components:

- HIV testing,
- Prevention with positives,
- Condom distribution, and
- Policy initiatives

There are three required activities:

- HIV planning,
- Capacity building and technical assistance, and
- Program planning, monitoring and evaluation, and quality assurance.

Category A funding will continue through 2016 at decreasing levels to eventually equal an almost 50% cut as compared to 2011 funding.

An additional $140,282 was awarded through PS12-1201 – Category C – for a demonstration project, the Enhanced Linkage to Care Project. The funding duration for the Enhanced Linkage to Care Project is undetermined, but will be for no less than two years and no more than four years.

The following are HIV prevention interventions conducted directly by the HIV/STD Program that address the required core components described in PS12-1201 (Categories A and C):

Required Core Component: HIV Testing

The HIV/STD Program conducts rapid HIV testing in the field as an essential component of HIV partner services. Rapid Hepatitis C testing is offered to all HIV PS contacts who identify as IDU. In addition, the HIV/STD Program has increased testing of high-risk individuals by increasing the number of HIV tests conducted during STD partner services. The following groups are prioritized for testing during STD partner services activities:

- MSM
- IDU (Rapid Hepatitis C testing is offered to all contacts who identify as IDU)
- Syphilis contacts
- Individuals with repeat STD infection

Required Core Component: Prevention with Positives

HIV Partner Services

HIV partner services (PS) are confidential, voluntary services that help persons with HIV notify their sex and drug-injection partners of possible HIV exposure, with the goal of offering testing and risk reduction counseling to partners. HIV PS plays an important role in offering services that can protect the health of partners, and to prevent sexually transmitted disease (STD) re-infection in persons with HIV.[46] The HIV/STD Program funds a .5 FTE disease intervention specialist (DIS) position to conduct HIV PS and 1.5 FTE DIS to conduct STD PS.

In Alaska, HIV PS is conducted by a DIS, sometimes in collaboration with public health partners in rural areas of the State. Newly diagnosed individuals are offered PS to help elicit partner information and then notify their sexual and/or injecting partners. Individuals previously diagnosed with HIV who come to the attention of the HIV/STD Program due to a new STD or who are named as a contact or unsafe partner in an STD or HIV disease investigation, may also receive PS. The DIS will locate and meet with sexual and injecting partners to notify them of potential exposure, offer prevention counseling, rapid testing, STD and Hepatitis C testing if needed, and provide test results and follow-up.

HIV PS has proven to be a very effective prevention tool as it identifies, counsels and tests individuals known to have risky sexual and/or injecting exposure to HIV positive individuals. PS data from 2007-2011 show that:

- 296 HIV-related interviews were conducted (newly and previously diagnosed HIV positive and high-risk negative individuals)

[46] CDC, *HIV/AIDS, Prevention with Positives, Partner Services,* Available online at: http://www.cdc.gov/hiv/pwp/partnerservices.html. Accessed on November 1, 2012.

- 519 partners were identified; of those

  - 328 were located and notified
  - 288 were tested for HIV
  - 13 were newly identified as HIV positive (5.5% positivity)
  - 92 were previously diagnosed and aware of status

- 215 HIV "clusters" (cluster interviews involve eliciting information from uninfected partners about their own partners and other persons in their social networks who might benefit from counseling and testing) were identified; of those

  - 170 were located and notified
  - 135 were tested
  - 2 were newly identified as HIV positive (1.5% positivity)
  - 21 were previously diagnosed and aware of status

Partner services activities identified 12% (18/154) of new diagnoses in Alaska from 2007-2011. The effectiveness of PS in reaching those at greatest risk is further demonstrated by an HIV positivity rate of 4.3% compared to a positivity rate of .2% in other testing funded by the HIV/STD Program during the same time period.

Linkage to Care

Linkage to care is a strategy to connect and retain HIV-positive individuals in medical care. Nationally, linkage to care is an emerging priority in the continuum of care for HIV-infected people, providing immediate support, education and counseling.[47] Linkage to care helps ensure people living with HIV receive life-saving medical care and treatment, and helps reduce their risk of transmitting HIV.[48]

In Alaska, the Linkage to Care (L2C) program works to connect and retain HIV-positive individuals in medical care. Program staff identify and contact HIV-positive individuals who are newly diagnosed or chronically out of care, and provide them with short-term, intensive support in engaging with an HIV care provider and with long-term medical case management. The support provided is customized to meet the needs of the client, but may include services such as:

- Assistance in identifying and connecting with medical providers

[47] Craw et al. Structural factors and best practices in implementing a linkage to HIV care program using the ARTAS model. *BMC Health Services Research*. 2010;10:246.
[48] CDC, High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infection in the United State, August 2011.

- Assistance in accessing HIV care including medical case management (MCM) and the AIDS Drug Assistance Program (ADAP)

- Support in connecting with social service organizations and aid in transitioning to long-term medical case management services

The L2C program also responds to requests from high risk HIV negative individuals to provide risk reduction counseling, HIV/STD testing and client follow-up as appropriate.

Successful linkage to care is an ongoing process during which HIV-positive individuals are able to assimilate their diagnosis, understand the implications of their HIV diagnosis to themselves and others, engage in appropriate medical care and services, and commit to enhancing their own health. High-risk HIV-negative individuals are able to identify high-risk behaviors and implement risk-reduction strategies.

Required Core Component: Condom Distribution

Condom distribution is included in all prevention activities conducted by the HIV/STD Program. All HIV/STD Program grantees are required to distribute condoms as a component of their HIV/STD Program-funded HIV prevention activities. In addition, the HIV/STD Program contracts with two agencies – one in Anchorage and one in Fairbanks – to identify and supply condoms to appropriate condom distribution sites targeting HIV positive and high-risk negative individuals.

Required Core Component: Policy Initiatives

The HIV/STD Program supports efforts to align structures, policies, and regulations in Alaska with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts. The HIV/STD Program is currently working on a policy initiative to improve syringe access statewide and will identify and address future policy initiatives as appropriate.

Required Activities

The HIV/STD Program maintains the staff and infrastructure necessary to implement all the required activities described in PS12-1201, including:

- HIV planning,
- Capacity building and technical assistance, and
- Program planning, monitoring and evaluation, and quality assurance

HIV Planning

The HIV/STD Program facilitates the HIV planning process which includes the following:

- Maintaining and recruiting for the HIV Planning Group (HPG) ensuring parity, inclusion, and representation as well as technical expertise beneficial to the planning process

- Writing the HIV plan with input from the HPG, consumers, treatment and care providers, and other key stakeholders

- Ensuring that the HPG has access to current HIV prevention information and analyses of data which may have implications for HIV information, to include surveillance data, program information and research, and the best available science

- Informing the HPG on the successes and barriers in implementing the HIV services identified in the Plan

- Convening and facilitating at least one meeting per quarter via teleconference or webinar and one meeting annually in person

- Updating the HPG on the progress of meeting goals and objectives

Capacity Building and Technical Assistance

Capacity building is a process by which individuals, organizations, and communities are helped in developing skills and abilities to enhance and sustain HIV prevention efforts. In 2010, the HIV/STD Program conducted an HIV Prevention Capacity Building Needs Assessment to determine the HIV prevention needs of current and potential providers. A follow-up needs assessment was conducted in 2012. The needs revealed by the assessments have been and will continue to be addressed to the best of the HIV/STD Program's ability. As a result of the needs assessment, the HIV/STD Program developed or provided the following:

- An interactive HIV 101 CD and online presentation created in response to the need for HIV education in areas of the State without HIV prevention resources

- An HIV Prevention Listserv to disseminate information addressing identified needs such as funding opportunities, materials and resource identification, training, epidemiologic data, intervention information, and identification of social marketing campaigns

- Training in HIV prevention counseling and rapid testing

- Training in program evaluation

When the HIV/STD Program is not able to address needs, assistance will be sought from CDC's Capacity-Building Request Information System (CRIS) or other capacity building assistance provider. Capacity-building needs assessment follow-up will be conducted every other year.

The HIV/STD Program also provides or seeks technical assistance for HIV prevention grantees and other programs in:

* Data collection, entry, and analyses using EvaluationWeb (a database provided by CDC) and data collection tools developed by the HIV/STD Program

* Conducting, interpreting, and providing results for HIV rapid tests

* Conducting evaluation

* Intervention design

Program planning, monitoring and evaluation, and quality assurance

The HIV/STD Program was required to submit a Comprehensive Program Plan as part of its PS12-1201 application. The comprehensive program plan includes program planning (goals, objectives, and activities), monitoring and evaluation (M&E), quality assurance (QA), and capacity building activities specific for PS12-1201.

Programs funded by the HIV/STD Program under PS12-1201

In spring 2012, the HIV Prevention Program issued a Request for Grant Proposals (RFP) with Part 1 focusing on a three year cycle (FY2013-FY2015) and Part 2 focusing on funding for one year (FY2013). The HIV/STD Program sought HIV prevention services as required in PS12-1201, targeting the priority populations identified in the Plan.

The HIV Prevention RFP included two parts:

Part 1 – A three-year funding cycle using PS12-1201 funds to address the following CDC-required core components:

1. HIV testing;
2. Prevention with positives; and
3. Condom distribution

Part 2 – A one-year funding opportunity using 2011 carry-over and low-cost extension funds to address the following CDC-recommended activities:

1. Intervention(s) targeting young men who have sex with men (MSM);
2. Health Communication/Public Information; and
3. Street and Community Outreach

Through the RFP process, the HIV/STD Program funded four community-based organizations to conduct HIV prevention activities (Table 11).

Table 11. HIV/STD Program-funded HIV Prevention Interventions by Agency – July 1, 2012 through June 30, 2013.		
Alaskan AIDS Assistance Association (Four A's)		
Area of Service: Anchorage		
Intervention	**Target Population**	**Description**
HIV Testing	MSM, IDU, HRH	HIV testing in non-healthcare settings is conducted at venues reaching high-risk negative individuals such as gay bars, syringe exchange program, correctional facilities, and substance abuse and mental health programs.
Condom Distribution	MSM, IDU, HRH	Condoms are distributed as a component of all funded activities. Condom distribution was established at sites targeting HIV positive and high-risk negative individuals.
Mpowerment*	MSM	The *Mpowerment Project* is a community-level intervention designed to address the HIV prevention needs of young gay and bisexual men.
Options*	IDU	*Options* in an individual-level HIV risk reduction intervention for HIV positive persons in medical care adapted by the Four A's to reach IDU who utilize the syringe exchange program.
Get It On Alaska* Social Marketing Campaigns	MSM, IDU, HRH	Get It On is a social marketing campaign that was launched in March of 2008 with the purpose of de-stigmatizing the use of condoms and creating conversations about condoms and their HIV risk reduction benefits. Current funding is to add a component to the campaign that would target high-risk populations.

***Funding is for one year only (through June 30, 2013) due to budget cuts from CDC.**

Alaska Native Tribal Health Consortium (ANTHC)		
Area of Service: Anchorage and Statewide		
Intervention	**Target Population**	**Description**
Incorporating HIV Prevention into the Medical Care of Persons Living with HIV	HIV Positive Persons	Prevention in the care setting uses the outpatient clinic and health care providers to screen for HIV transmission risk behaviors and sexually transmitted diseases, provide brief behavioral prevention interventions, and facilitate partner notification and counseling.

Municipality of Anchorage Reproductive Health Clinic (MOARHC)		
Area of Service: Anchorage		
Intervention	**Target Population**	**Description**
HIV Testing	MSM, IDU, HRH	HIV testing in non-healthcare settings is conducted at venues reaching high-risk negative individuals such as gay bars, correctional facilities, and substance abuse and mental health programs.

Interior AIDS Association (IAA)		
Area of Service: Fairbanks		
Intervention	**Target Population**	**Description**
HIV Testing	MSM, IDU, HRH	HIV testing in non-healthcare settings is conducted at venues reaching high-risk negative individuals such as gay bars, syringe exchange program, correctional facilities, and substance abuse and mental health programs.
Condom Distribution	MSM, IDU, HRH	Condoms are distributed as a component of all funded activities. Condom distribution was established at sites targeting HIV positive and high-risk negative individuals.
Street and Community Outreach (SCO)*	MSM, IDU, HRH	SCO provides a sustained and regular presence in the community to provide risk reduction messages and supplies and referral to testing.

*Funding **is for one year only** (through June 30, 2013) due to budget cuts from CDC.

Due to the re-allocation of CDC funds, the Alaska HIV/STD Program will not be able to continue funding several interventions. Specifically, **evidence-based interventions targeting MSM, IDU and high risk heterosexuals (HRH) will no longer be funded by the HIV/STD Program after June 30, 2013.** These losses include long-standing and popular interventions such as Mpowerment (targeting young MSM), Options (targeting IDU), street and community outreach (targeting MSM, IDU, and HRH), and social marketing/public information (targeting the general population including rural Alaska).

Other Direct or Indirect HIV Prevention Resources

The following summary describes additional resources for HIV prevention in Alaska that are funded for at least some part of the 2013-2016 period covered by the Alaska HIV Plan. These include federal and state funded programs that address risk factors associated with HIV such as substance abuse or sexual activity and that incorporate an HIV prevention component into their client services.

State of Alaska
Department of Health and Social Services

Division of Public Health – Section of Epidemiology, HIV/STD Program

Comprehensive STD Prevention Systems (CSPS) and STD-Related Infertility
Funding Source: Centers for Disease Control and Prevention
Funding Cycle: January 1, 2009 to December 31, 2013
Funding: Approximately $426,843 annually for five-year grant cycle
Program Contact: Susan Jones, RN, MN, susan.jones@alaska.gov, (907) 269-8061
Program Description: The Alaska HIV/STD Program, operating under the Department of Health and Social Services (DHSS), Division of Public Health (DPH), Section of Epidemiology (SOE), receives CDC funds to conduct STD control activities. Program functions include STD surveillance and data management, outbreak response activities, partner services, community and individual behavior change services, program evaluation, and training and professional development. Additionally, the Prevention of STD-Related Infertility (previously the Infertility Prevention Project or IPP) provides a small amount of chlamydia and gonorrhea test reagents for the State Public Health Laboratory (SPHL), as well as medications used in field-based treatment activities.

Division of Public Health – Section of Public Health Nursing

Public Health Nursing Centers
Funding Source: Alaska Division of Public Health
Funding Cycle: ongoing
Project Contact: Rhonda Richtsmeier, R.N., M.N., rhonda.richtsmeier@alaska.gov, (907) 334-2250
Project Description: State public health nursing provides services at 23 public health centers across the state, and itinerant services to more than 250 communities. In addition, the Section of Public Health Nursing provides state grant assistance for public health nursing services in the Municipality of Anchorage, Northwest Arctic/Maniilaq (Kotzebue), and the North Slope Borough (Barrow). Public Health Centers are located in Anchorage (contract with the Municipality of Anchorage, Department of Health and Human Services), Bethel, Cordova, Craig, Delta Junction, Dillingham, Fairbanks, Fort Yukon, Galena, Glennallen, Haines, Homer, Juneau, Kenai, Ketchikan, Kodiak, Kotzebue (contract with Maniilaq), Wasilla, Barrow (contract with North Slope Borough), Nome, Petersburg, Seward, Sitka, Tok, Wrangell, and Valdez. Public health nurses provide HIV counseling and testing, STD diagnosis and treatment and HIV/STD partner services. Other services include: immunizations, family planning, pregnancy testing, prenatal monitoring, postpartum home visits, senior clinics, chronic disease services, well child exams, Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT), outreach, screening, and referral, clinics for special needs children, Women, Infants, and Children (WIC) and Infant Learning Program (ILP) referrals, school screenings, audiograms, tuberculosis screening, epidemiological investigations, parenting education, health education, community

assessment, and participation in community partnerships in response to public health concerns. Fees are assessed for all clinic visits utilizing a sliding fee scale. However, no one is denied service due to an inability to pay.

Division of Public Health – Section of Women's, Children's, and Family Health

Reproductive Health Services
Source of Funding: Maternal and Child Health Services Block Grant
Funding Cycle: October 1, 2011 to September 30, 2013
Funding: Approximately $37,200 annually (FY2012 and FY2013)
Program Contact: Stephanie Birch, RNC, MPH, MS, FNP, stephanie.wrightsman-birch@alaska.gov, (907) 269-3400
Program Description: Professional services contracts are administered to provide reproductive health services at the Kodiak Public Health Center (where services are provided by a private advanced nurse practitioner) and the Juneau Douglas High School health centers (where services are provided through the City and Borough of Juneau). Comprehensive clinical family planning and reproductive health services include initial and annual medical and social history, preventive health examinations, health risk assessment, risk reduction counseling, lab testing as indicated, diagnosis and treatment of minor primary care needs including minor gynecological abnormalities and STIs, referral and follow-up.

Reproductive Health Services
Source of Funding: Title X Family Planning Services Grant
Funding Cycle: July 1, 2012 to June 30, 2013
Funding: Approximately $566,000
Program Contact: Kelly Keeter, kelly.keeter@alaska.gov, (907) 269-3461
Program Description: Two clinical service sites under this grant provide low-cost, confidential services that include (but are not limited to): clinical breast examinations, Pap smear screening and pelvic examination, counseling and screening and/or testing/treatment for sexually transmitted infections and contraceptive methods, and counseling and provision of, or referral for permanent contraception services (sterilization) for males and females. The clinical service sites also provide access to the full range of current, FDA-approved contraceptive methods and supplies to their family planning clients. In addition to clinical services, the sites provide counseling and education on reproductive and preventive health topics, including abstinence education, sexually transmitted infections/Human Immunodeficiency Virus (STI/HIV) prevention and risk reduction, and education, counseling, and referral for all pregnancy options.

Promoting Health Among Teens – Abstinence and Safer Sex Intervention
Funding Source: Office of Adolescent Health
Funding Cycle: 2010-2015
Funding: $600,000 per year for five years
Program Contact: Stephanie Birch, RNC, MPH, MS, FNP, stephanie.wrightsman-birch@alaska.gov, (907) 269-3400

Program Description: This program provides peer education to high-risk youth in Anchorage, Homer, and Bethel using the Alaska Promoting Health Among Teens curriculum – an abstinence-plus safer sex intervention aiming to reduce teen pregnancy, STDs and HIV.

The Fourth R
Funding Source: Family and Youth Services Bureau
Funding Cycle: 2010-2015
Funding: $250,000 per year for five years
Program Contact: Stephanie Birch, RNC, MPH, MS, FNP, stephanie.wrightsman-birch@alaska.gov, (907) 269-3400
Program Description: The Fourth R curriculum is taught in schools throughout Alaska, with focus on areas of the state with high teen birth rates. The goal of the curriculum is to reduce teen pregnancy, STDs, HIV, substance abuse, and unhealthy relationships.

Temporary Assistance for Needy Families (TANF) teen and out of wedlock pregnancy prevention
Funding Source: RSA with Division of Public Assistance
Funding Cycle: yearly
Funding: $395,000 per year
Program Contact: Stephanie Birch, RNC, MPH, MS, FNP, stephanie.wrightsman-birch@alaska.gov, (907) 269-3400
Program Description: This program provides educational campaigns, grants to communities, and supplies to community groups throughout Alaska with the goal of reducing teen and out of wedlock pregnancies.

Division of Behavioral Health

Comprehensive Behavioral Health Prevention and Early Intervention
Source of Funding: Alaska Division of Behavioral Health
Funding Cycle: July 1, 2011 through June 30, 2014
Funding: Approximately $4.1 million to 24 grantees
Program Contact: Diane Casto, MPA, l.casto@alaska.gov, (907) 465-3033
Program Description: The goal of this grant program is to provide integrated behavioral health prevention and early intervention services related to substance use and abuse, suicide, fetal alcohol spectrum disorders, youth development and resiliency, and promotion of wellness in Alaska. The state awarded funds ranging from $16,709 to $392,620 to 24 grantees in FY2012. Grants support a variety of projects, some of which are single-issue programs such as suicide prevention, while others address multiple behavioral health issues. Grantees include school districts, community-based organizations, hospitals, community clinics, Alaska Native health corporations, tribal entities, and rural city governments. The intended target populations of the programs include youth, adults, elders, individuals and family units.

Comprehensive Behavioral Health Treatment Program
Source of Funding: Alaska Division of Behavioral Health
Funding Cycle: July 1, 2012 through June 30, 2013
Funding: Approximately $68.5 million to 78 grantees
Program Contact: Viki Wells, viki.wells@alaska.gov, (907) 269-3794
Program Description: This program awards community grants to support integrated treatment across the spectrum of behavioral health services. Funded programs are statewide and serve all ages. Priority target populations eligible for grant funded mental health treatment include: individuals needing psychiatric emergency services, adults with serious mental illness, youth with serious emotional disturbance, and individuals with co-occurring substance use disorders. Priority target populations eligible for grant funded substance abuse treatment include: pregnant injection drug users, pregnant females, injection drug users, females with dependent children, persons and families whose presenting problem is addiction to, dependency on, or chronic disabling use/abuse of alcohol and other drugs, and individuals with co-occurring mental health disorders. Funded substance abuse treatment programs are required to have staff trained in, and all clients provided, hepatitis, TB, HIV and Fetal Alcohol Spectrum Disorder risk assessment, education, early intervention and risk reduction counseling. The program also funds two opioid treatment programs providing medication assisted treatment (Methadone maintenance): the Narcotic Drug Treatment Center in Anchorage and Project Special Delivery in Fairbanks, for a combined total of 140 treatment slots.

Pilot Project to Provide Medication-Assisted Substance Abuse Treatment
Source of Funding: Alaska Division of Behavioral Health (through alcohol tax revenue)
Funding Cycle: 2.25 years once funded
Funding: $1,262,660
Program Contact: Viki Wells, viki.wells@alaska.gov, (907) 269-3794
Program Description: This program will offer funding for a pilot project to provide medication-assisted treatment for alcohol and opioid dependent adults as an ancillary service to individuals concurrently enrolled in substance abuse disorder treatment.

Department of Education and Early Development

Division of Adolescent and School Health
Source of Funding: CDC Division of Adolescent and School Health (DASH), HIV prevention Cooperative agreement.
Funding Cycle: March 2008 through February 2013; future funding is dependent upon a successful application for the next competitive funding grant cycle beginning in March 2013.
Funding: $196,111 annually
Program Contact: Terri Campbell terri.campbell@alaska.gov, (907) 465-8719
Program Description: This program assists in the administration of the Youth Risk Behavior Survey and the School Health Education Profile, a survey for Principals and Lead Health Teachers about the health program content in their schools, their training and their

expertise. The remainder of the program funds goes to state trainings and leadership activities for a targeted initiative for Alaska's high risk youth in Alternative Schools settings.

According to the School Health Education Profile: 88% of Alaska high schools had a health education curriculum; 79% taught key pregnancy, HIV, or other STD prevention topics in a required course; 62% taught key topics related to condom use in a required course; and 83% taught how to access valid and reliable health information, products, or services related to HIV, other STDs, or pregnancy in a required course.

Alaska Native Tribal Health Consortium

HIV/STD Prevention

***I Know Mine* (www.Iknowmine.org)**
Funding Source: Indian Health Service
Project Contact: Cornelia Jessen, MA, cmjessen@anthc.org, (907) 729-1900
Project Description: *I Know Mine* is a youth wellness website that promotes healthy relationships and lifestyles to Alaska Native youth. The website contains information on topics ranging from sexual health to mental, physical and emotional health. Visitors to the website also have the opportunity to ask questions and engage with peers and *I Know Mine* staff through a variety of social media outlets. Through its website, the *I Know Mine* program provides condoms and STD testing kits free of charge to all Alaska residents.

***I Want the Kit* (www.iwantthekit.org)**
Funding Source: Indian Health Service
Project Contact: Brenna Simons, PhD, bcsimons@anthc.org, (907) 729-1900
Project Description: *I Want the Kit* allows Alaskans 14 and older to order self-collected STD (gonorrhea, Chlamydia and trichomonas) specimen kits free of charge through a partnership with Johns Hopkins University. Individuals who submit specimens are contacted regarding their test results. Those who test positive are linked to care. The *I Want the Kit* program is particularly targeted towards rural areas of the state where access to services may be limited.

Native American Research Centers for Health (NARCH)
Funding Source: Indian Health Service/National Institutes of Health
Funding Cycle: 2010-2013
Project Contact: Cornelia Jessen, MA, cmjessen@anthc.org, (907) 729-1900
Project Description: NARCH funds support several investigational projects at ANTHC. Safe *in the Village* (*SITV*) is a research project focusing on the development of video interventions which promote healthy relationships and safer sex behavior for rural Alaska Native youth, ages 15-24 years. *SITV* has two phases: Phase one consists of formative data collection to gather qualitative information to assist in identifying culturally-appropriate safe behaviors and in developing the storylines of the *SITV* videos. Phase two involves evaluation of the *SITV* video interventions to assess their impact and effectiveness. It is anticipated that *SITV* will be

implemented in village clinics, high schools, at cultural and social events, community youth centers, as well as at community and youth group meetings.

Community PROMISE is an evidence-based HIV/STD prevention intervention that has been adapted for urban Alaska Native women ages 21-30 years. The program consists of community outreach through peer outreach workers who distribute condoms along with role model stories that promote positive sexual behavior to women frequenting bars in Anchorage. The goal of this project is to evaluate the effectiveness of the cultural adaption of Community PROMISE.

NATIVE It's Your Game…Keep It Real
Funding Source: CDC and Administration for Children and Families
Funding Cycle: 2010-2015
Project Contact: Cornelia Jessen, MA, cmjessen@anthc.org, (907) 729-1900
Project Description: *NATIVE It's Your Game…Keep It Real* (*IYG*) is a research project designed to develop and test the efficacy of sexual health education programs for American Indian/Alaska Native (AI/AN) middle school students (7th and 8th grades, or 12-14 years of age). *IYG* teaches skills for dealing with peer pressure around sex, drugs and alcohol. ANTHC is developing an internet-based version of the *IYG* curriculum for AI/AN middle school aged youths in partnership with the University of Texas, Inter Tribal Council of Arizona and the Northwest Portland Area Indian Health Board; the curriculum will be called *NATIVE It's Your Game* (*NATIVE IYG*). The effectives of *NATIVE IYG* will be evaluated through a randomized controlled trial with approximately 1,200 AI/AN middle school students in Alaska, Arizona, and the Pacific Northwest

Alaskan AIDS Assistance Association*

Anchorage Syringe Exchange
Funding Source(s): Syringe Access Fund, Comer Foundation
Project Contact: Alex Barros, abarros@alaskanaids.org, (907) 263-2048
Program Description: The Anchorage Syringe Exchange (ASE), in Anchorage, provides access to sterile syringes and other drug injection equipment. Clients are offered cookers and cottons, a sharps container, tourniquets, and alcohol swabs. Services are provided on a drop-in basis and all clients are offered free rapid HIV and Hepatitis C testing and receive condoms and referrals to the Municipality of Anchorage Reproductive Health Clinic for STD testing and treatment and the methadone treatment facility.

Anchorage Syringe Exchange – Juneau
Funding Source(s): Syringe Access Fund, Comer Foundation
Project Contact: Alex Barros, abarros@alaskanaids.org, (907) 263-2048
Program Description: The Anchorage Syringe Exchange (ASE), in Juneau, provides access to sterile syringes and other drug injection equipment. Clients are offered cookers and cottons, a sharps container, tourniquets, and alcohol swabs. Services are provided on a drop-in basis and

all clients are offered free rapid HIV testing and receive condoms and referral to the Juneau Public Health Clinic for STD testing and treatment.

Alaska AIDS Assistance Association – Juneau Office
Funding Source: Pride Foundation
Project Contact: Heather Davis, hdavis@alaskanaids.org, (907) 263-2052
Project Description: The Four A's Juneau Office conducts HIV testing through their syringe exchange program and to walk-in clients. Four A's Juneau also provides HIV 101 risk reduction presentations at substance abuse treatment centers and community release centers.

* Other prevention interventions conducted by the Alaskan AIDS Assistance Association are described in Table 11.

Alaska Youth Advocates (formerly Alaska Youth and Parent Foundation)

Peer Outreach Worker Education and Referral (POWER) Program
Source of Funding: State of Alaska Section Women's, Children's and Family Health (WCFH) and Federal DHHS Office of Administration for Children and Families
Funding Cycle: Through 2014
Funding: $100,000 annually from Federal ACF and $75,000 annually from State WCFH
Program Contact: Heather Harris, hharris@akyouthadvocates.org, (907) 929-2633
Program Description: Alaska Youth Advocates offers the chance for a healthier life to young people who have little or no family support, often have quit school, may suffer from abuse or addiction, and have no place to go but the streets. Through POWER street outreach, presentations, a teen center and health clinic in downtown Anchorage, Alaska Youth Advocates reaches out to youth, offering a caring environment and information that can help them make good decisions in their lives. At Alaska Youth Advocates, young people who have overcome their own challenges learn how to help others by becoming peer counselors to provide community referrals, HIV/STD education, information, and mentoring to youth in Anchorage.

Interior AIDS Association*

Northern Exchange
Funding Source(s): National AIDS Fund, AIDS United, and by IAA's charitable gaming proceeds
Project Contact: Anna Nelson, anna@interioraids.org, (907) 452-4222
Program Description: Northern Exchange (NE) has been offering syringe exchange services in Fairbanks since 1989. Multiple secondary exchangers distribute syringes and supplies both in town and in more remote areas. Syringes are accepted for disposal and picked up on-site by a medical waste company. NE supports secondary exchanges, where individuals pick up safer injection supplies for others who can't or won't come in to the exchange. Outreach workers provide a range of support during each contact, including risk assessment and safer-injection education. NE offers syringes based on need, appropriate disposal containers, safety kits that include a syringe, water, antibiotic cream, alcohol wipes, cottons, cooker, and a condom, and

referrals as needed. Rapid HIV testing is offered by IAA to exchangers. In addition, HCV rapid testing is available. With the availability of the rapid HCV test, which is popular with exchangers, IAA has seen an increase in HIV testing of injection drug users who agree to do the tests at the same time.

Project Special Delivery
Funding Source(s): State of Alaska, Division of Behavioral Health
Project Contact: Anna Nelson, anna@interioraids.org, (907) 452-4222
Program Description: Project Special Delivery (PSD) is a program developed by and for opiate users who want to eliminate their dependency on illegal narcotic drugs by accessing and participating in a treatment program that offers methadone maintenance and is responsive to individual consumer needs. *The overall goal of the project is to provide opportunities and support within a harm reduction model to individuals interested in developing or regaining the control and skills needed to build and maintain an informed, productive and independent lifestyle.* Applicants to the program receive HIV and HCV testing at IAA. Persons at-risk are oriented to the syringe exchange program and receive harm reduction education, including safer-injection practices and referral to other community resources.

* Other prevention interventions conducted by the Interior AIDS Association are described in Table 11.

Kachemak Bay Family Planning Clinic

HIV/STD Prevention
Program Contact: Catriona Lowe, catriona.kbfpc@ak.net, (907) 235-3436
Program Description: Kachemak Bay Family Planning Clinic provides HIV and STD testing to men and women on the southern Kenai Peninsula. Available HIV testing is performed by either Oraquick rapid HIV tests or serology through Alaska State Public Health Laboratory. Additional STD tests include chlamydia and gonorrhea (vaginal self-swab, urine, cervical, rectal or pharyngeal), syphilis, herpes and hepatitis. Universal screening for HIV is included at annual Well Woman Visits and HIV/STD testing is available on a walk-in basis. KBFPC is a Title X agency and participates in the Region X Infertility Prevention Project. KBFPC is an independent contractor with South Peninsula Hospital to meet its desire to provide confidential testing and counseling for sexually transmitted infections outside the hospital facility. Other revenue to support our HIV and STD services comes from third party insurance and Alaska Medicaid. Income of self-pay clients is assessed on a sliding scale that allows discounts for those with incomes up to 250% of federal poverty guidelines; however, no one is denied services due to inability to pay. KBFPC also provides 7th and 9th grade sexual health education, including HIV/STD information as part of the local school curriculum and has a peer health education program that covers HIV/STD in great detail.

Narcotic Drug Treatment Center (NDTC)

Center for Drug Problems
Funding Source(s): State of Alaska, Division of Behavioral Health, Medicaid, self-pay, and private insurance
Project Contact: Jennifer Stukey, stopaids@alaska.net, (907) 276-6430
Program Description: Opioid treatment programs provide comprehensive substance abuse counseling and medication assisted treatment. Methadone is utilized to prevent the onset of withdrawal symptoms, reduce or eliminate drug craving and block the euphoric effects of any illicitly self-administered narcotics while the patient is undergoing rehabilitation. When clients apply for services at NDTC and placed on a waiting list, they are offered the following services: anonymous rapid HIV testing, risk reduction counseling, educational classes on safer injection techniques and all communicable diseases, and referral to the Anchorage Syringe Exchange. Once in treatment clients are offered anonymous rapid HIV testing and receive Hepatitis B and C testing and referral if positive.

Planned Parenthood of the Great Northwest

HIV/STD Prevention
Program Contact: Jennifer Jarvis, Jennifer.Jarvis@ppgnw.org, (907) 443-3718
Program Description: Planned Parenthood of the Great Northwest has five health centers in Alaska – one in Anchorage, Fairbanks, Juneau, Sitka, and Soldotna. HIV testing and STD testing and treatment is conducted in all five health centers. Anyone who comes in for an HIV-, STD-, or other sex-related visit receives risk reduction counseling. The Sitka health center receives federal funding to conduct a teen outreach and advocacy program which includes a sexual health curriculum. Planned Parenthood also provides education programs in local schools upon request.

Rural Alaska Community Action Program (RurAL CAP)

HIV Prevention Website
http://www.ruralcap.com/index.php?option=com_content&view=article&id=485&Itemid=368
Program Contact: Joie Brown, jbrown@ruralcap.com, (907) 865-7356
Program Description: The RurAL CAP HIV Prevention website includes the following that were developed as a part of a media campaign to promote HIV prevention in rural Alaska: (1) downloadable posters developed with input from rural Alaska community members and (2) digital stories developed by community members sharing brief, personal stories about HIV and STD. Also on the website is an interactive HIV 101 presentation (developed by the State HIV/STD Program).

University of Alaska

Student Health Services

Program Description: The Student Health Clinics at the University of Alaska campuses in Anchorage, Fairbanks, and Juneau offer HIV testing and counseling and STD testing, treatment, and counseling.

HIV Prevention Resources by Geographic Area

The majority of HIV prevention resources in Alaska are centered in Anchorage. As required by CDC, HIV prevention activities funded through PS12-1201 must be focused in the areas of the state with at least 30% of the HIV disease burden. The only area of Alaska that meets this requirement is Anchorage. Fairbanks receives a small amount of funding through PS12-1201. Community-based organizations in Anchorage and Fairbanks receive HIV prevention through PS12-1201 to conduct HIV testing, comprehensive prevention with positives, and condom distribution.

Urban centers such as Anchorage, Fairbanks, and Juneau may have concentrations of target populations whose members interact with sufficient frequency to make it possible to help shape community norms about HIV risk reduction, through targeting especially influential individuals or groups. The three urban centers also have sufficient populations of persons affected by HIV to have dedicated AIDS service organizations that offer a continuum of HIV care and prevention services and can employ staff who specialize in HIV prevention.
Mid-sized rural hubs, and some boroughs adjacent to urban centers, have health and social service resources that can incorporate HIV prevention into existing services that reach persons at risk, e.g. persons in substance abuse treatment facilities, public health clinics, and correctional facilities. Alaska Native regional health corporations based in rural hubs provide the health infrastructure to incorporate prevention into the care of beneficiaries living with HIV; they provide HIV counseling and testing, and reproductive health care, including STD diagnosis and treatment.

In less populous areas of the state, smaller population size and lower HIV prevalence often preclude the establishment of HIV/AIDS-specific initiatives. In these areas, partner services can be provided for the small number of persons for whom they are appropriate. Other HIV prevention activities generally are provided by agencies and organizations with broader missions that can integrate HIV prevention into counseling or health education services for their clients and communities. Prevention messages must be designed to reach a broad audience rather than specific risk populations as issues such as stigma may prevent priority target populations (e.g., MSM and IDU) from identifying with the message.

HIV Prevention Indication of Need

HIV Positive Persons

Approaches to prevention with positive persons generally fall into two broad categories. The first is to focus on behavioral interventions, i.e. discouraging PLWHA from engaging in risky behaviors such as unprotected sex with HIV-negative or other HIV-positive persons. The second is to provide care sufficient to ensure that positive persons' viral loads are reduced as much as possible (treatment as prevention), leading to a low probability of transmission. To determine barriers and opportunities for both approaches, a needs assessment will be conducted with HIV positive persons within the first two years of the planning cycle.

Men Who Have Sex with Men

Even though MSM contact contributes to a smaller number and proportion of new diagnoses than it did earlier in the epidemic, it is still the most commonly identified exposure category for new diagnoses (see Chapter 3).

In June 2006, the HIV/STD Program participated in a CDC Behavioral Assessment Project to conduct an anonymous survey of men who have sex with men in Anchorage. The purpose of the Behavioral Assessment Project was to collect behavioral data at selected public events targeted to groups not traditionally reached by behavioral surveillance activities or HIV testing services. The goals of the Rapid Behavioral Assessment portion of the Behavioral Assessment Project was to collect information about behavioral risk factors for HIV and HIV testing using a brief survey administered with a handheld computer. The assessment was conducted by CDC and HIV/STD Program personnel and community volunteers. The survey was fielded over the course of several days during Pride week events in Anchorage, Alaska.

Ninety men between the ages of 18 and 60 completed the survey. Of these:

- 73 (81%) reported that they had at least one male sex partner in the past 12 months or they self-identified as gay or bisexual. Of these MSM:
  - Fifty-five (75%) reported having anal sex with one or more partners during the past 12 months.
  - Sixty-four (88%) of the 73 MSM reported having even been tested for HIV and 36 (49%) had been offered an HIV test in the past 12 months.
  - Eight (11%) of the 73 MSM reported being diagnosed with an STD in the past 12 months.
  - Twenty-two (34%) of 64 respondents without a recently diagnosed STD had been tested for syphilis in the past 12 months.

- Of the 32 who identified more than one sexual partner in the past 12 months, 20 (62.5%) reported no condom use.

- Of the 23 who reported one sexual partner in the past 12 months, 14 (61%) reported no condom use.

See Appendix A – Needs Assessments – for a full report on the MSM Behavioral Assessment Project.

Injection Drug Users

During June-August 2012 the HIV/STD Program conducted a survey of injection drug users (IDUs) to determine needle use trends, including where IDUs are acquiring needles, what barriers they are encountering in obtaining clean needles, and to what extent to which IDUs are re-using and sharing needles.

Of the 149 survey respondents, 64% (n=95) reported having ever shared needles and 90% (n=133) reported having ever re-used needles. Rates of needle sharing and re-use were higher in certain areas of the state. In Fairbanks, 100% of survey respondents (n=16) reported sharing needles and re-using needles, while 81% of survey respondents at outreach events reported sharing needles and 88% reported re-using needles. Needle exchanges and pharmacies were the two most commonly reported sources of clean needles among survey respondents. Thirty-nine percent (n=98) of survey respondents reported obtaining needles through exchange programs, and 70% (n=105) reported having ever used a needle exchange program. Thirty-three percent (n=81) of survey respondents reported obtaining needles through pharmacies. Although pharmacies were a primary source of clean needles for many respondents, 62% (n=93) reported having attempted to purchase needles at a pharmacy and being denied.

See Appendix A – Needs Assessments – for a full analysis of the IDU survey data and results.

Heterosexual Women at Increased Risk

Epidemiologic data for Alaska indicate that minority females, especially Alaska Native females, are disproportionately affected by STD and HIV. 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 women for whom HIV counseling and testing may be appropriate but who might not otherwise seek HIV testing and risk reduction counseling.

From December 2006 through March 2007, the HIV/STD Program surveyed 232 women to assess their needs and preferences for HIV prevention services. The purpose of the project was to inform the efforts of the HPPG and the HIV/STD Program, its grantees, and other state

agencies and community partners that provide health and social services for women. Women surveyed were very knowledgeable about HIV transmission, risk reduction, and HIV testing resources. They also indicated high levels of social support for HIV concerns, and confidence in their ability to talk about and negotiate safer behaviors with sex partners. These high levels of knowledge, self-efficacy, and social support contrasted with a relatively low level of perceived vulnerability, a key component of behavior change.

Many of the women with a low perception of risk in fact reported a constellation of behavioral risk factors and a lack of condom use, even with male partners whose HIV status was unknown, and despite these partners' known, or suspected, risk factors. Inaction around HIV risk reduction and testing is a logical consequence of believing one is not at risk for HIV. The challenge is how to motivate women to evaluate their risks realistically and to support their decisions to adopt safer behaviors.

See Appendix A – Needs Assessments – for a full analysis of the heterosexual women needs assessment data and results.

Heterosexual Men at Increased Risk

Nationally[49,50,51] heterosexual men appear to have a low perception of HIV risk and are unlikely to seek out prevention interventions including HIV counseling and testing. As such, HIV prevention efforts must be incorporated into services reaching men at increased risk such as STD clinics, substance abuse treatment programs, correctional facilities and community residential centers (pre-release programs), and services for homeless men.

HIV Care Resources

Alaska has an increasing number of individuals living with HIV infection. While antiretrovirals have allowed individuals with HIV to live longer and healthier, there has been no decline in newly reported cases of HIV in the State. In addition, studies have shown that antiretroviral treatment (ART) use can reduce the risk of sexually transmitting HIV to others by over 90%.[52] The increased number of persons living longer and healthier with HIV and the emergence of ART as a prevention tool demonstrate the need for HIV Care services. The following section describes HIV care services, barriers and gaps within the state of Alaska.

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[49] Khawcharoenporn T, Kendrick S, Smith K. Human immunodeficiency virus risk perception and interest in pre-exposure prophylaxis among persons visiting a sexually-transmitted infection clinic in Chicago. 51st Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC). September 17-20, 2011. Chicago. Abstract H1-1148.

[50] CDC, HIV Among Women. Available at: http://www.cdc.gov/hiv/topics/women.

[51] University of California San Francisco, What are the HIV Prevention Needs of Heterosexual Men? Available at: http://caps.ucsf.edu/factsheets/heterosexual-men.

[52] CDC, Initiation of and Adherence to Treatment as Prevention, Available at: http://www.cdc.gov/hiv/pwp/antiretroviraltreatment.html.

Ryan White HIV/AIDS Treatment Modernization Care Act (RWCA)

The Ryan White HIV/AIDS Treatment Modernization Act of 2009 authorizes federal funding to:

(1) increase the availability of primary health care and support services such as case management and substance abuse and mental health treatment,

(2) reduce utilization of costly inpatient HIV/AIDS-related care,

(3) increase access to HIV/AIDS care for underserved populations, and

(4) improve the quality of life for people living with HIV/AIDS (PLWHA). Several entities in Alaska received Ryan White funding under different parts of the Act.

As of June 2012, a number of entities in, or with service responsibilities for, Alaska receive funding under Part B, Part C, and Part F. These include the following:

Part B

The State of Alaska HIV/STD Program receives formula funding under Part B for HIV Care services statewide. The State allocates base funds to two community agencies to provide or purchase HIV services for eligible PLWHA and families statewide:

a) The Interior AIDS Association (IAA) to serve the Fairbanks area, and

b) The Alaskan AIDS Assistance Association (Four A's) to serve Anchorage, Juneau/Southeast, and all other areas of the State not served by the IAA. The Four As has offices in Anchorage and Juneau.

IAA and Four A's, according to local needs and resources, define priorities for use of Part B funds under the direction of the State HIV Care grants guidance. The bulk of funds are directed towards medical case management (MCM). MCM services are directly provided by staff in grantee agencies. These services are available statewide and help individuals get access to medical and social services, HIV-related medications, and health insurance. Any funds remaining are used to purchase core medical services, followed by support services for individuals with HIV infection and support services for affected family members

To be eligible for RWCA services an individual must show proof of HIV infection (confirmation of positive serostatus or physician diagnosis) or be an affected family member. Infants born to infected mothers may also qualify for services until the infant's immune system clearly shows infection or lack of infection. Medical case management services are provided at no charge to eligible individuals.

Part B Earmark Funds – AIDS Drug Assistance Program (ADAP)

In addition to Part B base funds, the State receives Part B earmark funds allocated to the statewide AIDS Drug Assistance Program (ADAP). ADAP's purpose is to increase access for low income Alaskans to FDA-approved medications to treat HIV disease, opportunistic infections, and related conditions. To achieve this, the ADAP covers medications for eligible individuals, as well as health insurance for participants for whom it is appropriate. The State contracts with two agencies to provide ADAP services:

a) Great Land Infusion Pharmacy to order, dispense, and ship (when necessary) prescribed medications to enrolled individuals, as well as provide all client data, answers to questions about medications and advise prescribing providers and clients, and

b) Alaskan AIDS Assistance Association (Four A's) to manage ADAP enrollment, determine eligibility, oversee client utilization, and purchase third party health insurance, when appropriate, recertifying clients for eligibility, and ensuring that clients pick up medications, and work closely with the ADAP pharmacy services contractor.

Part C

The Anchorage Neighborhood Health Center (ANHC)
ANHC receives funding under Part C for outpatient early intervention services for PLWHA living in Anchorage, as well as those living in other parts of the state who travel to Anchorage for care. Services provided include outpatient medical care, medical case management and dental services. To access dental services, patients must receive medical care at ANHC.

The Alaska Native Tribal Health Consortium (ANTHC)
ANTHC receives Part C funds to provide outpatient early intervention services for PLWHA statewide, working with and through Regional Native Health Corporations. ANTHC serves Alaska Natives and all Alaskans outside Anchorage. The Part C Early Intervention Services (EIS) clinical team works on the campus of the Alaska Native Medical Center; program hub sites are in Anchorage, Sitka, Juneau, Bethel, and Fairbanks. In addition, the ANTHC clinical team provides medical consultation across the state. Part C EIS regional (or Hub) site coordinators provide case management and coordination of primary care services to clients living in rural areas. ANTHC providers are particularly vital for patients in the Interior, as they are the source of direct care for many clients in that area.

Part F

A subcontract to ANTHC from the Northwest AIDS Education and Training Center (NWAETC) provides statewide training opportunities for Tribal and non-Tribal clinicians and other providers associated with HIV medical care and treatment. The University of Washington's NWAETC also supports Alaskans by providing HIV preceptorships, education, clinical

consultations, clinical support tools, speakers, and technical assistance. ANTHC also receives Part F funds for a specialized Minority AIDS Initiative component focusing on capacity development for HIV response in targeted Alaska Native communities.

Non Ryan White HIV/AIDS Treatment Modernization Care Act Resources

Alaskan AIDS Assistance Association (Four A's)

Housing Opportunities for People with AIDS (HOPWA) – Southcentral
Source of Funding: U.S. Department of Housing and Urban Development
Funding Cycle: January 1, 2010 through December 31, 2012; 2013-2015 as yet to be awarded
Funding: $823,123 (2010-2012)
Program Contact: Maureen Suttman, msuttman@alaskanaids.org, (907) 263-2055
Program Description: Funds provide for HIV case management and supportive services, including nutrition, transportation, and substance abuse treatment. The focus of funds is to assist persons living with HIV/AIDS (PLWH/A) to maintain stable housing through tenant based rental assistance, housing placement assistance, short term rent, utility, and mortgage assistance.

Housing Opportunities for People with AIDS (HOPWA) – Southeast
Source of Funding: U.S. Department of Housing and Urban Development
Funding Cycle: January 1, 2012 through December 31, 2014
Funding: $398,489
Program Contact: Maureen Suttman, msuttman@alaskanaids.org, (907) 263-2055
Program Description: Funds provide for HIV case management and supportive services, including nutrition, transportation, and substance abuse treatment. The focus of funds is to assist persons living with HIV/AIDS (PLWH/A) to maintain stable housing through tenant based rental assistance, housing placement assistance, short term rent, utility, and mortgage assistance.

Supportive Housing Program (SHP)
Source of Funding: U.S. Department of Housing and Urban Development
Funding Cycle: July 1 2012 through June 30, 2013
Funding: $104,665
Program Contact: Maureen Suttman, msuttman@alaskanaids.org, (907) 263-2055
Program Description: Funds provide for housing support in the guise of rental subsidy and operations support--both for the 6Plex Project which includes the agency owned 6plex apartment building and also community-based rental subsidies. Funds are for those impacted by disabilities and homelessness.

Shelter Plus Care (S+C)
Source of Funding: U.S. Department of Housing and Urban Development
Funding Cycle: July 1 2012 through June 30, 2013
Funding: $117,492

Program Contact: Maureen Suttman, msuttman@alaskanaids.org, (907) 263-2055
Program Description: Funds provide support for rental subsidies in the community for those impacted by disabilities and homelessness.

Interior AIDS Association (IAA)

Housing Opportunities for People with AIDS (HOPWA)
Source of Funding: HUD
Funding Cycle: January 1, 2012 to December 31, 2014
Funding: 682,986, average $227,662 per year
Program Contact: Tracey White, tracey@interioraids.org, (907) 452-4222
Program Description: HOPWA funds provide for HIV Case Management and supportive services, including nutrition, transportation, and substance abuse treatment. The focus of funds are to assist PLWH/A to maintain stable housing through tenant based rental assistance, housing placement assistance, short term rent, utility, and Mortgage Assistance.

Other HIV Care Resources

The 2012 Alaska Statewide Coordinated Statement of Need (SCSN) of the State of Alaska's Ryan White grant identifies the following other HIV care resources in Alaska:

Alaska Native Health Consortia provide care for Alaska Native beneficiaries across the State. Primary care may be provided for some patients in their home region. However, all beneficiaries living with HIV/AIDS have access to the Part C funded team at ANTHC. Native Health Consortia, with the exception of the Southeast Alaska Regional Health Consortium (SEARHC), cover the cost of prescription medications, including antiretrovirals (ARVs) for their beneficiaries. SEARCH does not cover certain expensive medications, including ARVs. If otherwise eligible, SEARCH beneficiaries may access ARVs through the ADAP program.

HIV care services are also provided to individuals by private providers. A number of private practice physicians in the Anchorage area have developed knowledge in treating patients living with HIV/AIDS. However, in most other areas of the State, there is a dearth of providers with the requisite expertise to treat these patients. For providers who require assistance, ANTHC is available for medical consultation. The military also provides comprehensive services for servicemen and women living with HIV/AIDS. VA clinics refer patients to outside providers, including ANHC, for care. The Department of Corrections contracts with providers for most specialty care, including HIV.

A final important source of care for PLWHA in Alaska is out-of-state providers. Some individuals with HIV/AIDS prefer to travel out of state (for example, to Seattle) for care because of a desire to obtain care from a large teaching hospital, concerns over confidentiality, or simply ease of access (Seattle is of similar distance to or even closer to some Southeast communities than is Anchorage).

HIV Care Needs/Barriers

Socioeconomic

For many HIV patients who present with increased levels of socioeconomic barriers to care, dealing with these issues takes precedence over health care. PLWHA can better obtain services and are more likely to stay in services when basic needs for food and housing are met. Homelessness may disrupt medical services, make it impossible to adhere to complicated medication regimens, and make it difficult to obtain food that meets special dietary requirements.

Cultural

Health literacy and stigma are problems for a significant number of patients, particularly Alaska Natives living in rural areas as well as immigrants.

Health literacy, the ability to read, understand and use healthcare information to make decisions and follow instructions for treatment, is a problem for a significant number of patients, particularly Alaska Natives living in rural areas as well as immigrants, who may also require interpretation services.

HIV still carries significant stigma, especially in certain geographic areas, including rural areas. Stigma may be external, that is, stigma experiences through the actions or words of others, or it may be internal stigma experienced by the infected individual through his or her own thoughts or actions. Many individuals will not seek services in their area of residence due to perceived and experienced stigma.

Mental Health Issues

Many people have mental health issues that complicate their ability to maintain care. Part B and Part C providers estimate that up to 80% of PLWHA in care are in need of mental health services. Mental health conditions present in PLWHA may or may not be related to HIV disease. Not all individuals will seek services, as the stigma surrounding mental health problems may be perceived as more damaging than those related to HIV. This may be especially true for some rural residents who need to access itinerant providers for mental health services.

Substance Abuse

Clients with substance abuse problems face special challenges in following medical care schedules and medication regimens. Alcohol remains the most prevalent drug of abuse for Alaska PLWHA. Substance abuse treatment services are available in some areas of the state, although the different levels and types of treatment are not uniformly available in all areas. In addition, some individual factors may not be well accommodated; for example, lengths of stay

may be prescribed rather than individually established, services may not be perceived as culturally sensitive, and child care may be unavailable to those who need it. Furthermore, waiting lists exist for both inpatient and outpatient services. Access to treatment is problematic for substance abusing individuals with HIV dementia, for those who have disruptive behaviors, and to those who are convicted of a sexual offense. HIV status is not considered a priority factor in determining eligibility for state funded substance abuse treatment services.

HIV Gaps in Service

Prevention

An assessment of unmet HIV prevention services identified the following gaps in services:

- Due to the re-allocation of funds addressed in the National HIV/AIDS Strategy and PS12-1201, HIV prevention in Alaska will shift to more emphasis on HIV testing and comprehensive prevention with positives (including partner services and linkage to care). HIV prevention gaps in services will increase from the *2010-2012 Alaska HIV Prevention Plan* in the following areas:

  - Evidence-based behavioral interventions targeting MSM, IDU, and HRH will no longer be funded by the HIV/STD Program.

  - A social marketing campaign targeting HIV prevention in rural Alaska is no longer being funded.

  Therefore, after June 30, 2013 there will be no interventions in Alaska specifically targeting MSM, IDU, HRH, or rural Alaskans using PS12-1201 funds.

- According to the IDU needs assessment conducted in 2012, access to clean needles remains a problem in Alaska, particularly in areas outside of Anchorage.

- Advances in medical technology and medications used in the treatment of HIV/AIDS has progressed, resulting in better treatment outcomes for HIV-positive individuals. This decline in deaths among HIV-positive individuals, combined with the ongoing and steady occurrence of new infections, has resulted in a steady increase in the number of persons living with HIV in Alaska. The need for prevention will continue to grow as persons with HIV live longer, healthier lives. Currently, there is only one behavioral intervention that targets HIV positive persons. The intervention – Incorporating HIV Prevention into the Medical Care of Persons Living with HIV – is conducted by the Alaska Native Tribal Health Consortium. The intervention is primarily conducted in Anchorage with Alaska Native individuals.

Care

The following gaps in HIV Care services were identified in the *2012 Statewide Coordinated Statement of Need.*

Access to Providers in Certain Geographic Regions

Primary medical care is generally available throughout the state, though there are access issues in some geographic areas including rural areas and even in Fairbanks, where patients rely on Anchorage-based providers to provide itinerant care. Some patients, particularly those that live in the Southeast region, do travel out of state for care. As of 2012, there were no HIV medical providers taking new patients in the Interior region. As a result, ANTHC Part C providers also provide direct medical care for HIV positive individuals living in the Fairbanks area and receiving primary care at Interior Community Health Center. In many rural areas, many individuals are reluctant to access HIV testing and other services due to confidentiality concerns related to living in a small community.

Mental and Substance abuse services in rural areas

The availability of mental and substance abuse services, is also a major issue that requires capacity development. In certain areas of the state including rural areas, and even in the Interior region, the availability of mental health and substance abuse services is severely lacking.

Strategic Planning Meeting

The following additional gaps in HIV prevention, care, and treatment services were identified during the HIV Planning Group (HPG) meeting (January 18-19, 2013) involving HPG members and key community stakeholders:

- Funding and programming for Alaska Native MSM
- Services for gay, transsexual males
- Web-based information and support
- Services for immigrant populations, both legal and illegal
- mHealth technologies
- Elderly/Elders HIV prevention services
- Capacity building for rapid HIV testing outside of Anchorage, Fairbanks, and Juneau
- Lack of provider comfort on discussing sexual behavior
- Lack of a statewide health education curriculum, especially in rural communities
- Lack of faith-based initiatives or community outreach
- Use of videoconference technology in rural communities
- Lack of outreach to homeless population, especially young adults who may not access shelters for adults.

- Low urgent care/emergency room HIV testing and lack of triggers to prompt testing in ER setting
- Lack of outreach to sex workers, especially young people engaged in transactional sex

Chapter 5

Priority Populations and Interventions

Priority Populations

HIV prevention funds in Alaska are limited. To have the greatest impact on the epidemic, prevention efforts must be focused on populations at greatest risk of acquiring or transmitting HIV. Except for HIV positive persons, who are mandated as the number one priority by the CDC, these priority populations are determined by the Epidemiologic Profile, and are, in order of priority:

1. HIV positive persons,
2. Men who have sex with men (MSM),
3. Injection drug users (IDU),
4. Heterosexual women at increased risk, and
5. Heterosexual men at increased risk

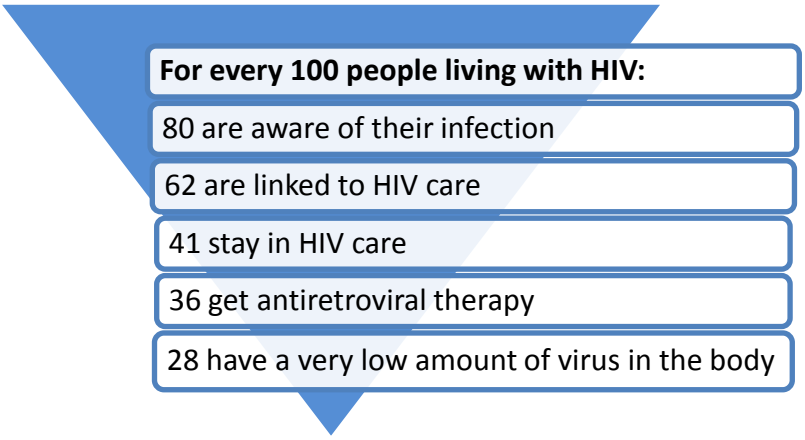
HIV Positive Persons

The CDC mandates that all jurisdictional planning groups make HIV-positive persons their number-one priority population. Antiretroviral treatment (ART) for HIV disease has contributed significantly to longer, healthier lives for persons with HIV, giving new importance to prevention work among PLWHA. In addition, recent studies show that ART in persons with HIV can reduce the risk of sexually transmitting the virus to others by over 90%.[53] However, according to the CDC, nationally, only 28% of HIV positive persons are getting the care they need to manage the disease and keep the virus under control.[54]

[53] CDC, *HIV/AIDS, Initiation of and Adherence to Treatment as Prevention.* Available online at:http://www.cdc.gov/hiv/pwp/antiretroviraltreatment.html. Accessed on November 29, 2012.

[54] CDC, *Vital Signs: New Hope for Stopping HIV – Testing and Medical Care Saves Lives,* December 2011. Available online at: http://www.cdc.gov/vitalsigns/HIVtesting/index.html. Accessed on November 29, 2012.

Figure 23: HIV Care in the United States – 1.2 million people are living with HIV[55]



Men who have Sex with Men

Forty eight percent (n=543) of all cases initially diagnosed with HIV in Alaska since 1982 and 61% of all cases initially diagnosed in males in Alaska have been among men reporting sexual contact with other men (MSM). When MSM/IDU cases are included, MSM comprise 62% of recent (2002-2011) cases in males. Even though the percentage of cases initially diagnosed in MSM has decreased since the beginning of the epidemic, from 60% in 1982-1991 to 43% in 2002-2011, male-to-male sexual contact remains the most significant transmission category for males of all races and ethnicities.

Internet sex-seeking sites have emerged as important venues for high risk sexual behaviors in association with acquisition of both HIV and syphilis. In a recent HIV outbreak in Fairbanks, eight of nine cases of HIV reported to the Section of Epidemiology between January 1, 2011 and January 31, 2012 were MSM. Seven (88%) of these eight persons reported meeting anonymous sex partners through internet sex-seeking sites.[56] Since 2000, 80 cases of syphilis were reported in Alaska; of those 80 cases, 64 (80%) were in MSM, many of whom reported having anonymous sexual encounters with men they met on the Internet. There has also been a very recent increase of gonorrhea cases in MSM. Due to the largely anonymous nature of sexual encounters involving online sex seeking sites, public health staff are often unable to identify, notify, and test exposed partners.[57] These events indicate the continued and evolving need for prevention and care services within the MSM community.

[55] Ibid
[56] Alaska Epidemiology *Bulletin*. "HIV Outbreak — Fairbanks, 2011–2012." 1982-2010. Available at: http://www.epi.hss.state.ak.us/bulletins/docs/b2012_03.pdf
[57] Alaska Epidemiology *Bulletin*. "Syphilis Outbreak —Alaska, 2011–2012." 1982-2010. Available at: http://www.epi.hss.state.ak.us/bulletins/docs/b2012_04.pdf

Injection Drug Users

Excluding MSM/IDU, injection drug use was responsible for 13% (n=151) of all cases initially diagnosed in Alaska since 1982, including 10% (n=34) from 1982-1991, 17% (n=77) from 1992-2001, and 12% (n=40) from 2002-2011. While there are active syringe exchange programs with comprehensive prevention services in Fairbanks, Anchorage and Juneau, there is a need for access to clean syringes and equipment in other parts of the State. Data from 2012 indicate that In Anchorage, where 255 injection drug users (IDU) were tested for HIV through the Anchorage Syringe Exchange (ASE), 133 of 255 (52%) exchangers who tested continued to share drug injection equipment. In Fairbanks, where testing is not conducted through the syringe exchange program, 124 of 176 (71%) IDU tested by the Interior AIDS Association (IAA) continued to share. These data demonstrates that, even IDU in Anchorage and Fairbanks, with syringe exchange programs, need HIV prevention services. However, prevention services including evidence-based behavioral interventions targeting IDU are lacking throughout the State.

Heterosexual Women at Increased Risk

High risk heterosexual contact (defined as sex with MSM, IDU, or HIV positive person) is the most significant transmission category among women, contributing to 57% (n=135) of all cases in females reported in Alaska from 1982-2011, including 65% (n=26) of diagnoses in females from 1982-1991, 50% (n=53) of diagnoses in females from 1992-2001, and 62% (n=56) of diagnoses in females from 2002-2011. Racial and ethnic disparities are significant: 47% of cases diagnosed in females from 2002-2011 were among American Indian/Alaska Native females, though they constituted roughly 16% of Alaska's female population over 15 years of age during this period. Similarly, 17% of diagnoses in females from 2002-2011 were among African-American and other black females, though they constituted roughly 4% of Alaska's female population over 15 years of age. HIV/AIDS diagnoses among females for whom heterosexual contact was identified or reported as the category of exposure accounted for 12% (n=135) of all HIV/AIDS cases initially diagnosed (n=1,130) in Alaska since 1982.

Heterosexual Men at Increased Risk

Though not as significant a transmission category in men as in females, high risk heterosexual contact (defined as sex with IDU or HIV positive person) continues to contribute to infection in males. Though heterosexual transmission was identified or reported as the category of exposure for just 6% (n=55) of cases initially diagnosed in males from 1982-2011, including 1% (n=2) of all cases initially diagnosed in males from 1982-1991, and 7% (n=24) of all cases initially diagnosed in males from 1992-2001, it accounted for 12% (n=29) of all cases diagnosed in males from 2002-2011.

HIV Prevention Interventions

With the advent of the National HIV/AIDS Strategy, the CDC, through PS-1201, has become more prescriptive as to what State Health Departments (HIV/STD Program) can fund or conduct using PS-1201 funds. The following are the required core components and recommended program components identified in PS12-1201.

Required Core Components

These interventions are either funded or conducted by the HIV/STD Program or are appropriate interventions to conduct with other funding sources:

1. HIV Testing

- Opt-out HIV testing of patients ages 13-64 in healthcare settings as described in Revised Recommendation for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings (CDC, 2006).

- HIV testing in non-healthcare settings to identify undiagnosed HIV infection in venues that reach persons at increased risk of transmitting or acquiring HIV.

2. Comprehensive Prevention with Positives

- Partner Services (PS)* – A systematic approach to notifying sex and needle-sharing partners of HIV- infected persons of their possible exposure to HIV so that these persons can be offered HIV testing and learn their infection status, or, if already infected, reinforce a message to prevent transmission to others. PS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

- Linkage to Care* – Linkage to care is a strategy to connect and retain HIV-positive individuals in medical care. Nationally, linkage to care is an emerging priority in the continuum of care for HIV-infected people, providing immediate support, education and counseling. Linkage to care helps ensure people living with HIV receive life-saving medical care and treatment, and helps reduce their risk of transmitting HIV. In Alaska, the Linkage to Care (L2C) program, conducted through the state HIV/STD Program, works to connect and retain HIV-positive individuals in medical care. The program identifies and contacts HIV-positive individuals who are newly diagnosed or chronically out of care, and provides them with short-term, intensive support in engaging with an HIV care provider and with long-term medical case management.

* Partner Services and Linkage to Care are conducted solely through the HIV/STD Program

- Evidence-Based Behavioral Interventions[58] – The following behavioral interventions have been identified by CDC as having proven potential to reduce new HIV infections among HIV positive persons:

  - **CLEAR –** CLEAR is a health promotion intervention for males and females ages 16 and older living with HIV/AIDS and high risk HIV-negative individuals. CLEAR is a client-centered program delivered one-on-one using cognitive behavioral techniques to change behavior. The intervention provides clients with the skills to make healthy choices.

  - **Healthy Relationships** – Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Decision-making and problem-solving skills are developed to enable participants to make informed and safe decisions about disclosure of their HIV status and risky behavior. The sessions create a context where people living with HIV (PLWH) can interact, examine their risks, develop skills to reduce their risks, and receive feedback from others.

  - **Partnership for Health (PfH)** –PfH uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention.

  - **Together Learning Choices (TLC) –** TLC is a small-group intervention to help young people living with HIV identify ways to increase use of health care, decrease risky sexual behavior and drug and alcohol use, and improve their quality of life. It emphasizes the influence of contextual factors on one's ability to respond effectively to stressful situations, solve problems, and act effectively to reach goals.

  - **Women Involved in Life Learning from Other Women (WILLOW) –** WILLOW is a small-group social-skills building and educational intervention for adult women living with HIV. It consists of 4 four-hour sessions that are delivered by two trained adult female facilitators, one of whom is a woman living with HIV.

  Not all evidence-based interventions (EBI) have been successful in Alaska, including interventions identified by CDC on their Diffusion of Evidence-Based Interventions (DEBI) website, http://www.effectiveinterventions.org. Evidence-based interventions

[58] Effective interventions: HIV Prevention that Works, Available at: http://www.effectiveinterventions.org/en/HighImpactPrevention/StructuralInterventions.aspx, Accessed December 6, 2012.

are often developed and tested in cities with specific community features (gay bars, housing projects, concentrated ethnic neighborhoods, etc.) and with larger populations and a higher HIV prevalence than Alaska. Alaska generally does not have sufficient numbers of the intended target population(s) to recruit or maintain the intervention(s) over a period of time. In addition, EBIs were developed as research projects with far greater resources for implementation than are available to Alaska CBOs. In addition, research projects have more trained and higher paid staff and incentives for participants that can rarely be replicated locally.

However, there are some advantages to implementing certain EBIs: evidence of effectiveness from rigorous evaluation research, essential core elements are clearly identified, packaged materials and curricula are often available, and national, standardized training for facilitators has been developed.

Any program considering implementing an EBI in Alaska should thoroughly research the intervention to determine whether they have the necessary staff, resources, and venues available and whether there are sufficient numbers of the intended target population to sustain the intervention.

- CDC Recommendations

  - **Incorporating HIV Prevention into the Medical Care of Persons Living with HIV** – Prevention in the care setting uses the outpatient clinic and health care providers to screen for HIV transmission risk behaviors and sexually transmitted diseases, provide brief behavioral prevention interventions, and facilitate partner notification and counseling.

- Treatment Adherence – Adherence interventions focus on educating and motivating patients, building patients' skills, providing tools for better medication management and ongoing support, and addressing other issues that may act as barriers to treatment adherence.

- Structural Interventions –Structural interventions re those designed to implement or change laws, policies, physical structures, social or organizational structures, or standard operating procedures to affect environmental or societal change such as housing for HIV positive individuals and STD testing and treatment.

3. Condom Distribution

- Making condoms widely available is integral to successful HIV prevention. Condom distribution programs have been shown to increase condom availability and should target venues that are accessed by HIV positive and high-risk negative individuals (e.g. Ryan White Clinics, gay bars, syringe exchange programs, etc.).

Recommended Program Components

The CDC, through PS12-1201 recommends that funding or conducting the following recommended program components be considered if the Health Department has the resources and capacity. The HIV/STD Program does not have the resources or the capacity to conduct or fund the recommended program components; however, the following are appropriate interventions to conduct with other resources:

1. **Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk of Acquiring HIV**

   – Evidence-Based Behavioral Interventions[59] – The following table describes behavioral interventions have been identified by CDC as having proven potential to reduce new HIV infections targeting high-risk negative persons:

Table 12: Evidence-Based Behavioral Interventions for High-Risk Negative Persons

Intervention	Target Population(s)	Brief Description
¡Cuídate!	Hispanic High-Risk Heterosexual (HRH) Youth 13-18 years	A culturally-based, group-level intervention to reduce HIV sexual risk behavior among Latino youth.
Connect	HRH and their main sexual partners	A six session, relationship-based intervention that teaches couples techniques and skills to enhance the quality of their relationship, communication, and shared commitment to safer behaviors.
d-up: Defend Yourself!	Black MSM	A community-level intervention designed to promote social norms of condom use and assist Black MSM to recognize and handle risk related racial and sexual bias.
The Future is Ours (FIO)	HRH Women	A small group, cognitive-behavioral intervention consisting of eight two-hour interactive sessions delivered over eight weeks to heterosexually active women living in high-risk communities.
Focus on Youth + Impact	HRH Black Youth	A community-based, eight session group intervention that provides youth with the skills and knowledge they need to protect themselves from HIV and other STDs.

[59] Ibid

Holistic Health Recovery Program	IDU	The Holistic Health Recovery Program (HHRP) is a 12-session, manual-guided, group-level program for HIV-positive and HIV negative injection drug users.
Many Men, Many Voices (3MV)	Black MSM	A seven-session, group-level HIV and STD prevention intervention for Black gay men.
Modelo de Intervención Psicomédica (MIP)	IDU	A behavioral intervention for reducing high-risk behaviors combining individualized counseling and comprehensive case management over a 3-6-month period.
Mpowerment	Young MSM	A community-level intervention for young gay and bisexual men. It mobilizes men to reduce sexual risk taking, encourages regular HIV testing, builds positive social connections and supports peers to have safer sex
Nia	Black HRH Men	A six hour, video-based, small group-level intervention.
Personalized Cognitive Counseling (PCC)	MSM	An individual-level, single session counseling intervention designed to reduce unprotected anal intercourse among MSM who are repeat testers for HIV.
Popular Opinion Leader	MSM	A community-level intervention that involves identifying, enlisting, and training key opinion leaders to encourage safer sexual norms and behaviors within their social networks through risk-reduction conversations
Project AIM	HRH Youth ages 11-14	A group-level youth development intervention designed to reduce HIV risk behaviors among youth.
Project START	Any	An individual-level, multi-session intervention for people being released from a correctional facility and returning to the community.
PROMISE	Any	A community-level HIV/STD prevention intervention that relies on role model stories and peer advocates from the community.
RAPP	HRH Women	A community mobilization program,

		designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use.
RESPECT	Any	An individual-level, client-focused, HIV prevention intervention, consisting of two brief interactive counseling sessions.
Safe in the City	HRH and MSM (STD clinic patients)	A 23-minute HIV/STD prevention video for STD clinic waiting rooms.
Safety Counts	IDU	An HIV prevention intervention for out-of-treatment active injection and non-injection drug users aimed at reducing both high-risk drug use and sexual behaviors.
SHIELD	IDU and other drug users	A group level intervention, trains current and former drug users to be Peer Educators who share HIV prevention information with people in their social networks (e.g., friends, family, sex partners, etc.).
SIHLE	Black HRH teenage women	A peer-led, social-skills training intervention aimed at reducing HIV sexual risk behavior among sexually active, African American teenage females, ages 14-18.
SISTA	Black HRH women	A group-level, gender- and culturally-relevant intervention designed to increase condom use among African American women.
Sister to Sister	Black HRH women	A brief, one-on-one, skill-based HIV/ STD risk-reduction behavioral intervention delivered during the course of a routine medical visit
Street Smart	HRH youth	An HIV/STD prevention program for runaway and homeless youth.
Voices/Voces	HRH Black and Hispanic Adults	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

2. Social Marketing, Media, and Mobilization

- Social marketing campaigns targeting relevant audiences (e.g. providers, high risk populations, or communities) including the use of campaign materials developed and tested by CDC for the purpose of increasing risk reduction behaviors including using condoms, increasing HIV testing, and decreasing stigma.

- Media technology (e.g., Internet, texting, and web applications) for HIV prevention messaging to targeted populations and communities for the purpose of connecting people with information and services.

3. Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post-Exposure Prophylaxis Services (nPEP)

- PrEP – PrEP is a new HIV prevention method in which people who do not have HIV infection take an antiretroviral pill daily to reduce their risk of becoming infected. The pill contains anti-retroviral medicines that reduce the potential of HIV transmission. In this way PrEP medicines can help keep the virus from establishing a permanent infection. For some individuals at very high risk for sexual exposure to HIV, PrEP may represent a much-needed additional prevention method. PrEP is an intensive approach that requires strict adherence to daily medication prescribed by a medical professional and regular HIV testing. It is not intended to be used in isolation, but rather in combination with other HIV prevention methods. Implementing PrEP in public health settings may prove challenging. While private insurance and some programs (e.g., Medicaid) may cover the cost of PrEP medications, there is not necessarily funding within public health programs to pay for these medications and associated costs (i.e., counseling and adherence support).[60]

- nPEP – Post exposure prophylaxis (PEP) involves taking HIV antiretroviral drugs after potential exposure to HIV to reduce the risk of acquiring HIV. Non-occupational post exposure prophylaxis (nPEP) can occur when someone is potentially exposed to HIV outside of the workplace (for example, unprotected sexual or injection drug risk with a known HIV positive person).

[60] NASTAD, Policy Statement: Pre-Exposure Prophylaxis (PrEP). Available at: http://www.nastad.org/Docs/114958_NASTAD%20PrEP%20Policy%20Statement%20FINAL%20-%206-25-12.pdf

Chapter 6

Goals, Objectives, Activities, and Recommendations

Statewide Strategic HIV Plan

On January 18-19, 2013, the HIV/STD Program and the HIV Planning Group (HPG) convened a meeting with key HIV prevention, care, and treatment stakeholders to develop a strategic plan to address HIV, STD, and Hepatitis in Alaska. The purpose of the strategic plan is to provide direction for the HIV/STD Program, HPG and key stakeholders, in addressing HIV prevention, care, and treatment in Alaska.

Because the HIV/STD Program will not be able to address all of the identified items in the strategic plan, it is our hope that the HPG and community stakeholders will use the strategic plan as a "roadmap" to identify and prioritize activities in Alaska. In addition, the strategic plan includes items identified and prioritized by the HIV/STD Program that the HIV/STD Program is responsible for implementing. **Bolded** activities in the goals, objectives, and activities matrix will be implemented by the HIV/STD Program. Other activities for which the HIV/STD Program is the likely responsible party may or may not be implemented, depending on statewide priorities and the availability of resources.

The objectives in the Statewide Strategic HIV Plan are not written as SMART (specific, measurable, attainable/achievable, relevant, and time bound) objectives, as the purpose of the plan is for community stakeholders and/or the HPG to take ownership of the objectives and activities and integrate them into their own service plans. The HIV/STD Program will provide technical assistance and capacity building, as requested, to the HPG and community stakeholders to assist with implementation of activities.

This chapter also includes recommendations for HIV/STD Program activities essential to addressing the strategic plan: capacity building, technical assistance, and needs assessments.

Goal 1: Increase the number of persons who know their HIV serostatus		
Objectives(s)	**Activities**	**Potential Responsible**
Objective 1: Provide HIV testing as a part of routine care for 13-64 year olds	1.1. Integrate Hepatitis C (HCV) testing with HIV testing for those born between 1945 and 1965	State Hepatitis Coordinator Community stakeholder(s)
	1.2. Coordinate HIV testing efforts with medical associations, hospital administrations and insurance companies	HIV/STD Program HPG
	1.3. Conduct cost-benefit analyses of the impact of priority interventions, for presentation to medical associations, hospital administrations and insurance companies	HIV/STD Program
	1.4. Conduct a review of HIV positive patient records to determine missed opportunities for screening and use data to educate providers on the need for increased testing	HIV/STD Program
	1.5. Conduct a knowledge, attitude, behaviors survey with providers on the barriers to implementing CDC's recommendations for HIV testing in healthcare settings	HIV/STD Program
	1.6. Conduct a needs assessment to identify barriers to provider screening for STD/HIV	HIV/STD Program
	1.7. Provide information to health care providers and allied health professionals: • On the importance of STD, HIV, and HCV screening and prevention • On how to communicate with their patients about STD/HIV/HCV • Regarding new coverage for HIV testing by private insurance companies, Medicaid, and Medicare through the Affordable Care Act (ACA). Use targeted media and existing platforms such as the Alaska Public Health Association, hospital Grand Rounds, Section of Epidemiology *Bulletins,* etc.	HIV/STD Program Community stakeholder(s)

Goal 1: Increase the number of persons who know their HIV serostatus		
Objectives(s)	**Activities**	**Potential Responsible**
	1.8. Work with the HPG to craft a policy statement regarding HIV screening that can be disseminated through medical associations and other key groups	HIV/STD Program HPG
	1.9. Create relationships with nursing and allied health professional schools and programs to integrate training on HIV testing and counseling into curricula	HPG Community stakeholder(s)
	1.10. Create a relationship with the nursing licensure board and advertise volunteer opportunities in STD/HIV testing agencies to increase testing capacity in agencies with limited human resources	Community stakeholder(s)
	1.11. Offer HIV and HCV testing through HIV and STD partner services (PS)	**HIV/STD Program**
	1.12. Offer STD PS to test, refer, and treat for gonorrhea (GC), chlamydia (CT), and syphilis	**HIV/STD Program**
	1.13. Offer HIV PS to identify, and link newly diagnosed HIV positive individuals to HIV care	**HIV/STD Program**
	1.14. Provide HIV test results, especially to those who test positive	**HIV/STD Program** Community stakeholder(s)
Objective 2: Provide HIV testing regularly in high-risk heterosexual populations	2.1. Coordinate with the judicial system to mandate HIV/STD/HCV testing and risk reduction counseling for convicted sex workers	HIV/STD Program
	2.2. Provide targeted interventions for sex workers, including young people engaged in transactional sex	Community stakeholder(s)
	2.3. Increase funding for programs which serve sex workers so programs can expand their hours of service and offer free, walk-in STD/HIV services	Community stakeholder(s)
	2.4. Conduct targeted marketing and HIV testing interventions for people who use online services such as Craigslist for anonymous sex finding and solicitation	HIV/STD Program Community stakeholder(s)

Goal 1: Increase the number of persons who know their HIV serostatus		
Objectives(s)	**Activities**	**Potential Responsible**
	2.5. Provide targeted educational and testing interventions for the heterosexual partners of IDU and MSM	Community stakeholder(s)
	2.6. Offer HIV and HCV testing through HIV and STD PS	**HIV/STD Program**
	2.7. Offer STD PS to test, refer, and treat for GC, CT, and syphilis	**HIV/STD Program**
	2.8. Offer HIV PS to identify, and link newly diagnosed HIV positive individuals to HIV care	**HIV/STD Program**
	2.9. Provide funding to conduct non-healthcare HIV testing in venues that cater to HRH individuals such as substance abuse and mental health treatment facilities, homeless shelters, and bars.	**HIV/STD Program**
	2.10. Provide HIV test results, especially to those who test positive	**HIV/STD Program** Community stakeholder(s)
Objective 3: Provide HIV testing regularly in the MSM population	3.1. Conduct strategic marketing and education campaigns to decrease unsafe sexual practices among MSM	Community stakeholder(s)
	3.2. Use social/new media advertisement (including online anonymous sex-seeking sites and mobile apps) to increase HIV testing, Hepatitis A (HAV) vaccination, and Hepatitis B (HBV) testing and vaccination	HIV/STD Program Community stakeholder(s) State Hepatitis Coordinator
	3.3. Reach MSM for education and testing through interventions which target their female friends	Community stakeholder(s)
	3.4. Adopt use of the one minute rapid HIV test for testing at outreach, particularly bars and associated venues	Community stakeholder(s)
	3.5. Offer HIV testing at MSM peer events, i.e. Mpowerment	Community stakeholder(s)

Goal 1: Increase the number of persons who know their HIV serostatus		
Objectives(s)	**Activities**	**Potential Responsible**
	3.6. Increase the presence of HIV education and testing resources at special events, cultural events, bookstores and seasonal activities to reach out to non-gay identified MSM	Community Stakeholder(s)
	3.7. Maintain/expand current MSM venue outreach testing	HIV/STD Program Community stakeholder(s)
	3.8. Provide targeted HIV testing outreach to transsexual men, bisexual men and young members of the LGBTQ population who do not self-identify with any particular group	Community stakeholder(s)
	3.9. Offer HIV and HCV testing through HIV and STD PS	**HIV/STD Program**
	3.10. Offer STD PS to test, refer, and treat for GC, CT, and syphilis	**HIV/STD Program**
	3.11. Offer HIV PS to identify, and link newly diagnosed HIV positive individuals to HIV care	**HIV/STD Program**
	3.12. Provide funding to conduct non-healthcare HIV testing in venues that cater to MSM such gay bars and community events	**HIV/STD Program**
	3.13. Provide HIV test results, especially to those who test positive	**HIV/STD Program** Community stakeholder(s)
Objective 4: Provide HIV testing regularly in the IDU population	4.1. Implement education and testing interventions that take an integrative approach to HIV and HCV	State Hepatitis Coordinator Community stakeholder(s)
	4.2. Incentivize testing with incentives that are appropriate to the IDU community	Community stakeholder(s)
	4.3. Expand support for needle exchange and testing programs to areas outside of Anchorage, Fairbanks and Juneau; particularly to Kenai and Mat-Su	Community stakeholder(s)

Goal 1: Increase the number of persons who know their HIV serostatus		
Objectives(s)	**Activities**	**Potential Responsible**
	4.4. Facilitate dialogue and outreach to leaders of the IDU community to identify 'best fit' interventions to increase HIV testing	Community stakeholder(s) HIV/STD Program
	4.5. Integrate HIV testing into all syringe exchange programs throughout the state	HIV/STD Program Community stakeholder(s)
	4.6. Create an HIV/HCV education and resource list for IDU	HIV/STD Program
	4.7. Offer HIV and HCV testing through HIV and STD PS	**HIV/STD Program**
	4.8. Offer STD PS to test, refer, and treat for GC, CT, and syphilis	**HIV/STD Program**
	4.9. Offer HIV PS to identify, and link newly diagnosed HIV positive individuals to HIV care	**HIV/STD Program**
	4.10. Provide funding to conduct non-healthcare testing in venues that cater to IDU such as syringe exchange program and substance abuse treatment facilities	**HIV/STD Program**
	4.11. Provide HIV test results, especially to those who test positive	**HIV/STD Program** Community stakeholder(s)
Objective 5: Provide HIV testing regularly in correctional facilities	5.1. Targeted education and testing for people in the correctional system	HIV/STD Program Community stakeholder(s)
	5.2. HIV and HCV testing are integrated into the standard exit appointment for Department of Corrections (DOC) facilities	Department of Corrections HIV/STD Program
	5.3. Increase availability of STD, HCV, and HIV testing in all correctional facilities in the state	Department of Corrections HIV/STD Program

Goal 1: Increase the number of persons who know their HIV serostatus		
Objectives(s)	**Activities**	**Potential Responsible**
	5.4. Offer HIV and HCV testing through HIV and STD PS	**HIV/STD Program**
	5.5. Offer STD PS to test, refer, and treat for GC, CT, and syphilis	**HIV/STD Program**
	5.6. Offer HIV PS to identify, and link newly diagnosed HIV positive individuals to HIV care	**HIV/STD Program**
	5.7. Provide funding to conduct non-healthcare testing in correctional facilities and community release centers	**HIV/STD Program**
	5.8. Provide HIV test results, especially to those who test positive	**HIV/STD Program** Community stakeholder(s) Department of Corrections
Objective 6: Provide HIV testing regularly in youth populations	6.1. Provide targeted interventions to increase HIV, STD and HCV education and testing in young adults engaging in high risk behaviors	Community stakeholder(s)
	6.2. Create/maintain a hotline which can respond to calls and text messages for STD/HIV information, testing, and resources	Community stakeholder(s)
	6.3. Develop a social media campaign which encourages youth to know their status	Community stakeholder(s)
	6.4. Create/maintain peer outreach programs to educate and test high risk youth	Community stakeholder(s)
	6.5. Offer HIV and HCV testing through HIV and STD PS	**HIV/STD Program**
	6.6. Offer STD PS to test, refer, and treat for gonorrhea (GC), chlamydia (CT), and syphilis	**HIV/STD Program**
	6.7. Offer HIV PS to identify, and link newly diagnosed HIV positive individuals to HIV care	**HIV/STD Program**

Goal 1: Increase the number of persons who know their HIV serostatus		
Objectives(s)	**Activities**	**Potential Responsible**
	6.8. Provide HIV test results, especially to those who test positive	**HIV/STD Program** Community stakeholder(s)
Objective 7: Integrate HIV testing into general sexual health and STD education	7.1. Use new media and technologies to create web, app, and text messaging based on HIV testing and educational resources	HIV/STD Program Community stakeholder(s)
	7.2. Develop HIV testing media campaigns which keep the information simple, and culturally and age appropriate to the target audience	Community stakeholder(s)
	7.3. Increase the presence of STD/HIV organizations which offer HIV testing at community health fairs	Community stakeholder(s)
	7.4. Develop interventions to better integrate community health aides/practitioners (CHA/Ps) into the continuum of care for the purpose of HIV testing	Community stakeholder(s)
	7.5. Coordinate with corporate and private partners to incentivize HIV testing	Community stakeholder(s)
	7.6. Increase presence and testing available at community events, including those not usually associated with sexual health	Community stakeholder(s)

Goal 2: Reduce the number of new HIV infections		
Objective(s)	**Activities**	**Potential Responsible**
Objective 1: Implement structural interventions to reduce new infections	**1.1. Work with the state pharmacists association to create standard policies and procedures for the sale of nonprescription needles and syringes**	**HIV/STD Program**
	1.2. Implement an incentivized directly observed therapy program	Community stakeholder(s)
	1.3. Increase condom availability by expanding condom distribution programs statewide. Distributed condoms should be of styles and types that are popular in the community	HIV/STD Program Community stakeholder(s)
	1.4. Make condoms available in correctional facilities	Department of Corrections Community stakeholder(s) HIV/STD Program
	1.5. Increase condom availability in rural areas by outreaching to pharmacists and store owners. Implement programs to address barriers of low and non-confidential condom access	Community stakeholder(s)
	1.6. Customize condom packaging with HIV prevention and education marketing and advertising campaigns	Community stakeholder(s)
	1.7. Outreach to bar owners and managers statewide to increase condom distribution in local venues	Community stakeholder(s)
	1.8. Coordinate with school districts to increase condom distribution in schools, particularly in rural areas where condom access is lower	Community stakeholder(s)
	1.9. Work with school districts to bundle health education efforts in schools and include HIV education and prevention messaging	Community stakeholder(s)
	1.10. Advocate for dedicated State funding for HIV/STD prevention efforts; bundle STD and HIV sexual health messaging to increase effectiveness	HPG Community stakeholder(s)

Goal 2: Reduce the number of new HIV infections		
Objective(s)	**Activities**	**Potential Responsible**
	1.11. Expand needle exchange programs, especially in Kenai and Mat-Su	Community stakeholder(s)
	1.12. Increase the presence of HIV prevention and treatment resources at Alaska conferences, including those that do not focus on STD/HIV	Community stakeholder(s)
	1.13. Provide funding for condom distribution through HIV/STD Program-funded interventions and condom distribution through venues identified as reaching HIV positive and high-risk negative individuals	**HIV/STD Program**
Objective 2 Implement clinical interventions to reduce new infections	2.1. Increase awareness of post-exposure prophylaxis (PEP), non-occupational post-exposure prophylaxis (nPEP), and pre-exposure prophylaxis (PrEP), including who they are appropriate for, among the provider populations	HIV/STD Program
	2.2. Expand HIV prevention and treatment education efforts to all provider types, including mid-levels, nurses, health aides, allied health professionals, dentists, and pharmacists	HIV/STD Program
	2.3. Coordinate with substance abuse treatment providers and organizations to integrate HIV prevention and treatment efforts	HIV/STD Program
	2.4. Provide interventions which address treatment as prevention and integrate HIV prevention and treatment across the continuum of care	Community Stakeholder(s)
	2.5. Provide linkage to care services that Increase the number of HIV-diagnosed clients (new and previous positives) linked to, engaged in, and retained in HIV care services	**HIV/STD Program**
	2.6. Offer STD PS to test, refer, and treat for GC, CT, and syphilis	**HIV/STD Program**
	2.7. Offer HIV PS to identify, and link newly diagnosed HIV positive individuals to HIV care	**HIV/STD Program**

Goal 2: Reduce the number of new HIV infections		
Objective(s)	**Activities**	**Potential Responsible**
Objective 3: Implement behavioral interventions, targeting individuals at risk, to reduce new infections	3.1. Conduct condom use education and demonstrations in youth venues, including schools	Community stakeholder(s)
	3.2. Fund and conduct behavioral interventions targeting priority risk populations that are known to work in Alaska, i.e. Mpowerment	Community stakeholder(s)
	3.3. Identify and adapt behavioral interventions to Alaska, i.e. Community Promise, Safe in the Village	Community stakeholder(s)
	3.4. Fund and conduct behavioral interventions targeting HIV positive individuals in HIV treatment and care settings	**HIV/STD Program** Community stakeholder(s)
Objective 4: Implement behavioral interventions, targeting providers, to reduce new infections	4.1. Conduct Grand Rounds on HIV prevention and treatment topics (i.e. prevention with positives, treatment as prevention, treatment adherence, PS, linkage to care, and PrEP and nPEP); offer CMUs and conduct in venues which target rural clinicians	HIV/STD Program Community stakeholder(s)
	4.2. Fund and conduct interventions that prioritize sexual health screening and treatment	Community stakeholder(s)
	4.3. Conduct targeted clinician education on HIV prevention and treatment best practices, particularly in targeted priority areas such as rural Alaska	Community stakeholder(s)

Goal 3: Reduce the number of HIV-positive persons who get AIDS		
Objective(s)	**Activities**	**Potential Responsible**
Objective 1: All people who are HIV-positive are linked to and retained in care	**1.1. Offer support programs for engagement and retention in care, including programs for family, friends and partners of HIV+ individuals**	**HIV/STD Program** Community stakeholder(s)
	1.2. Coordinate health services and dedicated providers for HIV+ individuals within key HIV service organizations	Community stakeholder(s)
	1.3. Train and educate behavioral health aides (BHAs) to address retention in HIV care in rural areas	Community stakeholder(s)
	1.4. Conduct interventions to increase medication adherence, including mHealth and appointment reminder systems	Community stakeholder(s)
	1.5. Provide mobile phones for homeless and transient clients, including simple and audience-specific lessons on how to use phone alarm and reminder systems	Community stakeholder(s)
	1.6. Provide linkage to care services that increase the number of HIV-diagnosed clients (new and previous positives) linked to, engaged in, and retained in HIV care services	**HIV/STD Program**
	1.7. Offer HIV PS to identify, and link newly diagnosed HIV positive individuals to HIV care	**HIV/STD Program**

Goal 4: Increase funding and support for HIV prevention, care and treatment in Alaska		
Objective(s)	**Activities**	**Potential Responsible**
Objective 1: Identify alternative funding sources for organizations working in HIV prevention, care and treatment in Alaska	1.1. Host a fundraising symposium which features: Donor agencies, foundations, corporate entities, Philanthropy NW, social enterprising, SAMSHA, collaborative grants, private donors and others **1.2. Offer technical assistance to agencies seeking alternative funding for HIV prevention and treatment activities, including assistance in data collection, needs assessments and grant writing**	HPG HIV/STD Program HPG **HIV/STD Program**
Objective 2: Receive dedicated funding from the State Legislature for HIV prevention and treatment activities	2.1. Increase advocacy for dedicated state funding for HIV prevention, care and treatment through organizations such as the HIV Planning Group (HPG) 2.2. Bundle HIV with other STD prevention activities 2.3. Use messaging around the relationship between STDs and HIV and the high STD (Gonorrhea and Chlamydia) prevalence in Alaska	HPG HPG HPG

Recommendations

Capacity Building

Capacity building activities help the HPG and community stakeholders enhance and sustain HIV prevention, care, and treatment services. Capacity building may include, but is not limited to, training, technical assistance, and quality assurance guidance. The HIV/STD Program will address the following capacity building recommendations directly or, when the HIV/STD Program is not able to address capacity building requests, the program will seek assistance from CDC's Capacity-Building Request Information System (CRIS) or other capacity building assistance providers:

- Conduct quality assurance site visits to review HIV rapid testing and risk reduction counseling with HIV/STD Program-funded providers.

- Provide technical assistance with grant writing, including the provision of HIV data when appropriate, and provide letters of support.

- Maintain and expand the Alaska HIV Prevention Listserv to identify potential capacity building resources such as:

  - Funding opportunities
  - Materials and resource identification
  - Training/webinar opportunities
  - Epidemiologic data
  - Intervention information
  - Identification of social marketing
  - New research and programs

- Identify and implement evidence-based interventions.

- Provide technical assistance with grant writing, including the provision of HIV data, when appropriate, and provide letters of support.

- Conduct a knowledge, attitudes, and behaviors (KAB) survey with HIV medical care providers addressing barriers to HIV testing in primary care, emergency room, and urgent care settings.

- Host an alternative funding symposium which features: Donor agencies, foundations, corporate entities, Philanthropy NW, social enterprising, SAMSHA, collaborative grants, private donors and others.

- Provide and/or identify training and technical assistance opportunities (potentially hosting a conference) to address topics such as:

  - HIV rapid testing
  - Risk reduction counseling
  - Program evaluation (potentially including needs assessments, focus groups, logic models, SMART objectives, and process and outcome monitoring)
  - Evidence-based interventions
  - Using social network and other technology (such as texting) for HIV prevention

- Provide technical assistance to HIV/STD Program prevention grantees on data entry and analysis using the CDC-required database, EvaluationWeb, for HIV testing and behavioral interventions for HIV positive individuals.

- Conduct a follow-up to the 2010 and 2012 capacity building needs assessments of current and potential HIV prevention, care, and treatment providers.

- Publish and disseminate yearly HIV and STD data updates and other relevant information (i.e. HIV testing guidelines) through Section of Epidemiology *Bulletins.*

Needs Assessments

Since 2007 the HIV/STD Program, upon the recommendation of the HPG, has conducted needs assessments addressing the HIV prevention needs of heterosexual females at increased risk, MSM, and IDU (including a survey of syringe access in pharmacies). To ensure that appropriate HIV prevention, care, and treatment interventions are identified, needs assessments are recommended for the following priority target population and providers:

- HIV positive persons

- Emergency rooms, urgent care, and primary health providers to determine barriers to and needs for conducting HIV testing

Other HIV/STD Program Activities

In addition to the HIV/STD Program's responsibilities to implement a comprehensive HIV prevention program – community planning, HIV prevention, and capacity building – the HIV/STD Program must maintain the staff and infrastructure to:

- Prepare grant applications and reports

- Monitor HIV Prevention and Care grants to assess and ensure that goals, objective, and activities are being met; and, if not to develop with the grantee, a plan of correction

- Respond to the surveillance data needs of the HPG, HIV programs, and providers

- Write Section of Epidemiology *Bulletins* on yearly HIV and STD data updates and other relevant topics

- Oversee a materials review process to ensure the accuracy and appropriateness of HIV educational and promotional materials

- Provide guidance on policy issues related to HIV for the State of Alaska

Appendix A

Needs Assessments

1. Men Who Have Sex with Men
2. Injection Drug Users
3. Heterosexual Women

MSM Behavioral Assessment Project

BACKGROUND

In the United States, men who have sex with men (MSM) make up the largest group of HIV-infected individuals. Of 908,905 cumulative AIDS cases reported through 2004, 402,722 (44 %) were MSM and 60,038 (7 %) were both MSM and injection drug users (IDU)[61]. In Alaska, males comprised 81% of the cumulative total of 1,050 HIV infected persons through December 31, 2005. MSM accounted for 500 (48%) of cumulative total HIV cases and MSM/IDU for 67 (6%) cases.

The purpose of the Behavioral Assessment Project is to collect behavioral data at selected public events targeted to groups not traditionally reached by behavioral surveillance activities or HIV testing services. The goals of the Rapid Behavioral Assessment portion of the Behavioral Assessment Project is to collect information about behavioral risk factors for HIV and HIV testing using a brief survey administered with a handheld computer.

The State of Alaska Department of Health and Social Services, in conjunction with the Alaskan AIDS Assistance Association (Four As), was funded by the CDC through the US Conference of Mayors to conduct the HIV Behavioral Assessment Project. This project conducts brief behavioral surveys at gay pride events in low prevalence areas. The State of Alaska Department of Health Services and the Four As were funded to conduct behavioral surveys at three events: Drag Queen Bingo, a National Testing Day event and Anchorage PrideFest. The Drag Queen Bingo event was held on June 22, 2006, at the University of Alaska, Anchorage, and was attended by approximately 45 individuals. The National Testing event was a barbeque hosted at the Raven, a local gay bar. The local health department offered free HIV testing at this event, which was attended by less than 20 people. The Anchorage PrideFest is an annual pride event that was held in Anchorage on June 24, 2006, at the Park Strip as part of the city's 2006 Gay Pride events. The afternoon event included entertainment and booths for community groups and was attended by approximately 200 individuals, including MSM.

The State of Alaska Department of Health and Social Services and the Four As partnered with the event organizers to conduct brief behavioral surveys during each event. Staff from the Behavioral and Clinical Surveillance Branch, Division of HIV/AIDS Prevention, Centers for Disease Control and Prevention, provided technical assistance and collaborated with local partners to implement the behavioral surveys. This report summarizes the results of these activities.

[61] http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2004report/table1.htm

METHODS

Events

1. Drag Queen Bingo- 6 pm to 9 pm, Thursday, June 22, 2006.
2. National Testing Day Barbeque – 7 pm to 10 pm, Friday, June 23, 2006.
3. Anchorage PrideFest – 12 pm to 5 pm, Saturday, June 24, 2006.

Definitions

Men who have sex with men (MSM) were defined as respondents who reported one or both of the following:

- Identification as homosexual or bisexual;
- One or more male anal sex partners in the past 12 months.

Survey

The CDC team trained nine counselors from partner community-based organizations (CBOs) and the State of Alaska Department of Health and Social Services to administer surveys using handheld personal computers on Wednesday, June 21, at the Four As offices. The survey included questions about demographics, HIV testing attitudes and practices, sexual practices, drug use, circumcision, pre- and post-exposure prophylaxis with antiretroviral drugs, and exposure to prevention services (Appendix 1). Convenience samples of respondents who attended events were selected to participate in the survey, however, interviewers were strategically placed at events and they recruited every nth male (with n representing a number pre-specified by the interviewer) crossing an imaginary line in an effort to reduce selection bias. Eligibility criteria included age ≥18 years, male sex at birth, and gender self-identification as male. Persons who were unable to give informed consent (e.g., because they appeared to be under the influence of alcohol or drugs) were ineligible for the survey.

Ethics review

The Division of HIV/AIDS Prevention determined that the intent of testing and surveys at Minority Gay Pride festivities was not to conduct research but to implement and evaluate a novel rapid assessment method to collect behavioral surveillance data.

Data collection, cleaning and analysis

Data were collected with Questionnaire Development System (QDS) version 2.4 software (Nova Research, Bethesda, MD) and imported into SAS version 9.1 (SAS Institute, Cary, NC) for cleaning and analysis. Tables 2-10 in this report summarize data on MSM respondents only.

RESULTS

Participation and eligibility

Of 144 persons approached by interviewers, 96 (67%) accepted the initial intercept (Table 1). Of 96 persons who accepted the initial intercept 91 (95%) were eligible to participate and all 91 consented to be interviewed. One interview was excluded from the analysis due to missing data. This report is restricted to the 73 (81%) of the 90 respondents who reported that they had at least one male partner in the past 12 months or who identified themselves as gay/homosexual or bisexual.

Demographics

Demographic characteristics of 73 male respondents are summarized in Table 2. The median age of respondents was 27 years (range: 18-64 years). Sixty-two (85%) were white, 15 (21%)

respondents were American Indian/Alaskan Native, 4 (6%) were non-Hispanic blacks, 4 (6%) were Asian. Seventy (96%) respondents reported that they were currently living in Alaska at the time of the interview. Thirty-five (48%) of the respondents had completed some college or had received their associate or technical/vocational degree. Twenty-six (36%) respondents did not have some form of health insurance. Sixty-one (84%) respondents identified as gay or homosexual and 12 (16%) as bisexual. Of 64 respondents who had previously been tested for HIV, 57 (89%) were HIV-negative and 5 (8%) were HIV-positive the last time they were tested.

Sexual partners

Sexual partner data are summarized in Table 3. The majority of the respondents reported having male sex partners; however, of the 73 respondents, 6 (8%) reported having vaginal or anal sex with one of more women during the previous 12 months. Among the 55 MSM who reported having anal intercourse (AI) with one or more male partners during the past 12 months, the median number of male partners was 1 (range: 1-20). Thirty-four (62%) of these 55 respondents reported having unprotected anal intercourse (UAI) with at least one male partner in the past 12 months.

Twenty-three (42%) of the 55 men who reported having AI had one male partner and 32 (58%) had more than one partner during the past year. Among the 23 respondents who had only one male partner, 14 (61%) reported UAI with their partner in the past 12 months. Only one (7%) man reported having UAI with a partner of unknown serostatus. Of the 23 men who reported that they had only one male partner, 8 (35%) reported meeting their partner on the internet, 6 (26%) met their partner at a bar/club, and 9 (39%) met their partner somewhere else.

Among the 32 respondents who reported having more than one male partner in the past 12 months, 20 (63%) reported UAI with their male partners. Twenty (63%) of the 32 MSM reporting AI with more than one partner reported having 2-3 partners in the past 12 months. Two (10%) of the 20 respondents who reported UAI reported that they had a sero-discordant partner and in 5 cases (25%), the HIV status of the respondent or the partner was unknown. Among the 32 respondents who reported having more than one male partner in the past 12 months, 12 (38%) reported meeting one or more partners at a bar/club, 16 (50%) met partners on the internet, and 24 (75%) met partners somewhere else. A small number of respondents reported meeting partners at cruising areas, gyms, and circuit parties/raves.

The majority of the respondents reported having male sex partners; however, of the 73 respondents, 6 (8%) reported having vaginal or anal sex with one of more women during the previous 12 months. Of the 6 men reporting that they had sex with a woman, 5 (83%) identified as bisexual. Four (67%) of the men reported that they did not know the HIV status of their female sex partners.

Of the 55 respondents who reported having AI with another man in the past year, 39 (71%) reported that their last male partner was a steady partner and 14 (25%) reported that this partner was a casual partner (Table 4). Thirty-five (64%) respondents reported having insertive anal sex with their last male partner; 16 (46%) of the 35 respondents did not use a condom and 16 (46%) used a condom the whole time during this sex act. Thirty-four (62%) respondents reported having receptive anal sex with their last male partner; 17 (50%) of the 34 respondents did not use a condom and 16 of the 34 (47%) respondents used a condom the whole time during this sex act. Twenty-four (44%) respondents used either alcohol, drugs or both alcohol and

drugs before or during their last sex act. Five (9%) of the 55 respondents who reported having AI with another man in the past 12 months reported that they did not know the HIV status of their last sexual partner. Five (13%) of the 39 respondents who reported that their last male partner was a "main" partner stated that they had sex with someone other than their main partner while they were in their partnership with the main partner.

Sexual identity

On average, respondents were most open with respect to their sexual identity (i.e., "out") with other MSM, friends, family members, and health care providers, and least out with coworkers, classmates and members of their religious community (Table 5).

Drug use

Table 6 outlines drug use among MSM. Among the 39 (53%) respondents who reported using illegal drugs in the past 12 months, 4 (10%) reported injection drug use (IDU) and 31 (79%) reported non-injection drug use (proportions reported in Table 6 demonstrate the percentage of drug users among all MSM). Six percent of all MSM in this sample reported injection drug use. This finding is consistent with the National HIV Behavioral Surveillance findings (i.e., 566 injection drug users among 10,030 MSM interviewed). Of the respondents who reported IDU, 4 (100%) reported using crystal methamphetamine; use of speedballs, cocaine and Oxycontin were also reported. Needle sharing was not commonly reported. The non-injection drug that was most commonly reported among respondents was marijuana, with 26 (84%) of respondents reporting its use, followed by ecstasy (32%), poppers (23%), powdered cocaine (13%) and oxycontin (13%). The majority of the 33 respondents who reported recreational drug use reported that they never (30%) or rarely or occasionally (36%) used drugs before or during sex (calculated percentages for these proportions not included in table 6). A small number of persons reported using Viagra, Cialis or Levitra with other drugs before or during sex. The majority of the respondents reported that they never (22%) or rarely or occasionally (41%) drank alcohol before or during sex.

HIV and sexually transmitted disease (STD) testing

Sixty-four (88%) of 73 respondents reported having ever been tested for HIV and 36 (49%) respondents had been offered an HIV test in the past 12 months (Table 7). As noted in the demographic section of this report, 64 respondents had been previously tested for HIV; 57 (89%) reported that they were HIV-negative and 5 (8%) reported they were HIV-positive the last time they were tested. The 9 (12%) respondents who had not been tested for HIV before offered the following main reasons for not having been tested: they did not believe they had conducted behaviors that put them at risk for HIV (n = 5), they did not know where to get tested (n = 1), they did not have time to be tested (n = 1), they did not have transportation to a site to be tested (n = 1), and they were "too lazy" to get tested (n= 1). Eight (11%) survey respondents reported being diagnosed with an STD in the past 12 months. STDs reported included syphilis, herpes, gonorrhea, HPV, hepatitis B and scabies. Twenty-two (34%) of 64 respondents without a recently diagnosed STD had been tested for syphilis in the past 12 months. CDC Guidelines recommend annual syphilis testing for all sexually active MSM.[3]

Circumcision

Sixty-four (88 %) survey respondents were circumcised, 7 (10%) were not circumcised; one (1%) respondent refused to provide information concerning his circumcision status, and one (1%) response was missing.

Pre-exposure prophylaxis and post-exposure prophylaxis
Thirteen (18%) survey respondents had heard of people taking antiretroviral medications before risky activity in an attempt to reduce their risk for infection with HIV; 11 (85%) of these respondents were HIV-negative (Table 9). None of the 13 respondents had used antiretrovirals before or after engaging in high-risk behavior or had given their antiretroviral medications to an HIV negative sex partner.

Prevention services
Fifty-eight (79%) survey respondent had received free condoms (Table 10). Thirty-seven (64%) respondents received condoms from a CBO, 8 (14%) from the health department, 33 (57%) from a bar/club, 4 (7%) from a circuit party/rave, and 21 (36%) from somewhere else. Other sources of free condoms included adult bookstore/theaters and gyms. Twenty-six (36%) respondents had received HIV/STD prevention information, and 8 (11%) had received a referral for STD testing in the past 12 months. Sixty-five (89%) of respondents had heard of Adam & Steve, a non-profit group dedicated to empowering young gay, bisexual and curious men to get involved with and build a better community for themselves and their friends in Anchorage. Thirty-four (47%) had heard of the Alaska Native Aurora Society, a group that offers HIV prevention messages to Alaskan Native MSM in Anchorage. Thirty-three (45%) respondents reported that they assume that they are getting accurate information from partners who report that they are HIV-negative. Twenty-nine (43%) of 68 respondents who were not HIV-positive said that they thought that it is common for HIV-positive persons to tell their sex partners that they are HIV-positive. Among 5 HIV-positive respondents, 4 (80%) reported that they always tell their sex partners their HIV status.

Conclusion
Two-thirds of persons approached for this survey at the Anchorage PrideFest and other gay pride events in Anchorage, AK, agreed to be interviewed and the prevalence of self-reported HIV infection among MSM respondents was 7%. Over a third of respondents did not have health insurance, but almost 90% had been tested for HIV at some point in their lives. Approximately half (49%) of the men surveyed reported that their providers offered HIV testing during the past 12 months, and over half of the respondents reported that they were out about their sexual identity to most or all of their health care providers. Of the respondents who reported insertive or receptive anal sex with their last partner, almost half reported not using a condom (46% and 50% respectively). A substantial number of respondents (over 40%) reported using a variety drugs (most commonly marijuana) during the past year, including a small percentage (less than 10% overall) of MSM reporting that they used recreational drugs always or most of the time before or during sex. Nearly 80% of respondents reported receiving free condoms from various organizations in the past 12 months.

The collaboration between the Alaskan AIDS Assistance Association (Four As) and the State of Alaska Department of Health & Social Services facilitated rapid behavioral assessments of persons at risk for HIV in Anchorage, Alaska. This collaboration should be fostered and maintained. Risk assessment activities in combination with HIV testing should be considered for future Anchorage Gay Pride Festivals to promote ongoing HIV prevention activities, to monitor the prevalence of HIV and high risk behaviors among minority MSM, and to continue to build trust with the MSM community in Alaska.

References

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2. HIV/AIDS Among Racial/Ethnic Minority Men Who Have Sex with Men – United States, 1989-1998, MMWR, January 14, 2000/49(01); 4-11.
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Table 1: Data Summary

	N	(%)
Total intercepts	**144**	**(100)**
Accepted initial intercept		
Yes	96	(67)
No	44	(31)
Missing	4	(3)
Total	144	(100)
Eligible intercepts		
Yes *	91	(95)
No (due to age < 18 years or transgender identity)	5	(5)
Total	96	(100)
Included in analysis		
Yes †	73	(80)
No: not MSM‡	17	(19)
No: missing data	1	(1)

* All 91 eligible intercepts consented to participate in the survey.

†Percentage of MSM-only surveys among consented intercepts.

‡ Non-MSM were classified as those who did not report at least one of the following: (a) self-identifying as homosexual or bisexual; (b) ≥ 1 male sex partner in last 12 months

Table 2: Demographics

VARIABLE	N = 73	(%) §
Age in years (Median [Range] = 27 [18-64])		
18-24	29	(40)
25-34	15	(21)
35-44	16	(22)
45-54	11	(15)
≥ 55	2	(3)
Ethnicity/Race		
American Indian/Alaska Native	15	(21)
Asian	4	(6)
Black	2	(3)
Hispanic	4	(6)
Native Hawaiian/Pacific Islander	3	(4)
White	62	(85)
State of current residence		
Alaska	70	(96)
Massachusetts	1	(1)
Minnesota	1	(1)
New Jersey	1	(1)
Education		
< High school	4	(6)
High school diploma or equivalent	5	(7)
Some college, associate or technical/vocational degree	35	(48)
Bachelors degree	21	(29)
Post graduate degree	8	(11)
Health insurance		
Public	3	(4)
Private	42	(58)
None	26	(36)
Don't know	2	(3)
Sexual Orientation		
Gay or homosexual	61	(84)
Bisexual	12	(16)
Self-reported HIV status among those tested for HIV (N=64)		
HIV positive	5	(8)
HIV negative	57	(89)
Result pending	1	(2)
Missing	1	(2)

§ Percentages may not equal 100% due to rounding or if respondents were able to provide >1 response to a question.

Table 3: Sexual Partners in the Past 12 months

VARIABLE	N	(%) §
Any anal sex with male partner/s (N = 55)	**55**	
Median # of male partners (Median [Range] = 1 [1-20])		
Any unprotected sex	34	(62)
***Anal sex with one male partner* (N = 23)**	**23**	
Unprotected anal sex	14	(61)
Same HIV status as partner (HIV negative)	*13*	*(93)*
Respondent HIV status unknown	*1*	*(7)*
Where respondent met partner		
Internet	8	(35)
Bar/club	6	(26)
Somewhere else	9	(39)
***Anal sex with >1 male partner* (N = 32)**	32	
Number of partners		
2-3 partners	20	(63)
4-5 partners	6	(19)
6-10 partners	4	(13)
>10 partners	2	(6)
Unprotected anal sex	20	
Same HIV status as partner/s	*13*	*(65)*
Different HIV status from partner	*2*	*(10)*
Respondent or partner HIV status unknown	*5*	*(25)*
Where respondent met partners		
Bar/club	12	(38)
Internet	16	(50)
Cruising area	1	(3)
Gym	2	(6)
Circuit party/rave	1	(3)
Somewhere else	24	(75)
Number reporting female sex partners in past 12 m (N = 6)	6	
Median # of female partners (Median [Range] = 1 [1-9])		
Respondent reported being bisexual	5	(83)
Respondent or partner HIV status unknown	4	(67)
Unprotected sex with female partners	2	(33)

§ Percentages may not equal 100% due to rounding or if respondents were able to provide >1 response to a question.

Table 4: Last Male Sex Partner

VARIABLE	N = 55	(%) §
Relationship with last male partner		
Main partner	39	(71)
Casual partner	14	(25)
Exchange partner	2	(4)
Had insertive anal sex with last partner		
No	20	(36)
Yes	35	(64)
Did not use a condom	*16*	*(46)*
Used a condom some of the time	3	*(9)*
Used a condom the whole time	*16*	*(46)*
Had receptive anal sex with last partner		
No	21	(38)
Yes	34	(62)
Did not use a condom	*17*	*(50)*
Used a condom some of the time	1	*(3)*
Used a condom the whole time	*16*	*(47)*
Not Applicable		
Used alcohol and/or drugs before or during last sex act		
Neither	31	(56)
Alcohol only	2	(4)
Drugs only	11	(20)
Both alcohol and drugs	11	(20)
HIV status of last male partner		
HIV negative	47	(64)
HIV positive	3	(4)
Don't know HIV status	5	(7)
	N = 39	(%)
Partner had sex with other people (n=39) ||		
Definitely did not	25	(64)
Probably did not	11	(28)
Probably did	2	(5)
Definitely did	1	(3)
Respondent had sex with other people (n=39) ||		
No	34	(87)
Yes	5	(13)

§ Percentages may not equal 100% due to rounding.

|| Only among MSM reporting that last males sex partner was "main" partner.

Table 5: Outness ¶

	Out to:													
	MSM friends		**Other friends**		**Family members**		**Health care providers**		**People at work**		**People in school**		**People in religious community**	
	n=73	(%)	n=73	(%)	n=73	(%)	n=73	(%)	n=73	(%)	n=73	(%)	n=73	(%)
None	1	(1)	2	(3)	12	(16)	20	(27)	19	(26)	7	(10)	20	(27)
Few	4	(6)	6	(8)	4	(6)	2	(3)	9	(12)	7	(10)	2	(3)
Some	3	(4)	11	(15)	6	(8)	5	(7)	7	(10)	6	(8)	4	(6)
Most	7	(10)	25	(34)	9	(12)	4	(6)	8	(11)	6	(8)	3	(4)
All	56	(77)	27	(37)	40	(55)	36	(49)	24	(33)	15	(21)	8	(11)
Not applicable	1	(1)	1	(1)	1	(1)	5	(7)	5	(7)	31	(43)	35	(48)
Missing	1	(1)	1	(1)	1	(1)	1	(1)	1	(1)	1	(1)	1	(1)

¶ Outness questions were only asked of men who reported having one or more male sex partner in the past 12 months.

Table 6: Drug and Alcohol Use

VARIABLE	N = 73	(%) §
Used any illegal drugs in the past 12 months		
No	39	(53)
Yes	33	(43)
Missing	1	(1)
Injected drugs in the past 12 months		
No	69	(95)
Yes	4	(6)
Shared needle or syringe in the past 12 months (N = 4)		
No	3	(75)
Yes	1	(25)
Drugs injected (N = 4)		
Crystal meth	4	(100)
Speedballs	1	(25)
Cocaine	2	(50)
Oxycontin	1	(25)
Used non-injection drugs		
No	41	(56)
Yes	31	(43)
Crystal meth	*2*	*(6)*
Crack cocaine	*1*	*(3)*
Powdered cocaine	*4*	*(13)*
Downers	*3*	*(10)*
Oxycontin	*4*	*(13)*
Hallucinogens	*3*	*(10)*
Ecstasy	*10*	*(32)*
Special K	*1*	*(3)*
GHB	*1*	*(3)*
Heroin	*1*	*(3)*
Marijuana	*26*	*(84)*
Poppers (amyl nitrate)	*7*	*(23)*
Other drug	*2*	*(6)*
Used non-injection drugs before/during sex among those reporting non-injection drug use (N = 31)		
Crystal meth	2	(6)
Cocaine	2	(6)
Downers	1	(3)
Painkillers	1	(3)
GHB	1	(3)
Ecstasy	4	(13)
Heroin	1	(3)
Marijuana	15	(48)
Poppers (amyl nitrate)	7	()
Other drug	1	(1)

Used Viagra, Cialis or Levitra with other recreational drugs before/during sex among those reporting non-injection drug use (N = 31)		
No	28	(90)
Yes	3	(10)
Used recreational drugs before/during sex (N = 73)		
Never	10	(14)
Rarely or occasionally	12	(16)
About half the time	6	(8)
Most of the time	4	(6)
Always	2	(3)
Not applicable	39	(53)
Drank alcohol before/during sex (N = 73)		
Never	16	(22)
Rarely or occasionally	30	(41)
About half the time	16	(22)
Most of the time	8	(11)
Always	1	(1)
Not applicable (don't drink)	2	(3)

§ Percentages may not equal 100% due to rounding.

Table 7: HIV Testing and STDs

VARIABLE	N = 73	(%) §
Ever tested for HIV		
No	9	(12)
Yes	64	(88)
Offered HIV test in past 12 m		
No	37	(51)
Yes	36	(49)
Result of most recent HIV test (N=64)		
Negative	57	(89)
Positive	5	(8)
First positive test	*5*	*(100)*
Result pending	1	(1)
Missing	1	(2)
Diagnosed with STD in past 12 months (N=73)		
No	64	(88)
Yes	8	(11)
Missing	1	(1)
Had syphilis test in past 12 months even though not diagnosed with STD (N = 64)	22	(34)

§ Percentages may not equal 100% due to rounding.

Table 8: Circumcision

VARIABLE	N = 73	(%) §
Circumcised		
No	7	(10)
Yes	64	(88)
Refused	1	(1)
Missing	1	(1)

§ Percentages may not equal 100% due to rounding.

Table 9: Pre-exposure prophylaxis and post-exposure prophylaxis

VARIABLE	N = 73	(%)
Heard of people taking antiretrovirals before risky activity		
No	59	(81)
Missing	1	(1)
Yes	13	(18)
HIV negative	*11*	*(85)*
HIV positive	*2*	*(15)*
Among persons who are HIV-negative: *Used antiretrovirals before risky activity* (N = 11)		
No	*11*	*(100)*
Among persons who are HIV-negative: *Used antiretrovirals after risky activity (*N = 11)		
No	*11*	*(100)*
Among persons who are HIV positive: gave *antiretrovirals to HIV negative sex partner (*N = 2)		
No	*2*	*(100)*

Table 10: Receipt of prevention services

VARIABLE	N = 73	(%) §
Received condoms in the past 12 months		
No	10	(14)
Yes	58	(79)
From community-based organization	*37*	*(64)*
From health department	*8*	*(14)*
From bar/club	*33*	*(57)*
From adult bookstore/theater	*2*	*(3)*
From circuit party/rave	*4*	*(7)*
From gym	*1*	*(2)*
From somewhere else	*21*	*(36)*
Don't know	4	(6)
Missing	1	(1)
Referred by health care provider/outreach worker for STD testing		
No	64	(88)
Yes	8	(11)
Missing	1	(1)
Received information on protection from HIV/STDs		
No	46	(63)
Yes	26	(36)
Missing	1	(1)
Heard about Adam & Steve	65	(89)
Heard about Alaska Native Aurora Society	34	(47)
Assumes that partner's negative status is true		
No	36	(49)
Yes	33	(45)
Refused to answer	1	(1)
Don't know	2	(3)
Missing	1	(1)
Among persons who are not HIV-positive: Is it common for people who are HIV+ to tell their sex partners about their HIV status? (N = 68)		
No	24	(35)
Yes	29	(43)
Don't know	14	(21)
Missing	1	(2)
Among persons who are HIV positive: How often do you tell your sex partners about your HIV status? (N = 5)		
Most of the time	1	(20)
Always	4	(80)

§ Percentages may not equal 100% due to rounding or if respondents were able to provide >1 response to a question.

State of Alaska
HIV/STD Program
Injection Drug User Survey Analysis
November, 2012

Executive Summary

Of the 149 survey respondents, 64% (n=95) report having ever shared needles and 90% (n=133) report having ever re-used needles. Rates of needle sharing and re-use were even higher in certain areas of the state. In Fairbanks 100% of survey respondents (n=16) reported sharing needles and re-using needles, while 81% of survey respondents at outreach reported sharing needles and 88% reported re-using needles. Needle exchanges and pharmacies were the two most commonly reported sources of clean needles among survey respondents. 39% (n=98) of survey respondents reported accessing needles through exchange programs, and 70% (n=105) reported having ever used a needle exchange program. 33% (n=81) of survey respondents reported accessing needles through pharmacies. Although pharmacies were a primary source of clean needles for many respondents, 62% (n=93) reported having attempted to purchase needles at a pharmacy and being denied.

Access to clean needles remains a problem in Alaska, particularly in areas outside of Anchorage. To address this, clean needle access through exchange programs and pharmacies should be expanded throughout the state. Needle exchange programs should be expanded to other urban and sub-urban locations through the state and pharmacies should expand the practice of selling needles without a prescription.

Introduction

June through August 2012 the State of Alaska (SOA) HIV Prevention Program (HPP) conducted a survey to injection drug users (IDUs) to determine current needle use trends, including where IDUs are acquiring needles, what barriers they are encountering in accessing clean needles, and to what extent IDUs are re-using and sharing needles. The survey also aimed to gauge the percentage of IDUs who have been tested for human immunodeficiency virus (HIV) and hepatitis C virus (HCV).

All survey respondents were recruited through convenience sampling (n=149). In Anchorage respondents were recruited at the Center for Drug Problems and at the needles exchange program hosted by the Alaska Aids Assistance Association (4A's). In Fairbanks, respondents were recruited at the needle exchange program hosted by the Interior AIDS Association (IAA). Surveys were also conducted at outreach events, primarily at organizations and businesses in and around the Fairbanks urban area and at the drug rehabilitation program offered at Wildwood Correctional Facility, located in Kenai. Respondents from Wildwood were originally from throughout Alaska.

Demographic Profile

The majority (68%; n=101) of respondents were located in the Anchorage urban area, while 11% (n=16) were located in Fairbanks (Figure 1). 21% (n=32) of respondents were surveyed during outreach events. Respondents were fairly evenly split between males (40%) and females (48%). A small number of respondents refused to supply demographic information (Figure 2).

Figure 1: IDU survey, respondents by location

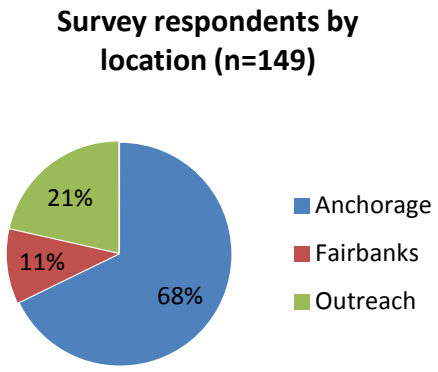
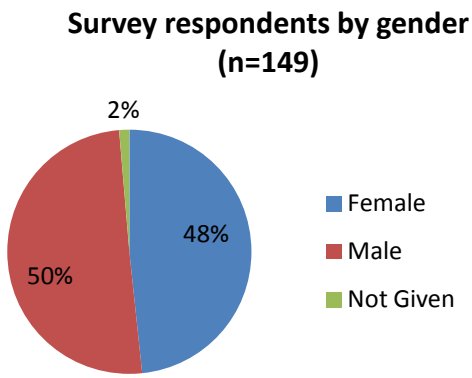
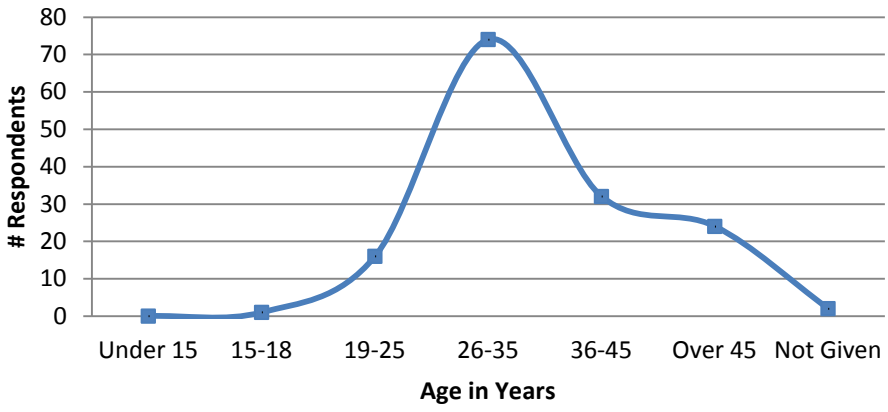


Figure 2: IDU survey, respondents by gender



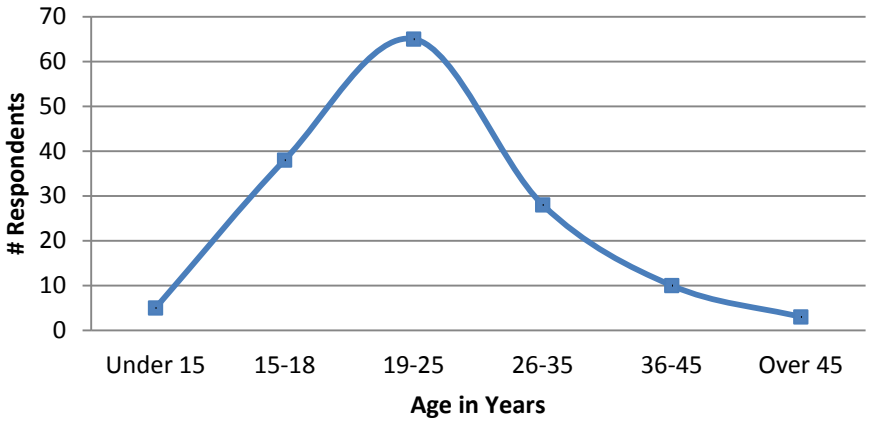
The majority of respondents were between 19-45 years of age (n=122) and a small portion were over the age of 45 (n=24). No respondents were under the age of 15 years, and only one respondent was 15-18 years of age (Figure 3).

Figure 3: IDU survey respondents by age



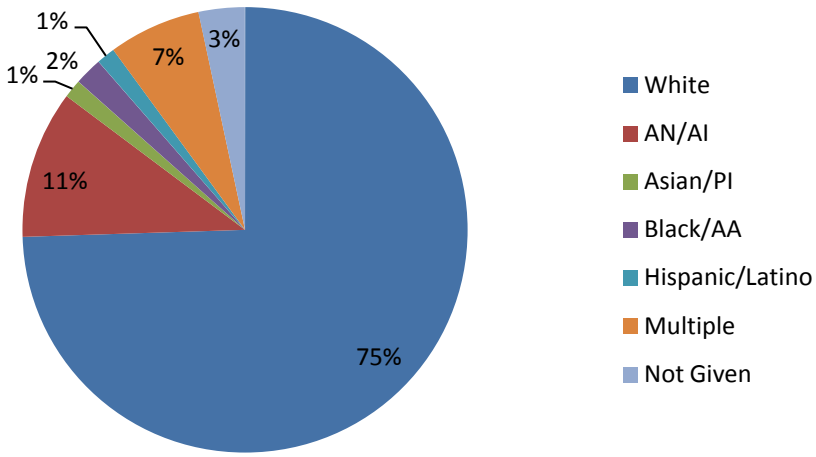
Over 69% (n=103) of respondents began injecting drugs between the ages of 15-25 years (Figure 4). A small number (n=5) began injecting drugs prior to 15 years of age, and a minority (n=13) began injecting later in life, at older than 36 years of age.

Figure 4: IDU survey respondents by age first began injecting drugs



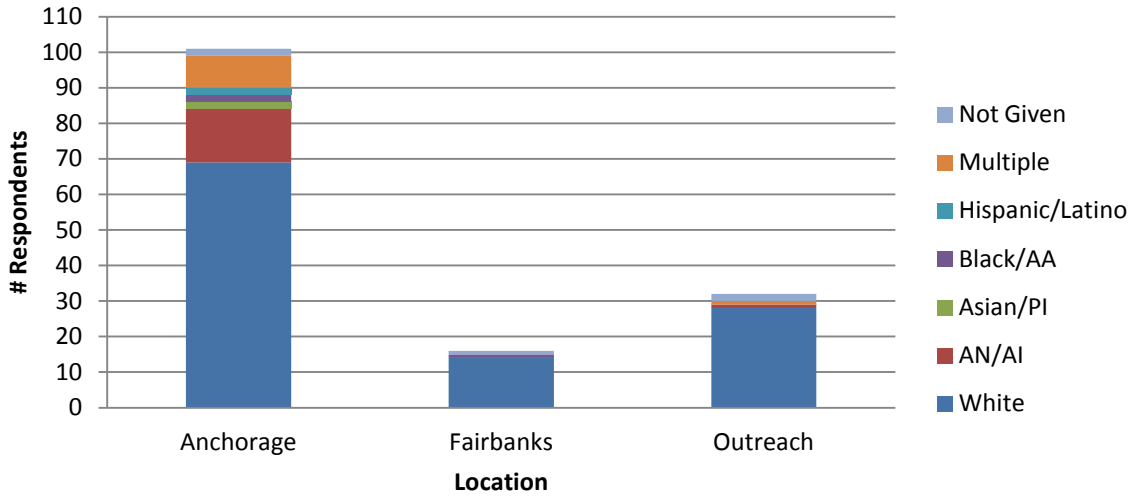
The majority of respondents were White (75%), in line with current estimates on the racial profile of injection drug users in Alaska (Figure 5). Alaska Native/American Indians were the second largest racial group represented (11%). The remaining 14% of respondents identified as Asian/Pacific Islander (1%), Black/African American (2%), Hispanic/Latino (1%), Multiple races/ethnicities (7%), or not given (3%).

Figure 5: IDU survey respondents by race/ethnicity (n=149)



The greatest variation of race and ethnicity was seen in Anchorage; the majority of respondents from Fairbanks and Outreach identified as either White, Multiple Races, or declined to provide racial/ethnic demographic information (Figure 6).

Figure 6: IDU survey respondents by race/ethnicity and location



Survey Results

The majority of respondents reported having at some point shared needles (Figure 7). Respondents in Anchorage were much less likely to report sharing needles than respondents in Fairbanks and at Outreach; 52% versus 88% (Figure 8). The high number of people reporting sharing needles outside of Anchorage may indicate greater challenges in accessing clean needles outside the Anchorage urban area.

Figure 7: IDU survey respondents who reported ever sharing needles (n=149)

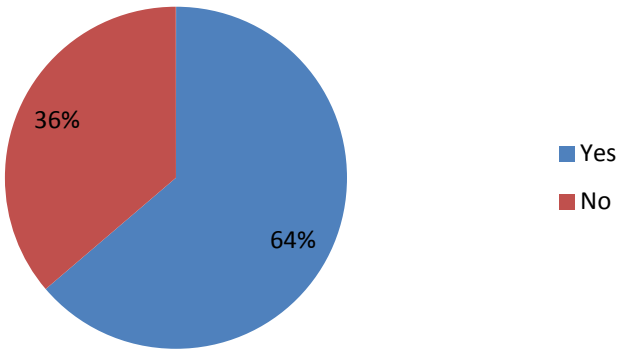
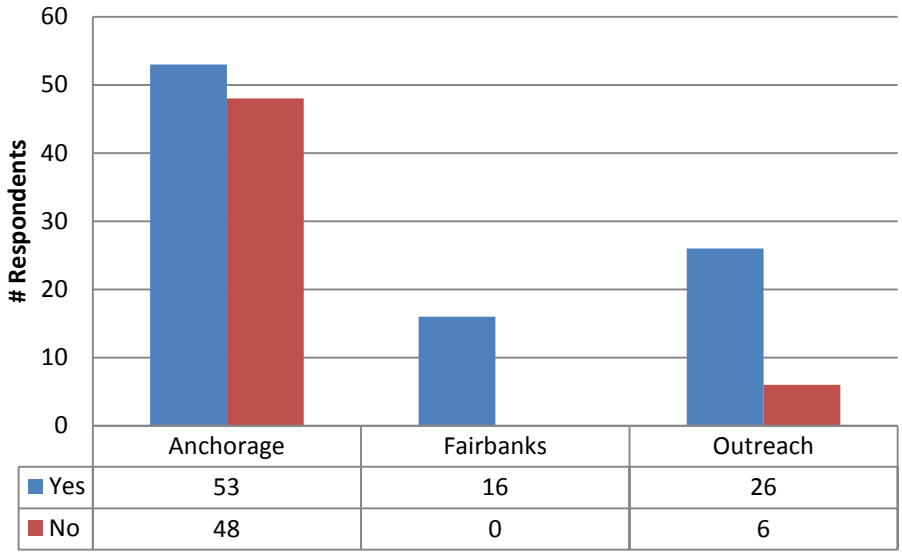
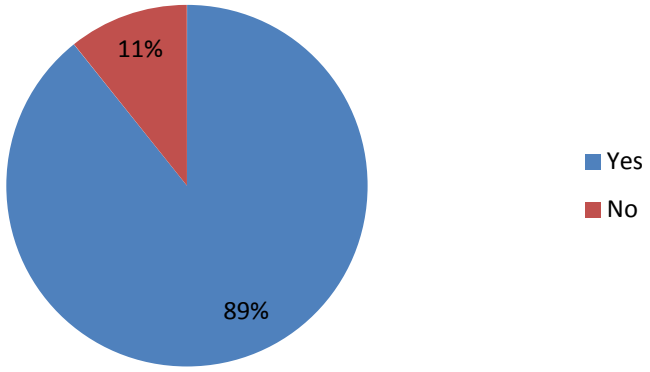


Figure 8: IDU survey respondents who reported ever sharing needles, by location



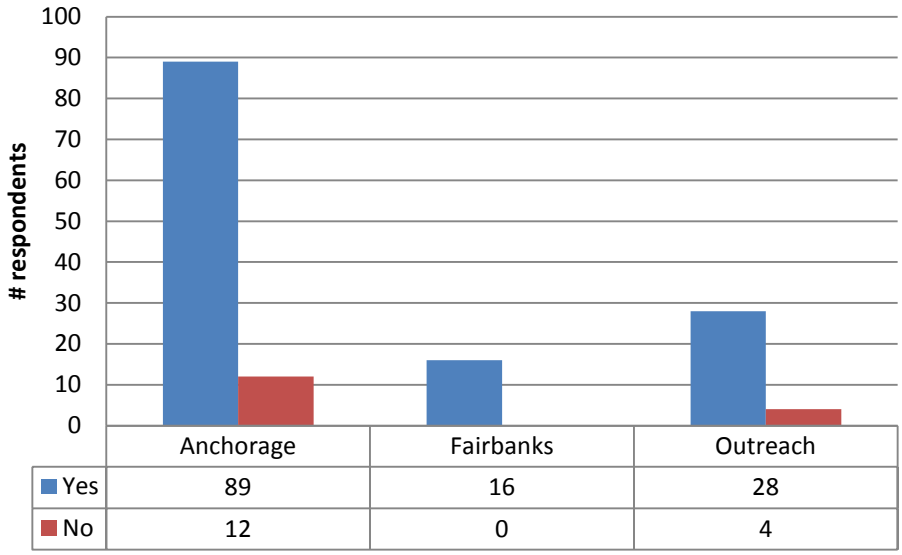
Almost 90% (n=133) of respondents reporting re-using needles (Figure 9). Although not a risk factor for transmission of HIV or HCV, re-using needles can be indicative of lack of access to clean needles and the high rate of re-using needles throughout the state indicates that increasing access to clean needles should be a program priority.

Figure 9: IDU survey respondents who reported ever re-using needles (n=149)



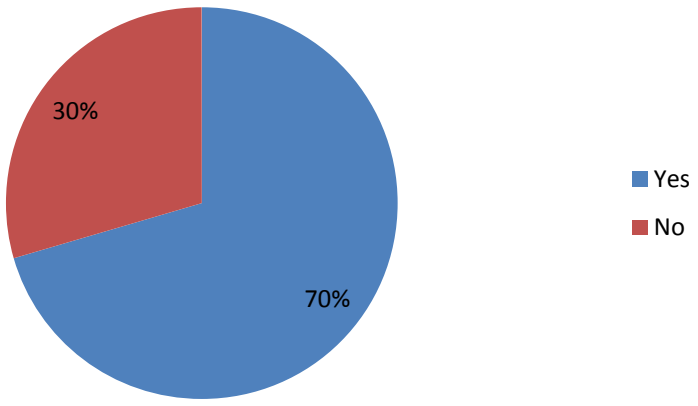
Rates of needle re-use were high across all surveyed locations; 100% of respondents in Fairbanks, 86% of respondents at Outreach and 88% of respondents in Anchorage reported re-using needles (Figure 10). This may indicate a need for increased availability of needles, either through exchange programs or for purchase through pharmacies, across the state.

Figure 10: IDU survey respondents who reported ever re-using needles, by location



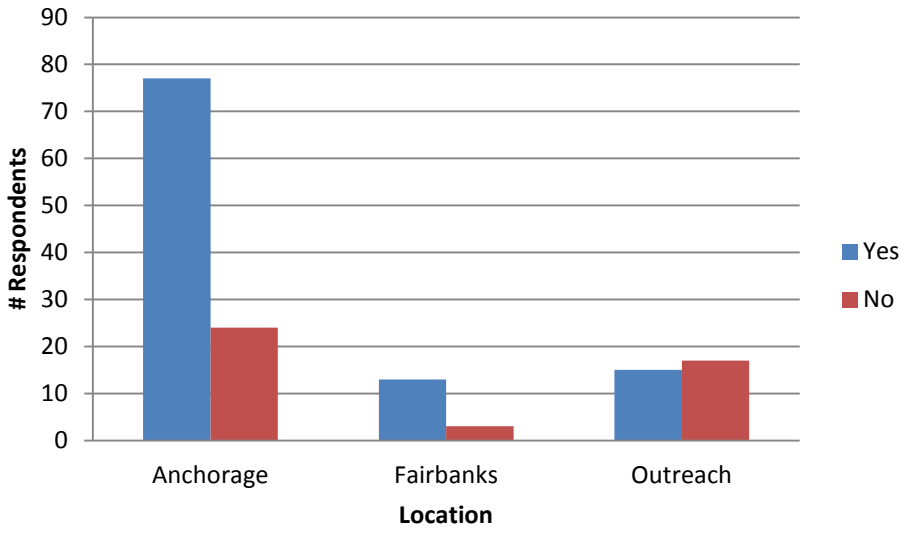
Survey participants were asked whether they had ever used a needle exchange program. The question was not specific to needle exchange program use in Alaska, and respondents who have used exchange programs in other states may have responded affirmatively. Despite this limitation, 70% (n=104) of respondents reported that they have used a needle exchange in the past (Figure 11). This indicates that the majority of respondents are aware of needle exchange programs and the services that they offer, although it is impossible to predict whether that knowledge has translated to use of needle exchange programs in the state.

Figure 11: IDU survey respondents who reported ever using a needle exchange program (n=149)



Alaska has two fully operational needle exchange programs, one in Anchorage and one in Fairbanks. Needle exchange services are also intermittently and currently available in Juneau. In both Anchorage and Fairbanks the majority of people reported having used a needle exchange at some point (76% and 81% respectively). At outreach, where respondents were more likely to be from parts of the state other than Anchorage and Fairbanks, respondents were much less likely to have used a needle exchange program (47%; Figure 12), indicating that access to a needle exchange program is a major predictor of use of a needle exchange program

Figure 12: IDU survey respondents who reported ever using a needle exchange program, by location



Survey participants were asked whether they had ever attempted to purchase needles at a pharmacy and been denied. As the question did not specify whether the attempt was made in a pharmacy in Alaska, it is possible that respondents referenced occurrences that happened in pharmacies outside of Alaska. The question also did not distinguish between people who had never attempted to purchase needles at a pharmacy, those who had attempted to purchase needles at a pharmacy and been successful and those who had attempted to purchase needles at a pharmacy and been unsuccessful. This means that while it can be assumed that every 'Yes' answer means that the person has both attempted to purchase needles at a pharmacy in the past and been denied that purchase, the 'No' responses include both people who have never attempted to purchase needles at a pharmacy and those who have purchased needles at a pharmacy and not been denied.

Of the 149 survey respondents, 93 (62%) reported having attempted to purchase needles at a pharmacy and been denied (Figure 13). When broken down by region, the majority of respondents in both Fairbanks and at Outreach reported having attempted to purchase needles at a pharmacy and being denied, while in Anchorage responses were more evenly

split between those who had attempted to purchase needles at a pharmacy and been denied and those who had either never attempted to purchase needles at a pharmacy or who had never been denied (Figure 14).

Figure 13: IDU survey respondents who reported ever attempting to purchase needles at a pharmacy and being denied (n=149)

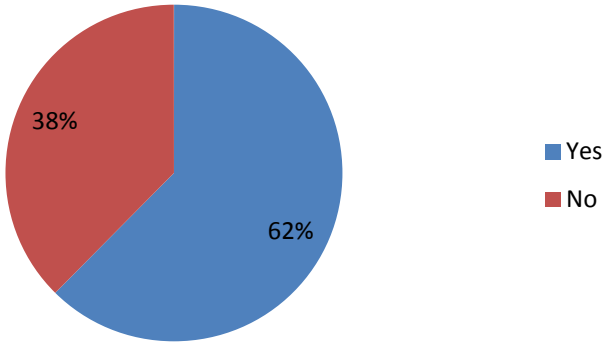
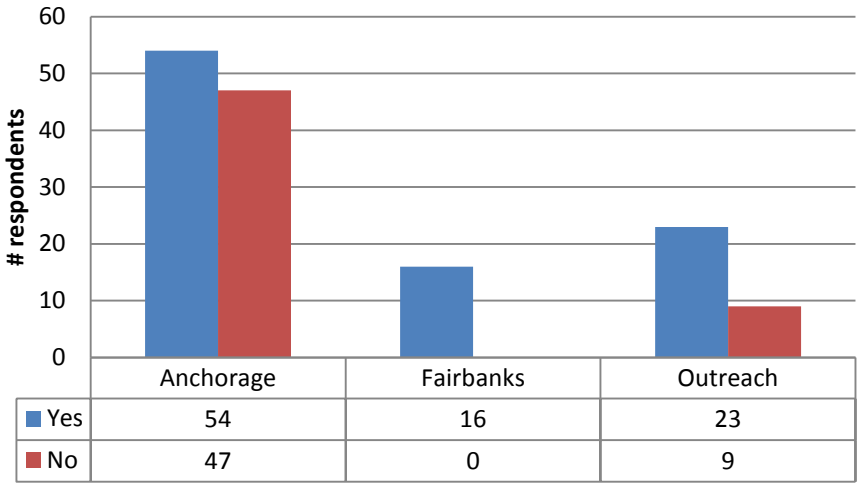
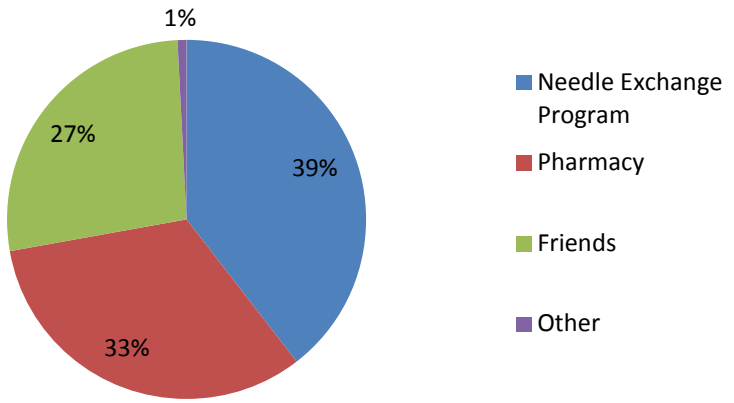


Figure 14: IDU survey respondents who reported ever attempting to purchase needles at a pharmacy and being denied, by location



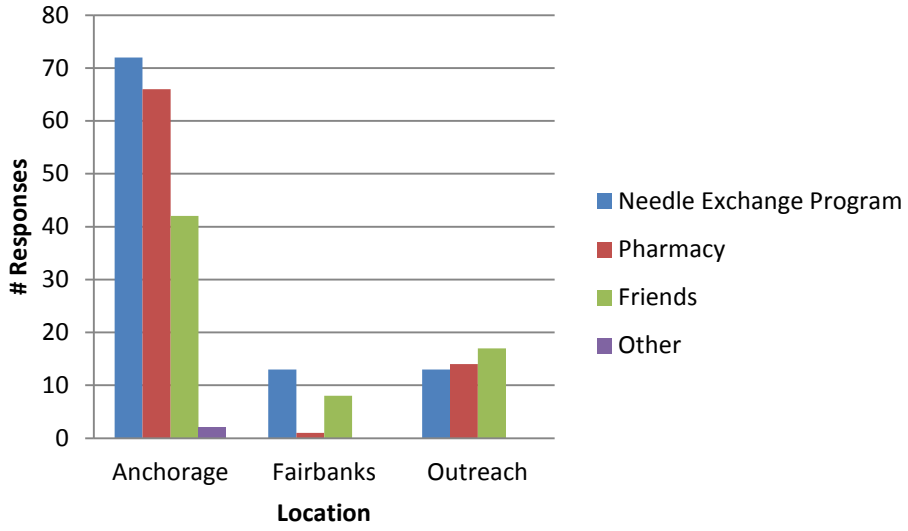
Survey respondents reported accessing needles at needle exchange programs, pharmacies and from friends (Figure 15).

Figure 15: IDU survey where respondents report accessing needle (n=149)



By location, respondents from Anchorage, Fairbanks and Outreach all reported accessing needles through needle exchange programs. In Anchorage and at Outreach many respondents also reported accessing needles through pharmacies (36% and 32% respectively). Only at Outreach did the majority (39%) of respondents report accessing needles from friends, indicating that there may be reduced access to needles through exchange programs and pharmacies outside of Anchorage and Fairbanks (Figure 16).

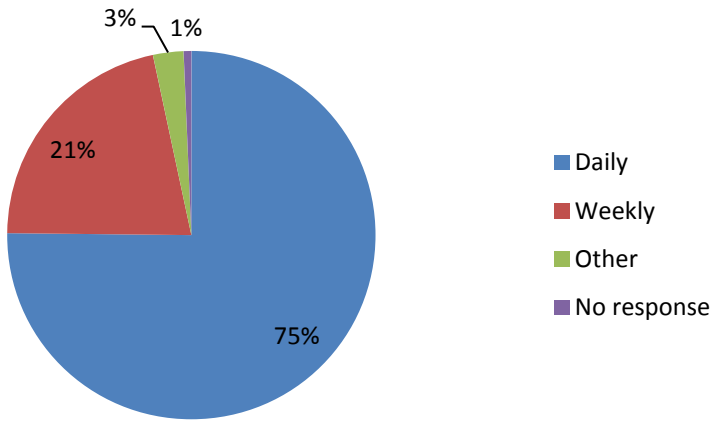
Figure 16: IDU survey where respondents report accessing needles, by location (n=248*)



* Due to multiple responses, 248 responses were received from 149 unique respondents

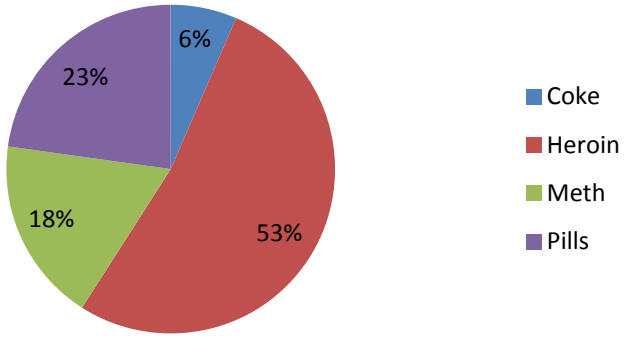
The majority of respondents (75%, n=112) reported injecting drugs weekly (Figure 17). It should be noted the question did not clarify whether it was requesting information about current drug use habits or ever drug use habits.

Figure 17: IDU survey how often respondents report injecting drugs (n=149)



Heroin was the self-identified drug of choice for most survey respondents (53%, n=113). Respondents also reported using meth, pills and to a lesser extent coke (Figure 18). It should be noted that the survey question did not identify drug use versus injection drug use. Although it is common practice to inject pills, survey administers anecdotally communicated that respondents who administered pills in ways other than by injection did still identify pills as a drug of choice.

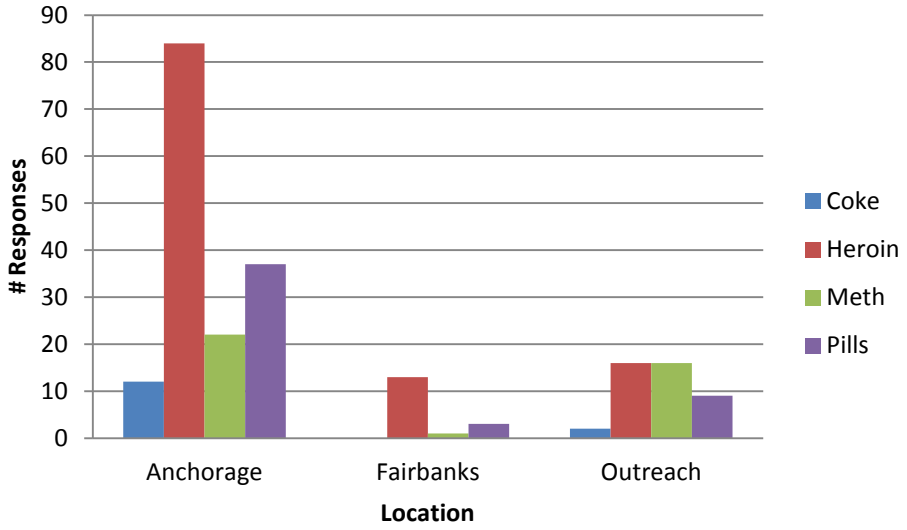
Figure 18: IDU survey what respondents report as their drug(s) of choice (n=215*)



* Due to multiple responses, 215 responses were received from 149 unique respondents

Heroin remained the most popular or one of the most popular drugs of choice when the data are broken down by location. Meth and pill use were distributed throughout all locations, while coke use was predominantly in Anchorage (Figure 19).

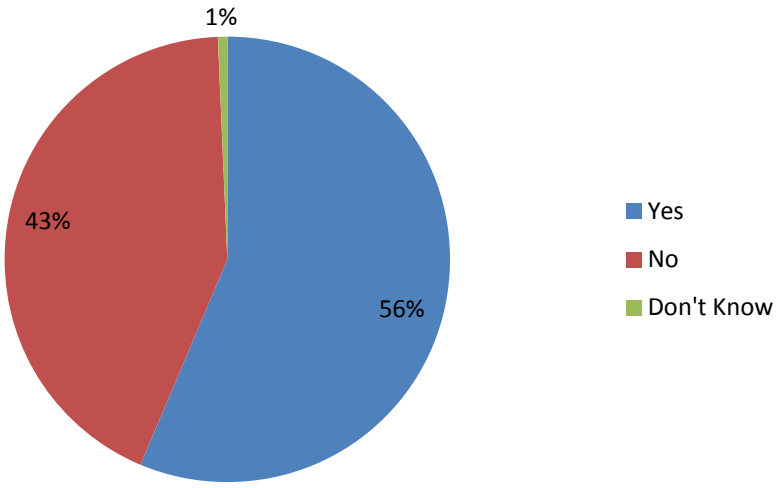
Figure 19: IDU survey what respondents report as their drug(s) of choice, by location (n=215)



* Due to multiple responses, 215 responses were received from 149 unique respondents

Only 56% (n=84) of survey respondents reported having ever been tested for HIV (Figure 20). This indicates that injection drug users should be a high priority population for HIV testing and outreach programs.

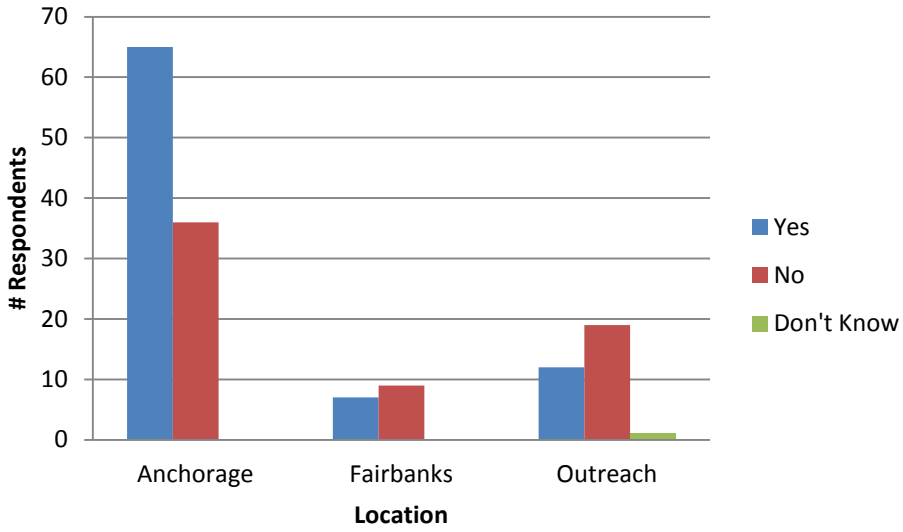
Figure 20: IDU survey whether respondents report ever having been tested for HIV (n=149)



Survey respondents in Anchorage had the highest rates of HIV testing, 64%, compared to 44% of respondents in Fairbanks and 36% of respondents at Outreach (Figure 21). This indicates that access to education about the importance of testing for HIV and access to HIV tests themselves may be greater in Anchorage than it is in other parts of the state. While all

parts of the state could benefit from an increase in education and testing for HIV, programs should place particular focus on reaching injection drug users outside the Anchorage area.

Figure 21: IDU survey whether respondents report ever being tested for HIV, by location



48% (n=72) of survey respondents reporting having ever been tested for HCV (Figure 22). Of those who reported having ever been tested for HCV, the vast majority (89%; n=64) were in Anchorage. None of the respondents from Fairbanks and only eight respondents from Outreach reported having been tested for HCV (Figure 23). These data indicate that HCV testing in areas of the state outside of Anchorage, particularly in other urban centers such as Fairbanks, should be a top program priority.

Figure 22: IDU survey whether respondents report ever being tested for Hepatitis C (n=149)

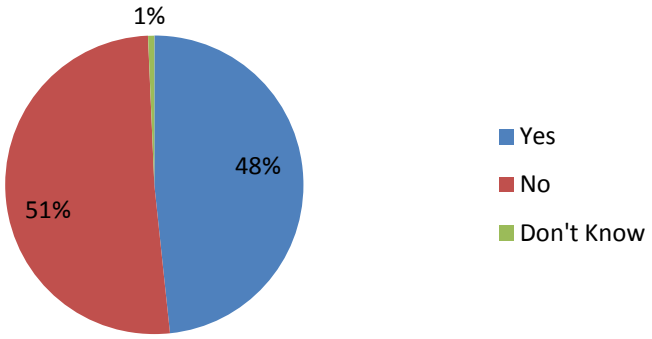
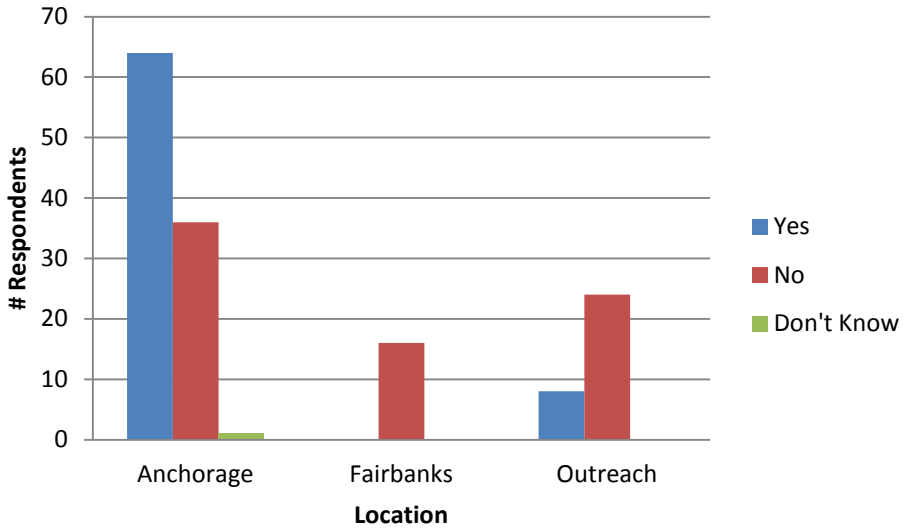


Figure 23: IDU survey whether respondents report ever being tested for Hepatitis C by location



Recommendations

Although the results of the injection drug user survey are not statistically significant, they are practically relevant in determining program recommendations for HIV prevention in the injection drug use community. Based off of survey results, four public health recommendations concerning the injection drug use community have been developed:

1. Programs which increase access to clean needles should be introduced across the state. High rates of needle sharing and needle re-use indicate that injection drug users living outside of Anchorage do not have regular, safe access to clean needles. Lack of access to clean needles increases risk for blood borne pathogens, particularly HIV and HCV.

2. Access to clean needles through needle exchange programs and pharmacies should be expanded across the state. Needle exchange programs should be expanded to other urban and sub-urban locations throughout the state and pharmacies should expand the practice of selling needles without a prescription.

3. HIV testing should be expanded in areas of the state outside of Anchorage. While respondents in Anchorage reported high rates of testing for HIV, testing rates from other parts of the state were much lower. As injection drug users are a high-risk, priority populations for HIV prevention and easy, affordable HIV testing options should be available and marketed to IDUs throughout the state.

4. HCV education and testing opportunities should be expanded, particularly outside of Anchorage. Low rates of HCV testing in IDUs surveyed in Fairbanks and at outreach

indicate that not all IDUs have access to HCV testing, or are aware of the importance of testing for HCV. Although testing positive for HCV is not an indicator of HIV infection, it can be indicative of engagement in high-risk activities and should be a component of a comprehensive HIV prevention program.

Alaska Women's HIV Prevention Needs Assessment

June 2007

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PURPOSE

From December 21, 2006 to March 30, 2007, the State of Alaska HIV/STD Program conducted a survey of women to assess the needs and preferences for HIV prevention services. The purpose of the project was to inform the efforts of the Alaska HIV Prevention Planning Group and the HIV/STD Program, its grantees, and other state agencies and community partners that provide health and social services for women.

Women at Increased Risk

Heterosexual women at increased risk are identified as a priority population in the *2007 – 2009 Alaska HIV Prevention Plan.*[1] In the United States, female adults and adolescents made up 26% of HIV/AIDS cases diagnosed in 2006. Nineteen percent (19%) of the cumulative total of 1,145 cases of HIV/AIDS ever reported in Alaska through December 31, 2006 were in females.[2] Nationally and in Alaska, ethnic minority women are disproportionately affected by HIV. Of the HIV/AIDS cases in U.S. women diagnosed in 2005, 66% were African-American and 14% were Hispanic.[3] In Alaska, 34% of the cumulative total of HIV/AIDS cases in women through 2005 were Alaska Native.[4]

Most women are infected with HIV through heterosexual contact.[3,4] The virus is transmitted more efficiently from men to women during sexual intercourse and the presence of some sexually transmitted diseases increases a woman's vulnerability to HIV infection. Alaska has very high rates of chlamydia and gonorrhea. In 2006, the highest chlamydia and gonorrhea case rates in Alaska were among females aged 15 to 24 years.[5,6] By contrast, the highest proportion of HIV cases in women in Alaska reported between 2001 and 2005 was in the 25 to 29 year age group.[1]

Research on women with HIV infection indicates a relationship between HIV infection and substance abuse as well as a host of social and economic factors including: interpersonal violence, inequality in relationships, low income, unemployment and homelessness, risk behaviors of male partners, and women's lack of awareness of their partner's risk factors.[3]

The Alaska Women's Needs Assessment

The needs assessment was designed to gain insight into Alaska women's understanding of their risk for HIV. Research on behavior change indicates that people are more likely to adopt safer behaviors if they perceive they are vulnerable to a specific risk and need to make a change, have social support for behavior change, have the knowledge and skills needed to make changes, and can access the needed resources. The needs assessment included questions to assess the extent of women's risk and the presence of these factors that support change. Specifically, the survey sought to learn:

- What do women know about HIV transmission and risk reduction?
- Do women get tested for HIV and why might they not get tested?
- Do women believe that they have the ability to protect themselves?
- Do women have social support for reducing risk and getting tested?
- Do women have access to health care?
- Do women think they are personally at risk?
- What circumstances and behaviors put women at risk for HIV infection?
- What prevents women from protecting themselves against HIV?

- Where do women get information about HIV transmission, prevention and testing?
- What kind of HIV resources do women prefer?

METHOD

The survey consisted of a computer-assisted self-administered interview (CASI) developed with QDS™ software and administered on two laptop computers. Questions were developed with input from an advisory group of women involved in HIV prevention in Anchorage. The 15 to 20 minute interview was anonymous; no names or identifying information were recorded. Women were advised beforehand that the survey contained some sensitive questions and that they could skip questions or end the interview at any time. A $5 gift card was offered afterwards to thank participants for their time. Women who volunteered to participate sat down at a laptop computer, read the questions and response choices on the screen and, if they chose to, heard the questions and response choices through headphones. Women could choose to do the interview in English or Spanish, and paper copies of the survey were available as an alternative to using the computer. Project staff members were present to orient women to the computer and to assist if needed. To evaluate the use of the computer-assisted method, respondents were asked to complete a brief, written feedback questionnaire at the end of the interview. The results of the user feedback questionnaire are included in Appendix B.

Because of the disproportionate impact of HIV among African-American women and Latina nationally, and among Alaska Natives in Alaska, the project attempted to over sample ethnic minority women. In order to assess the knowledge and attitudes about HIV risk and risk reduction among women potentially at increased risk due to socio-economic, substance use and interpersonal factors found to be prevalent in women with HIV, the project recruited participants at agencies serving women with life circumstances that may increase their vulnerability to HIV infection. Project personnel recruited a convenience sample by approaching women in the waiting area of health and social service agencies, at community events, and through posters and announcements in facilities with resident clients. The sample does not constitute a random sample that is statistically representative of the adult female population of Alaska or the communities from which women were recruited.

Interviews were conducted at 18 locations in Anchorage, Kenai, and Wasilla including:

- Three substance abuse treatment programs in Anchorage and Kenai
- Five Division of Public Assistance offices in Anchorage, Wasilla and Kenai
- WIC (Women, Infants, and Children) program office in Anchorage
- Municipality of Anchorage Health Department clinics
- Women's shelter in Anchorage
- Homeless shelter and soup kitchen in Anchorage
- Anchorage Neighborhood Health Center
- Community residential facility (halfway house) and
- Two community events in Anchorage.

RESULTS

Two hundred thirty two (232) women completed the survey. The average age of respondents was 36 years with a range from 18 to 65 years (Table 1). Over half of the women had completed high school or some post-secondary education (Table 2).

Table 1. Age N=232

Age Group	Number (%)
≤ 19	10 (4.3)
20-29	70 (30.2)
30-39	58 (25)
40-49	65 (28)
50+	27 (11.6)

Table 2. Education N=232

Education Level	Number (%)
8th grade or less	11 (4.7)
Some high school	38 (16.4)
High school diploma or GED	69 (29.7)
Vocation or tech school	6 (2.6)
Some college	71 (30.6)
College degree	22 (9.5)
Graduate school	14 (6)

Participants self-reported their ethnicity in one or more categories. For purposes of this report, the ethnicity responses were grouped into White (40%), Alaska Native/American Indian (32%), African American (9%), Latina (9%), Asian (5%), Native Hawaiian/Pacific Islander (3%) and other (2%). Although 20 Latina participated, only eight (40%) chose to use the Spanish version of the interview.

Of the 232 women, the majority (55.6%) had a household income of under $20,000 per year (Table 3). As an indication of financial dependency, women were also asked if they have a personal source of money independent of a spouse, parent or relative. Eighty-nine women (38.4%) said they did not have an independent source of money; 25% had an independent personal income less than $10,000 per year (Table 4). Ninety-three women (40%) reported being homeless at some time within the past 12 months.

Table 3. Annual Household Income N=232

Annual household income	Number (%)
Less than $20,000	129 (55.6)
$20,001 to $50,000	69 (29.7)
More than $50,000	28 (12.1)

Table 4. Annual Personal Source of Income N=232

Independent income per year	Number (%)
No personal source of money	89 (38.4)
Less than $10,000	58 (25)
$10,001 to $20,000	31 (13.4)
$20,001 to $50,000	41 (17.7)
More than $50,000	10 (4.3)

Interpersonal Violence

Experience of interpersonal violence as an adult or as a child has been correlated with HIV infection in women.[3] Victimization may contribute to a range of factors that increase a woman's vulnerability to HIV either by increasing risk-taking behavior and substance abuse or by decreasing the ability to withstand coercion. On the needs assessment survey, 32% of women reported that they had been physically abused by a man (hit, slapped, kicked or otherwise hurt physically) within the past twelve months. Over a third of the women (36.7%) had been forced to have sex as an adult; 16.4% once and 20.3% multiple times. One hundred women (43%) had been forced into sexual activity before the age of 16.

Knowledge of HIV Transmission and Risk Reduction

The survey included 19 questions about HIV and transmission (Appendix A, Table A1). Assigning a point for each correct answer, a knowledge score with a maximum of 19 points was calculated for each respondent. The average knowledge score was 15.8 with a range of 6 to 19 points. The distribution of knowledge scores grouped into low, medium, and high categories is shown in Table 5.

Table 5. Knowledge of HIV and Transmission N=232

Knowledge Score	Number (%)
Low 6-11	12 (5.2)
Medium 12-15	81 (34.9)
High 16-19	139 (59.9)

Knowledge of risk reduction was based on eight questions on the relative effectiveness of various birth control methods for protection from sexual transmission of HIV (Appendix A, Table A2). The maximum score for this set of questions was 16. The average score was 11.1 with a range of zero (3 persons) to 16. Grouped into low, medium, and high, the distribution of risk reduction knowledge scores is shown in Table 6.

Table 6. Knowledge of Risk Reduction N=232

Risk Reduction Score	Number (%)
Low 0-5	27 (11.6)
Medium 6-10	51 (22)
High 11-16	154 (66.4)

HIV Testing Experience

A higher percentage of women participants in the needs assessment had been tested for HIV than the general population of Alaska or the U.S. as a whole. Not counting tests done when donating blood, 173 (74.6%) respondents said they had ever been tested for HIV: 125 reported testing within the last five years; 65 reported testing within the last 18 months. The same question is asked on the national Behavioral Risk Factor Surveillance System (BRFSS), a representative survey of the general population. According to the BRFSS survey results for Alaska in 2005, 48% of females and 47% of males between ages18 and 64 reported ever being testing. Nationally in 2005, 38% of U.S. adults 18 to 64 had ever been tested. According to a Kaiser Family Foundation survey, 55% of women in the U.S. aged 18 to 64 report ever being tested.[7] Most women in the needs assessment survey were last tested at a private doctor's office, hospital or clinic (Appendix A, Table A3).

Of the 232 women participants in the needs assessment, 89 (38.4%) had been pregnant in the past five years. Of these, 66 (74.2%) reported being tested for HIV during their pregnancy. On the Alaska PRAMS (Pregnancy Risk Assessment and Monitoring System), an ongoing survey of women who have given birth within the past year, 60% responded in 2004 that they had been tested for HIV during their pregnancy.

Most women reported that they would like to get an HIV test in the future: 185 (79.7%) would get tested in the future and all but three of these identified at least one place they would go to get an HIV test (Appendix A, Table A4). Forty women (17.2%) did not intend to be tested in the future. Their reasons were largely due to lack of perceived need rather than lack of access to testing (Table 7).

Table 7. Reasons for No Intention to be Tested for HIV N=40

Reasons for not testing for HIV in the future N=40	Number*
I am not at risk	31
I have already been tested	16
Other	7
I don't know where to go	1

* Participants could select more than one response

Access to and Use of Health Care Services

Access to health care is an important protective factor, providing a source of risk reduction education, STD screening and treatment, reproductive health care, as well as HIV testing. Women in the survey most often cited health care providers (HCP) as a source of their information about HIV

(Appendix A, Table A5). Women were asked: "Has a doctor or nurse ever talked with you about how to protect yourself from getting HIV?" Almost 75% responded in the affirmative (Table 8) and 72% said they would like it if their doctor or nurse talked with them about sexual health including HIV and STD prevention.

Table 8. Women Reporting that a Health Care Provider Talked with them about Prevention N=230

HCP talked about protection from HIV	**Number (%)**
Never	60 (25.9)
Once	37 (15.9)
More than once	133 (57.3)

One hundred twenty-six women (54%) reported that they had health insurance (including Medicaid and Medicare) and 51 (22%) reported that they get health care through the military, the Veteran's administration or an Alaska Native health facility. Eighty-three women (36%) had neither health insurance nor federally funded health care (Table 9), and 90 (39%) said that cost was a barrier to seeing a health care provided in the past twelve months.

Table 9. Health Care Coverage N=232

Health Insurance, Medicare, Medicaid	Health Care through Military, VA or AK Native Health Facility	
	No	Yes
No	**83**	22
Yes	97	29
Total	180	51

Within the past two years, 188 (81%) of the women had visited a health care provider for a woman's health check-up (Pap test, pelvic, and breast exam). For 34 women (15%) it had been more than two years since their last women's health check-up and six women (2.6%) had never had a women's health check-up.

Self-Efficacy

Research on behavior change indicates that self-efficacy is a factor that facilitates adopting healthier practices. The survey included nine questions to assess women's sense of their own ability to initiate safer sex with a male partner (Appendix A, Table A6). The maximum possible self-efficacy score based on responses to these questions was 9; the average score was 7 with a range from 0 to 9. Table 10 shows the scores grouped into low, medium, and high.

Table 10. Self-Efficacy Scores N=232

Self Efficacy Score	Number (%)
Low 0-3	8 (3.4)
Medium 4-6	54 (23.3)
High 7-9	170 (73.3)

Social Support for Protection

Having friends or other influences that indicate concern about HIV and acceptance of protective behaviors is supportive of adopting safer behaviors. Four questions were asked relating to attitudes among women's sources of social support (Appendix A, Table A7). With a possible score of four for this set of questions, the average score was 2.96 with a range from 0 to 4. Table 11 shows the distribution of scores grouped into low, medium, and high. Religious objection to condom use was not a significant barrier.

Table 11. Social Support Scores N=232

Social Support Score	Number (%)
Low 0-1	20 (8.6)
Medium 2	49 (21.1)
High 3-4	163 (70.3)

Perceived Vulnerability

The survey included three statements related to perception of personal vulnerability to HIV: believing one's own actions put one at risk; believing a sex partner could be at risk; and personally knowing a woman with HIV (Appendix A, Table A8). Knowing a person like oneself who has HIV tends to heighten awareness of personal risk. Agreement with one of these statements was given two points; a 'not sure' response was assigned one point. The maximum possible score was 6; the average score was 2.2 with a range of 0 to 6. Table 12 shows the distribution of scores grouped into low, medium, and high.

Table 12. Perceived Vulnerability Scores N=232

Perceived Vulnerability Score	Number (%)
Low 0-2	139 (60)
Medium 3-4	58 (25)
High 5-6	35 (15)

Risk Behaviors

The survey included a question from the BRFSS that probes for personal risk behaviors. The question, hereafter referred to as the BRFSS risk question, asks: Without saying which ones, do any of the following situations apply to you - injected drugs in the past year, treated for a sexually transmitted disease in the past year, gave or received money or drugs in exchange for sex in the past year, had

anal sex without a condom in the past year. Sixty-four (28%) of women in our survey responded 'yes'; 162 (70%) said 'no'; six declined to answer. This is a much higher percentage of yes responses than on the 2005 BRFSS in Alaska, on which 3.3% of women responded that yes, one or more of these situations applied to herself.

Substance abuse can increase women's risk of HIV due to exposure to contaminated drug use equipment, sexual transmission from male partners at high risk for HIV due to their drug use or sexual behavior, victimization while high or drunk, exchange of sex for alcohol and other drugs, and decreased ability to negotiate safer sex.

Approximately a third of the women in the survey reported drug use to get high, 16% had used methamphetamine in the past 12 months, 26% reported drinking to blackout, and 44% had engaged in sex while high or drunk (Table 13).

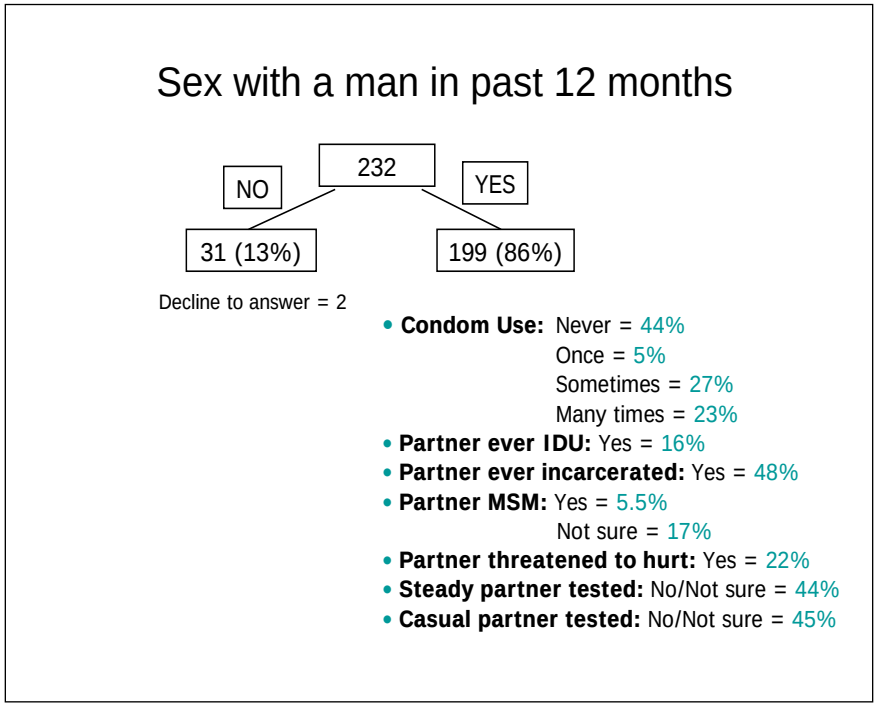
Table 13. Substance Use in Past Twelve Months N=232

Substance Use in past 12 months	**Number responding once, sometimes, or many times (%)**
Used drugs (not including alcohol or marijuana) to get high	74 (32%)
Used methamphetamine	36 (16%)
Drank alcohol to the point of blacking out	61 (26%)
Had sex while high or drunk	102 (44%) Once = 20 (9%) Sometimes = 63 (27%) Many times = 19 (8%)

Eighty-nine women (38%) have ever been in a substance abuse treatment program; 62 of these or 27% of the total sample have been in substance abuse treatment more than once.

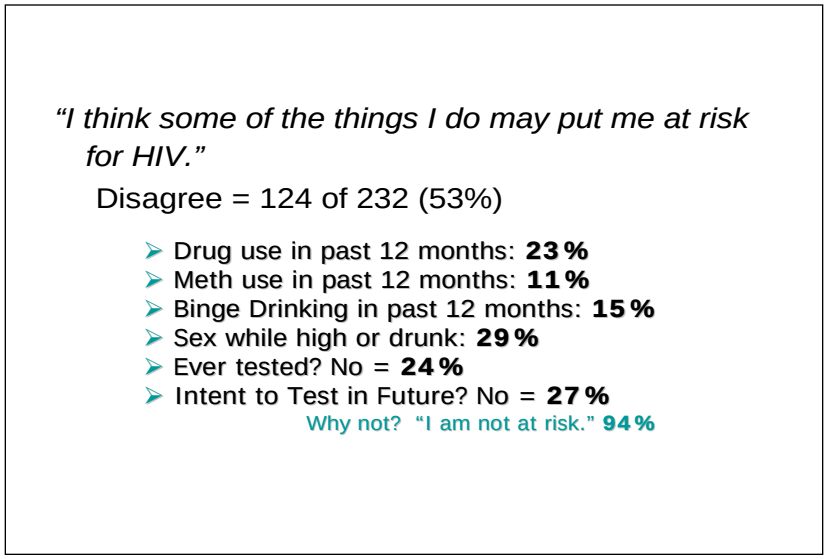
Of the 232 women surveyed, 199 (86%) had had sex with a man in the past twelve months. Among these sexually active women, 44% indicated that they never used condoms during this time period; 27% sometimes; 5% only once. Many of the sexually active women had male partners potentially at high risk for HIV: 16% of women had partners with a history of injection drug use; 48% of women had partners that had been incarcerated; 5.5% of women knew their partner had sex with other men and an additional 17% of women were not sure if their partner had sex with other men. Yet, 44% of the women were either unsure of or knew that their steady partner or husband had not been tested for HIV; 45% did not know the testing status of their casual partners or dates. Twenty-two percent (22%) of the women had partners within the past 12 months who had threatened to hurt them (Figure 1).

Figure 1. Risk Factors of Sexually Active Women. N= 199



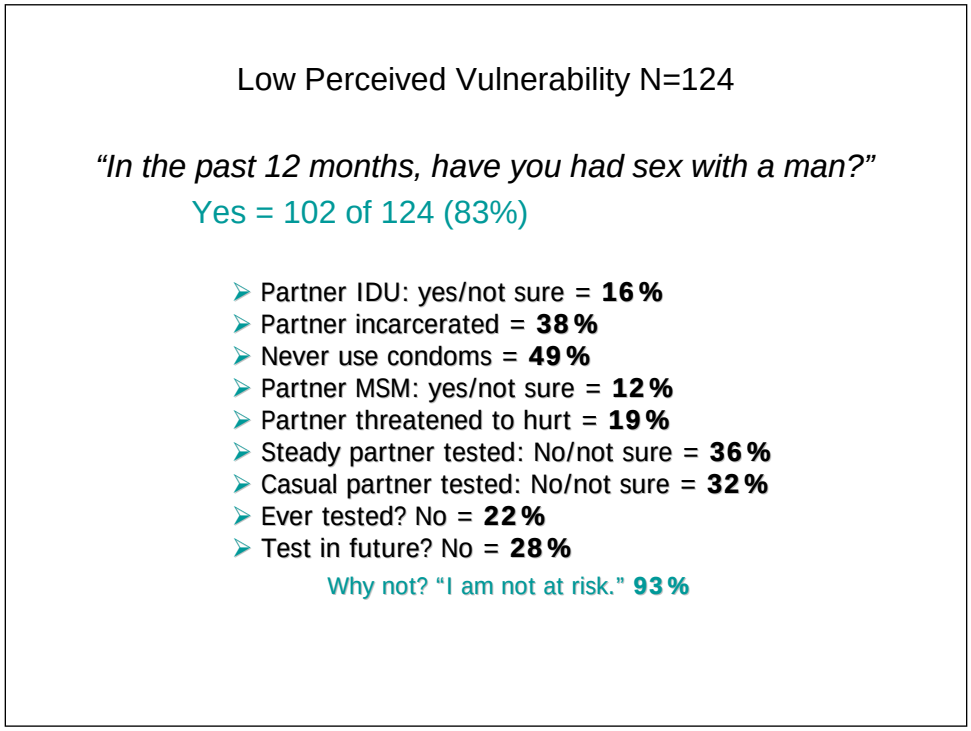
There are contradictions between how women perceive their risk and the risk behaviors they report. Among the 124 women who disagreed with the statement "I think some of the things I do may put me at risk for HIV," 23% disclosed drug use, 11% methamphetamine use, and 29% had sex while high or drunk in the past twelve months. Low perception of risk is likely to influence HIV testing. Of these 124 women, 24% had not been tested and 27% did not intend to be tested in the future, mostly because they do not consider themselves at risk (Figure 2).

Figure 2. Risk Factors of Women with Low Perception of Vulnerability N=124



Of the 124 women with low perceived vulnerability, 102 (83%) had sex with a man in the past twelve months. Almost half (49%) of these sexually active women, reported never using condoms in the past year. Women reported having male partners with risk factors: 16% with possibly injection drug using partners; 12% with partners who possibly have sex with men; and 38% with partners who had been incarcerated (Figure 3).

Figure 3. Risk Factors of Women with Low Perception of Vulnerability who are Sexually Active N=102



Sixty-four (28%) of the 232 survey participants acknowledged having at least one of the risk factors listed in the BRFSS risk question: injection drug use, treatment for a sexually transmitted disease, exchange of sex for money or drugs, or anal sex without a condom, in the past 12 months. Compared to women who said they did not have one of these risks in the past year, these 64 women indicated a higher prevalence of risk factors. However, women responding no to the BRFSS risk question were not without other risks related to substance use or sexual activity. Women with none of the BRFSS question risks were less likely to have ever tested for HIV, less likely to intend to test in the future and less likely to have used condoms with their male partners in the past year than were the women with an acknowledged risk on the BRFSS question (Tables 14 and 15).

Table 14. BRFSS Risk Question and Other Risk Factors N= 226

Yes = 64 (28%)	BRFSS Risk Question: Injection drug use, sexually transmitted disease treatment, exchange of sex for money or drugs, or anal sex without condoms in the past 12 months.	**No** = 162 (72%)
% of 64	**Other Risk Factors in the past 12 months**	% of 162
56%	Drug use	19%
33%	Methamphetamine use	9%
42%	Drinking to blackout	19%
81%	Sex while drunk or high	30%
17%	Never tested for HIV	27%
5%	No intent to test in future	23%
	(Why not? "I am not at risk")	89%

Table 15. BRFSS Question Risk and Other Risk Factors in Women with a Sex Partner in the Past 12 Months N = 226

Yes = 64	BRFSS Risk Question: Injection drug use, sexually transmitted disease treatment, exchange of sex for money or drugs, or anal sex without condoms in the past 12 months.	**No** = 162
Sex in past year Yes = 64 (100%) of 64	**Other risk factors of women with sex partners in the past year**	**Sex in past year** Yes = 130 (80%) of 162
(% of 64)		**(% of 130)**
20%	Condom use in past 12 months: Yes	55%
53%	Partner IDU: Yes/Not sure	15%
73%	Partner ever incarcerated: Yes/Not sure	39%
38%	Partner MSM: Yes/Not sure	15%
47%	Steady partner tested: No/Not sure	42%
63%	Casual partner tested: No/Not sure	37%

There are some differences in the behaviors reported by women who have never been tested for HIV compared to women who have been tested. Among the 125 women who had been tested for HIV

within in the past five years, 52% reported condom use in the past twelve months compared to 34% of the 55 women who had never had an HIV test. As shown in Table 16, women who have been tested within the past five years also report higher levels of risk factors than do the women who have never tested.

Table 16. Risk Factors Reported by Women Never Tested for HIV and by Women Tested in the Past Five Years

	Never Tested for HIV N=55 (9 not sexually active)	HIV Test within past 5 years N= 125 (12 not sexually active)
BRFSS Risk: Yes	18%	37%
Partner IDU: Yes/ Not sure	9%/ 9%	15%/ 11%
Partner ever imprisoned: Yes	27%	50%
Partner MSM: Yes/ Not sure	6%/ 7%	5%/ 18%
Drug use in past 12 months: Yes	24%	37%
Meth use in past 12 months: Yes	11%	19%
Drinking to blackout in past 12 months: Yes	24%	32%
Sex while high or drunk in past 12 months: Yes	33%	54%

Discussing Safer Sex

Most women in the survey expressed no difficulty discussing safer sex with a sex partner. Only 52 (22%) agreed with the statement "It is hard to talk about safer sex with a sex partner;" 24 (10%) were not sure.

Asked to identify reasons why they find it difficult to talk with a sex partner about safer sex or were unsure, these 76 women cited embarrassment and concerns related to their partner's reactions, but very few worried about physical retaliation (Table 17).

Table 17. Barriers to Talking about Safer Sex N=76

Reason	Number*
I would feel embarrassed.	38
He might be insulted.	37
He might think I am cheating on him.	25
Other	25
He might think I have an STD.	24
He might reject or leave me.	14
He might hurt me physically.	8

***Participants could select more than one response.

Preferences for HIV Information

Health care providers, the media, and friends were the three sources of information about HIV most often cited by the women (Appendix A, Table A5).

Slightly more than half (53%) of the women said that they had attended a presentation about HIV. Substance abuse treatment programs and high school were mentioned most often as the venue of the most recent presentation attended (Table 18).

Table 18. Location of Most Recent HIV Presentation Attended N= 124

Location of last presentation	Number	(%)
Substance Abuse Treatment Program	27	(21.8)
High school	26	(21.0)
Community Event	15	(12.1)
Workplace	14	(11.3)
Jail or prison (any correctional facility)	13	(10.5)
Other	13	(10.5)
Social Service Agency	9	(7.3)
College	6	(4.8)
Military	1	(0.8)

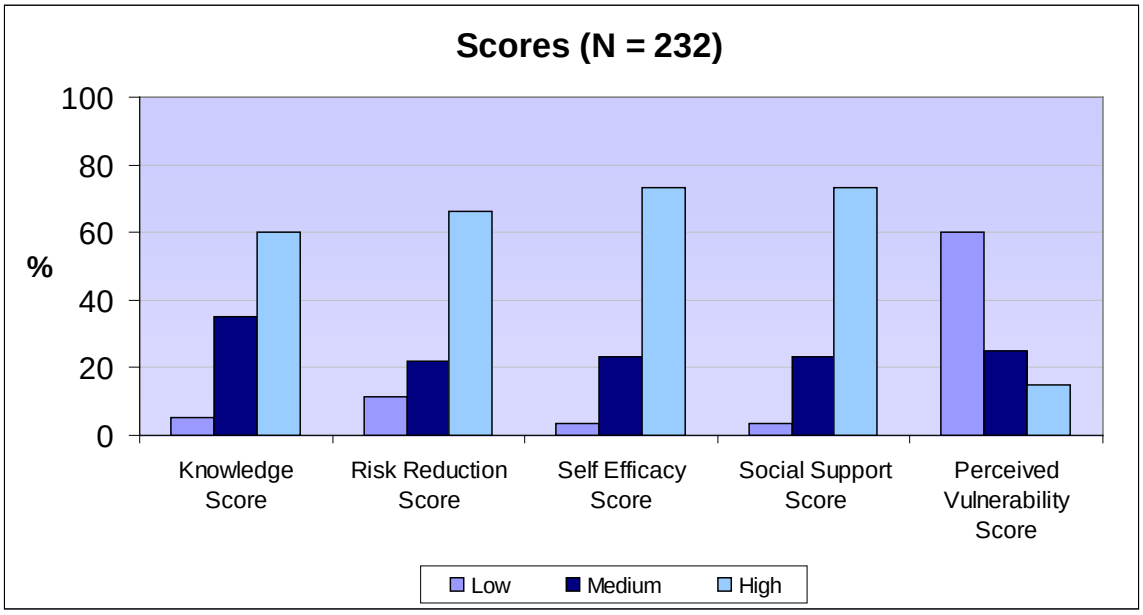
Asked about their preferences for HIV information in the future, 168 women (72%) said they would like it if their doctor or nurse talked with them about sexual health including HIV and STD prevention. One hundred twenty-two women (53%) said they would be interested in attending a women's group about women's sexual health and prevention of HIV and STDs and 142 (61%) said they would be interested in a group about how to talk with children/teens about sexual health and preventing HIV and STDs.

SUMMARY

Women were recruited for this needs assessment mainly at health clinics and social service agencies serving women with life circumstances that are associated with increased vulnerability to HIV – low income and financial dependency, housing insecurity, incarceration or partners with a history of incarceration, unequal power in relationships and experience of interpersonal violence. In addition to these social and economic risk factors, results of the needs assessment indicate the presence of a considerable level of behavioral risk factors in this population. These venues, as well as substance abuse treatment programs and health clinics providing STD and HIV testing and other reproductive health services, are clearly important venues for HIV education and counseling.

As research on behavior change informs us, knowledge alone is not sufficient to make changes in health behaviors. Change also requires motivation, social support, self-efficacy, and access to necessary resources. Women in this sample were very knowledgeable about HIV transmission, risk reduction, and HIV testing resources. They also indicated high levels of social support for HIV concerns, and confidence in their ability to talk about and negotiate safer behaviors with sex partners. These high levels of knowledge, self-efficacy, and social support are in contrast to the relatively low level of perceived vulnerability, a key component to behavior change (Figure 4).

Figure 4. Knowledge, Self-Efficacy, Social Support, and Perceived Vulnerability Scores N=232



Many of the women with a low perception of risk reported a constellation of behavioral risk factors and lack of using protection, even with male partners whose HIV status was unknown despite known or suspected risk factors. Inaction about HIV risk reduction and testing is a logical consequence of believing one is not at risk for HIV. The challenge is how to motivate women to realistically evaluate their risks and to support their decisions to adopt safer behaviors. To that end, community organizations and providers of health and social services can help make risk reduction and voluntary HIV testing a routine part of the lives of women. Women in the survey indicated an interest in attending presentations about sexual health and HIV/STD prevention. Parenting women can be motivated to attend forums focused on educating their children on these topics. Women in the survey were receptive to having their health care providers talk with them about sexual health and HIV/STD prevention. This is compatible with recent recommendations by the Centers for Disease Control and Prevention on routine HIV testing of adults, adolescents, and pregnant women in health-care settings.[8] HIV education is best coupled with individualized risk assessment and motivational enhancement when feasible. This can take place in the context of routine reproductive health care, in association with HIV testing, and can also be incorporated into treatment plans for women in substance abuse treatment and pre-release counseling for incarcerated women. All agencies and community organizations can participate in routinizing HIV prevention and testing by displaying educational materials and resource information, thereby sending a clear message that all women should think about HIV prevention.

Appendix B

2013-2016 List of Acronyms

3MV	Many Men, Many Voices
ACS	American Community Survey
ADAP	AIDS Drug Assistance Program
AKDOL	Alaska Department of Labor and Workforce Development
AMP	Alaska Mpowerment Project
AN/AI	Alaska Natives and American Indians
AIDS	Acquired Immune Deficiency Syndrome
AK	Alaska
ANHC	Anchorage Neighborhood Health Center
ANTHC	Alaska Native Tribal Health Consortium
A/PI	Asian/Pacific Islander
ART	Antiretroviral Therapy
ASE	Anchorage Syringe Exchange
AYA	Alaska Youth Advocates (formerly Alaska Youth and Parents Foundation)
BHA	Behavioral Health Aide
BRFSS	Behavioral Risk Factor Surveillance System
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CHA	Community Health Aide
CLEAR	Choosing Life: Empowerment! Action! Results!
CRIS	Capacity-Building Request Information System
CSPS	Comprehensive STD Prevention Programs
CT	Chlamydia trachomatis
CTR	(HIV) Counseling, Testing, and Referral
DASH	Division of Adolescent and School Health, CDC
DBH	Division of Behavioral Health
DEBI	Diffusion of Effective Behavioral Interventions Project
DHAP	CDC Division of HIV/AIDS Prevention
DHSS	Department of Health and Social Services, State of Alaska
DIS	Disease Intervention Specialist
DPH	Alaska Division of Public Health
EBI	Evidence-Based Intervention
EIS	Ryan White Early Intervention Services
EPSTD	Early and Periodic Screening, Diagnostic, and Treatment Services
FIO	The Future is Ours

Four A's (4A's)	Alaskan AIDS Assistance Association
FOA	Federal Opportunity Announcement
FOY	Focus on Youth + ImPACT (Informed Parents & Children Together)
FY	Fiscal Year
GC	Neisseria gonorrhoeae
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HD	Health Department
HIP	High Impact Prevention
HE/RR	Health Education and Risk Reduction
HHRP	Holistic Health Recovery Program
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People with AIDS
HPPG	Alaska HIV Prevention Planning Group
HPG	Alaska HIV Planning Group
HRH	High Risk Heterosexual
HRSA	Health Resources and Services Administration
IAA	Interior AIDS Association
IDU	Injection Drug User
ILP	Infant Learning Program
IYG	It's Your Game…Keep It Real
L2C	Linkage to Care
M&E	Monitoring and Evaluation
MCM	Medical Case Management
mHealth	Mobile Health (the practice of medicine and public health, supported by mobile devices)
MIP	Modelo de Intervenciòn Psicomèdica
MOARHC	Municipality of Anchorage Reproductive Health Clinic
MSM	Men Who Have Sex with Men
NARCH	Native American Research Centers for Health
NDTC	Narcotic Drug Treatment Center
NE	Northern Exchange
NHAS	National HIV/AIDS Strategy for the United States
NH/PI	Native Hawaiian/Pacific Islander
NIR	No Identified Risk
NRR	No Risk Reported
NWAETC	Northwest AIDS Education and Training Center
nPEP	Non-Occupational Post Exposure Prophylaxis
PS	Partner Services
PLWHA	People Living With HIV and/or AIDS
POL	Popular Opinion Leader
POWER	AYA Peer Outreach Worker Education and Referral Program
PRAMS	Pregnancy Risk Assessment Monitoring System

PrEP	Pre-Exposure Prophylaxis
PROMISE	Peers Reaching Out and Modeling Intervention Strategies
PS	Partner Services
PSD	Project Special Delivery
PS12-1201	CDC FOA – Comprehensive HIV Prevention Programs for Health Departments
PfH	Partnership for Health
PwP	Prevention with Positives
QA	Quality Assurance
RAPP	Real AIDS Prevention Project
RFP	Request for Proposals
RurAL CAP	Rural Alaska Community Action Program
RWCA	Ryan White HIV/AIDS Treatment Modernization Care Act
S+C	Shelter Plus Care
SAMHSA	Substance Abuse and Mental Health Services Administration
SCO	Street and Community Outreach
SCSN	Statewide Coordinated Statement of Need
SEARHC	Southeast Alaska Regional Health Consortium
SEP	Syringe Exchange Program
SHEP	School Health Education Profile
SHIELD	Self-Help in Eliminating Life-threatening Diseases
SHP	Supportive Housing Program
SIHLE	Sisters Informing, Healing, Living, and Empowering
SISTA	Sisters Informing Sisters on Topics about AIDS
SITV	Safe in the Village
SM/PI	Social Marketing/Public Information
SOE	Alaska Section of Epidemiology
SPHL	State Public Health Laboratory
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SVL	State Virology Laboratory
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TLC	Together Learning Choices or Teens Linked to Care
UAA	University of Alaska Anchorage
VOICES/VOCES	Video Opportunities for Innovative Condom Education and Safer Sex
WCFH	Alaska Section of Women's, Children's, and Family Health
WIC	Women, Infants, and Children
WILLOW	Women Involved in Life Learning from Other Women
YRBS	Youth Risk Behavior Survey

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